



स्वास्थ्य एवं
परिवार कल्याण मंत्रालय
MINISTRY OF
HEALTH AND
FAMILY WELFARE



17th COMMON REVIEW MISSION



NOVEMBER 2025

17th

**COMMON REVIEW
MISSION**

NOVEMBER 2025

2025



जगत प्रकाश नड्डा
JAGAT PRAKASH NADDA



मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India

MESSAGE

Ministry of Health & Family Welfare remains firmly committed to strengthening public health systems to ensure equitable access towards affordable and quality healthcare for all. The National Health Mission (NHM) continues to play a pivotal role in improving service delivery, strengthening institutional capacities and enhancing overall performance of health system, guided by evidence-based policies rooted in field-level realities.

The National Common Review Mission (CRM) serves as a critical platform for assessing extent of programme implementation, quality of care and governance processes across States and Union Territories. Since its inception, CRM has generated valuable field-based evidence to inform policy decisions and programmatic improvements. Findings of the 17th CRM highlight both achievements and priority areas for focused action under NHM.

As India advances towards the vision of *Viksit Bharat 2047*, strengthening a resilient, responsive and integrated health system remains a national priority. The insights and recommendations emerging from CRM will support States and Union Territories in further refining their strategies to address emerging needs and ensure all inclusive, people-centred healthcare delivery system.

I commend the dedicated efforts of the officials of the Ministry, our field experts, CRM teams and participating States and Union Territories for building and sustaining this important platform for knowledge generation, learning and evidence-based action under NHM.

(Jagat Prakash Nadda)

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अनुप्रिया पटेल
ANUPRIYA PATEL



Message

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MINISTER OF STATE
HEALTH & FAMILY WELFARE
AND CHEMICALS & FERTILISERS
GOVERNMENT OF INDIA



The National Common Review Mission (CRM), conducted by the Ministry of Health & Family Welfare, is a key instrument of the Government of India for ensuring accountable, responsive, and outcome-oriented implementation of the National Health Mission across States and Union Territories.

The CRM brings together policymakers, programme managers, public health experts, academicians and implementing agencies, enabling a comprehensive understanding of health system functioning at the grassroots level. These collaborative engagements reinforce cooperative federalism and contribute significantly to strengthening governance, efficiency, equity, and accountability within the public healthcare system.

The Seventeenth CRM was undertaken at a significant moment, as India advances decisively towards the vision of *Viksit Bharat 2047*. Over the years, sustained policy reforms and focused investments by the Government have resulted in notable improvements in access, equity, and affordability of healthcare services. Robust review mechanisms such as the CRM remain central to translating national health goals into measurable outcomes, particularly in addressing last-mile challenges and improving service quality. This helps us to develop more citizen centric and equitable policies towards Government's principle of *Leaving no one behind*.

I congratulate the Ministry of Health & Family Welfare, along with all States and Union Territories, for generating rich evidence and for strengthening institutional learning, knowledge management, and evidence-based decision-making under the National Health Mission.


(Anupriya Patel)

April 24, 2026
New Delhi.

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प्रतापराव जाधव
PRATAPRAO JADHAV



सत्यमेव जयते



राज्य मंत्री (स्वतंत्र प्रभार)
आयुष मंत्रालय
व
राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार
MINISTER OF STATE
(INDEPENDENT CHARGE) OF
MINISTRY OF AYUSH AND
MINISTER OF STATE OF
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

FOREWORD

I am pleased to reaffirm the Ministry of Health and Family Welfare's unwavering commitment to strengthening the monitoring of healthcare initiatives and programmes at both the national and state levels through the 17th Common Review Mission (CRM). As a structured exercise for evidence generation, the CRM plays a critical role in identifying key enablers and challenges in last-mile implementation, thereby ensuring Government policies are effectively translated into measurable outcomes on the ground. The Government remains committed to advancing Universal Health Coverage, anchored in the principles of equity, accessibility, affordability, and quality of care. Concurrently, focused efforts continue to strengthen a resilient and responsive public health system that can address current as well as future health needs and challenges.

Under the leadership of Hon'ble Prime Minister and the guidance of Hon'ble Union Minister of Health and Family Welfare, significant strides have been made to strengthen health systems and expand the reach of essential health services across the country. Regular monitoring mechanisms such as the CRM reaffirm the Government's commitment to continuously improve health outcomes and ensure that all citizens receive affordable, equitable, and quality healthcare.

I commend the commitment and diligence shown by the members of the 17th CRM teams in undertaking this extensive exercise. Their findings offer useful guidance for improving programme implementation, strengthening accountability, and supporting informed decision-making by States and Union Territories.

The long-term effectiveness of our health programmes will rest on our shared capacity to adapt to changing contexts, foster innovation and respond proactively to emerging challenges. I am confident that the insights and recommendations arising from the 17th CRM will serve as a valuable resource in strengthening policy and programme implementation and will contribute substantially to the development of a robust, responsive, and future-ready public health system for the nation.

New Delhi.
24th April, 2026.

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पुण्य सलिता श्रीवास्तव, भा.प्र.से.
सचिव

PUNYA SALILA SRIVASTAVA, IAS
Secretary



सत्यमेव जयते



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

It is my privilege to present this foreword to the Common Review Mission (CRM), a distinctive and integral feature of the National Health Mission (NHM), which plays a vital role in strengthening health systems through collective reflection, learning and accountability. This report provides a comprehensive and nuanced assessment of the progress achieved and the performance of NHM across 17 States, offering valuable insights to guide evidence-based decision making.

NHM has several commendable features, among which the CRM stands out as a distinctive and valuable mechanism for institutional learning and program strengthening. Conducted annually with teams comprising diverse skill sets and technical expertise, this exercise brings together the collective insights of public health practitioners and researchers from across the country. NHM has significantly strengthened India's health system; and institutionalized by the Ministry of Health and Family Welfare, the CRM remains a key mechanism for evidence-based programme review and timely mid-course corrections. It provides a comprehensive, field-based assessment of health systems, offering an integrated view of systemic strengths and challenges affecting the delivery of quality healthcare. Its findings span key domains of health systems strengthening and address programmatic aspects across all NHM thematic areas, as well as relevant allied sectors. I place on record my appreciation of the CRM teams for their dedication and diligence in conducting the exercise across diverse contexts. I acknowledge the NHM teams in States and UTs and community members for their active participation and cooperation.

The recommendations emerging from this detailed report will serve as important and informative inputs in guiding future strategies and policy measures for further strengthening the health systems framework. The Ministry remains firmly committed to working in close collaboration with States and all stakeholders to identify and address key challenges and barriers in the delivery of quality healthcare services, with the overarching objective of ensuring care that is equitable, affordable, and accessible to all.

I am confident that the insights generated through the 17th CRM will make a meaningful contribution to advancing the goal of **"Health for All"** furthering the vision of a **Viksit Bharat @2047**.

Date : 23.04.2026
Place : New Delhi

Punya Salila
(Punya Salila Srivastava)

#StopObesity

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अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)

Aradhana Patnaik, IAS

Additional Secretary & Mission Director (NHM)



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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

The National Health Mission (NHM) plays a vital role in strengthening Programme implementation across States and Union Territories, thereby improving health service delivery and outcomes. Effective implementation requires regular, field-based review and continuous assessment of systems at all levels. Accordingly, MoHFW undertakes periodic assessments and the annual Common Review Mission (CRM) to capture field realities and guide Programme improvements. Sixteen CRMs have been completed, generating valuable evidence that has strengthened Programme implementation by leveraging existing strengths and enabling timely corrective measures to address gaps.

In the current year, NHM undertook a significant redesign of its monitoring and review activities through *Seventeenth CRM*, to ensure that outcomes are firmly grounded in evidence from the field. This shift was aimed at reducing reliance on secondary data, which is already available through established digital platforms; and instead directing efforts towards identifying the key strengths and weaknesses in Programme implementation. Teams received secondary information, but the on-ground exercise focused on validation and real-time, state-specific challenges. This enabled tailored solutions, fostering customized strategies that strengthened Programme delivery.

The *17th CRM* marked a significant milestone in our collective journey towards achieving the objectives of the National Health Policy (NHP) 2017 and the Sustainable Development Goals (SDGs). Multidisciplinary teams, comprising policymakers, implementers, researchers, and public health experts worked in close interdepartmental coordination to embody the principle of inclusivity, in alignment with the national vision of *Health in All Policies*.

Covering 17 States, the mission ensured broad representation and diversity of contexts, thereby generating robust, state-specific evidence. This evidence serves as a critical foundation for designing responsive and targeted strategies to strengthen health systems. By integrating diverse perspectives and fostering collaborative engagement, the CRM has reaffirmed our commitment to building resilient, equitable, and sustainable health care delivery mechanisms that advance India's progress towards universal health coverage and global health goals.

I extend my sincere appreciation to all stakeholders of the *17th CRM*, State/UT governments, ministries beyond health, MoHFW, NHSRC, and above all, **our field teams**. Their collective efforts in evidence generation and knowledge management remain central to effective programme implementation. This exercise underscores the importance of translating knowledge into action. I urge policymakers, implementers, and stakeholders to utilize the evidence generated to strengthen programme outcomes and advance a resilient, inclusive, and responsive public health system.

Dated: 28th April, 2026

(Aradhana Patnaik)

#StopObesity

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Message

Within the defined framework of NHM, the *Common Review Mission (CRM)* plays a vital role in shaping policy direction. By conducting systematic assessments across States/UT, CRM provides evidence-based insights into program implementation, highlights gaps, and identifies best practices that can be replicated nationwide. This participatory review process ensures accountability, transparency, and responsiveness in policy formulation. Most importantly, CRM enables mid-course corrections, ensuring that our strategies remain adaptive to ground realities and aligned with the mission's vision of decentralized, community-owned health systems. Thus, CRM is not merely a monitoring exercise, but a powerful policy instrument that strengthens the NHM and advances our collective goal of better health outcomes for all.

The 17th CRM undertaken across seventeen States in November 2025, represents a comprehensive assessment of health system performance across critical domains of Health Systems Strengthening, spanning community and facility-based levels of care. It has brought to light significant advances in the health care service delivery. It further reflects a deepening commitment to quality, with greater adherence to protocols and standard treatment guidelines, alongside sustained efforts to fortify critical health system enablers across the domains of health systems strengthening.

I acknowledge the invaluable contributions of all stakeholders from the CRM teams, MoHFW/NHSRC teams, public health experts & researchers, participating ministries, and most importantly State teams, whose dedicated efforts made this exercise possible. Their continued commitment remains central to advancing India's public health goals. I am confident that the findings and recommendations presented herein will serve as a vital resource for strategic planning & policy making and reinforce collective efforts to strengthen service delivery across all levels of care.

As we move forward, let this report stand as both a testament to collaborative achievement and a guiding framework for building resilient, inclusive, and equitable health systems that embody the vision of a healthier India.


(Sibin C.)

Dated:- 27th April 2026

Room No. 11036-37, 'A' Wing, Kartavya Bhawan-1, New Delhi-110001



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MBBS, MD (Community Medicine), MBA

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Ministry of Health and Family Welfare

Government of India



Message

NHM framework places strong emphasis on monitoring and evaluation as a cornerstone of accountability and evidence-based decision making. It highlights Common Review Mission (CRM) as an effective monitoring and review mechanism with a multi-tiered approach that ensures transparency, enables timely identification of gaps, and promotes adaptive strategies responsive to diverse State/UT contexts. By combining ground level insights with programmatic orientation, the mechanism reinforces inclusivity, strengthens Programme management & advances the collective goal of building resilient and equitable health systems.

Redesigned in alignment with MoHFW efforts towards National Health priorities, the 17th CRM adopted a structured and participatory methodology designed to capture ground level realities and diverse state experiences. Multidisciplinary teams comprising officials from the MoHFW, NHSRC, Public Health Experts, Academia, SHSRC/PRCs, concerned Ministries and State health departments undertook extensive field visits to health facilities, including interactions with service providers, frontline workers, and communities. Evidence was triangulated through direct observations, facility records, data and community feedback, ensuring a comprehensive and credible assessment of Programme performance. This approach not only highlights systemic strengths and challenges but also documents innovations and best practices that can be adapted and replicated, thereby reinforcing accountability, enabling mid-course corrections, and strengthening the responsiveness of India's health systems.

I extend my sincere appreciation to the teams involved in designing the Terms of Reference, engaging actively in field interactions, and documenting the results that have culminated in this evidence rich report. Each contribution has been integral to strengthening this platform of knowledge management and evidence generation. The proactive support of the States further magnified the enthusiasm of our CRM teams in the field, a spirit that is clearly reflected in the observations captured and shared. These collective measures are driving a more structured, patient-centric, and responsive model of service delivery, underscoring the resolve to build resilient and equitable health systems.

The national report of the 17th CRM stands not only as robust evidence to inform policy decisions, but also as a testimony to the dedicated efforts of the CRM teams and the proactive approach demonstrated by the respective States. It reflects the collective resolve to strengthen India's health systems through collaboration, innovation, and accountability. As we advance, this report shall serve both as evidence for strategic action reflecting our collective resolve to deliver robust, inclusive, and equitable healthcare services through NHM and beyond.

27th April 2026

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ABBREVIATIONS

4Ds	Defects at birth, Diseases, Deficiencies, and Developmental delays
AAM	Ayushman Arogya Mandir
ABDM	Ayushman Bharat Digital Mission
ABG	Arterial Blood Gas
ABHA	Ayushman Bharat Health Account
ABSULS	Active Case Detection & Regular Surveillance for Leprosy
ACLS	Advanced Cardiac Life Support
ACT	Artemisinin-based Combination Therapy
ADL	Activity of Daily Life
ADR	Adverse Drug Reaction
AEFI	Adverse Events Following Immunisation
AERB	Atomic Energy Regulatory Board
AFHC	Adolescent Friendly Health Clinic
AIDS	Acquired Immunodeficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ALS	Advance Life Support
AMB	Anaemia Mukht Bharat
AMC	Annual Maintenance Contract
AMR	Antimicrobial Resistance
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMOL	ANM Online
APBS	Aadhaar Payment Bridge System
APHC	Additional Primary Health Centre
API	Application Programming Interface
API	Annual Parasite Incidence
ARI	Acute Respiratory Infections
ART	Anti-Retroviral Therapy
ARV	Anti-Rabies Vaccine
ASE	Audited Statements of Expenditure
ASHA	Accredited Social Health Activists
ASV	Anti-Snake Venom
AVVY	Ayushman Vay Vandana Yojana
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga Unani Siddha Homeopathy
BAM	Block Accounts Manager
BCM	Block Community Mobiliser
BDM	Block Data Manager

BEMMP	Biomedical Equipment Maintenance and Management Program
BEmONC	Basic Emergency Obstetric and Newborn Care
BERA	Brainstem Evoked Response Audiometry
BHAVYA	Bihar Health Application Visionary Yojana for All
BLS	Basic Life Support
BMW	Bio-Medical Waste
BPHL	Block Public Health Laboratory
BPHO	Block Public Health Officer
BPHU	Block Public Health Unit
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
CAC	Comprehensive Abortion Care
CAPD	Continuous Ambulatory Peritoneal Dialysis
CBAC	Community Based Assessment Checklist
CBNAAT	Cartridge-Based Nucleic Acid Amplification Test
CBWTF	Common Bio-medical Waste Treatment Facility
CCB	Critical Care Block
CCU	Coronary Care Unit
CDR	Child Death Review
CDSR	Child Death Surveillance and Response
CEA	Clinical Establishments (Registration and Regulation) Act, 2010
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CFMS	Comprehensive Financial Management System
CGA	Comprehensive Geriatric Assessment
CHC	Community Health Centre
CHO	Community Health Officer
CKD	Chronic Kidney Disease
CLMC	Comprehensive Lactation Management Centre
CMC	Comprehensive Maintenance Contract
CME	Continuous Medical Education
CMHIS	Chief Minister's Health Insurance Scheme
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
COTPA	The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003
CPAP	Continuous Positive Airway Pressure
CPHC	Comprehensive Primary Health Care
CPR	Cardiopulmonary Resuscitation
CRM	Common Review Mission
CRS	Civil Registration System

CS	Central Sector
CSR	Corporate Social Responsibility
CSS	Centrally Sponsored Scheme
CSSD	Central Sterile Supply Department
CT	Computed Tomography
DAC	District Audit Committee
DALYs	Disability Adjusted Life Years
DAM	District Accounts Manager
DBC	Domestic Breeding Checker
DBT	Direct Benefit Transfer
DCCC	Day Care Cancer Centre
DCM	District Community Mobiliser
DDC	Drug Distribution Counter
DDMIS	Drug Distribution Management Information System
DEIC	District Early Intervention Centre
DEO	Data Entry Operator
DH	District Hospital
DHAP	District Health Action Plan
DHQ	District Head Quarter
DHS	District Health Society
DIO	District Immunization Officer
DM&HO	District Medical & Health Officer
DM	Diabetes Mellitus
DMHP	District Mental Health Programme
DNB	Diplomate of National Board
DoE	Department of Expenditure
DPDMIS	Drug Procurement and Distribution Management Information System
DPM	District Program Manager
DPMU	District Programme Management Unit
DQAC	District Quality Assurance Committee
DTCC	District Tobacco Control Centre
DVDMS	Drug & Vaccine Distribution Management System
ECG	Electrocardiogram
ECRP	Emergency Covid Response Package
EDL/EML	Essential Drugs List/Essential Medicine List
ELISA	Enzyme-Linked Immunosorbent Assay
EMAS	Emergency Medical Ambulance Services
EMR	Electronic Medical Record
EMRI	Emergency Management and Research Institute
EMT	Emergency Medical Technicians
ENT	Ear Nose Throat

EPF	Employee Provident Fund
EPFO	Employee Provident Fund Organisation
EPS	Expanded Package of Services
EQAS	External Quality Assurance System
ETAT	Emergency Triage Assessment and Treatment
ETP	Effluent Treatment Plant
EVA	Electric Vacuum Aspiration
e-VIN	Electronic Vaccine Intelligence Network
FBNC	Facility Based Neonatal Care
FDSI	Free Drugs Service Initiative
FDSI	Free Diagnostics Service Initiative
FEFO	First Expiry, First Out
FHC	Family Health Centre
FIFO	First In, First Out
FMR	Financial Monitoring Report
FP	Family Planning
FPLMIS	Family Planning Logistics Management Information System
FRS	Face Recognition System
FRU	First Referral Unit
GDMO	General Duty Medical Officer
GeM	Government e-Marketplace
GFR	General Financial Rules
GGE	General Government Expenditure
GH	General Hospital
GHE	Government Health Expenditure
GIS	Geographic Information System
GJAY	Gopabandhu Jana Arogya Yojana
GNM	General Nursing and Midwifery
GoI	Government of India
GPS	Global Positioning System
GSDP	Gross State Domestic Product
GST	Goods & Services Tax
GTT	Glucose Tolerance Test
HBIG	Hepatitis B Immunoglobulin
HBNC	Home Based Newborn Care
HBsAg	Hepatitis B Surface Antigen
HBVC	Home Based Young Child Care
HCV	Hepatitis C Virus
HCW	Health Care Worker
HDI	Health Dynamics of India
HDU	High Dependency Unit

HIV	Human Immunodeficiency Virus
HMC	Hospital Management Committee
HMIS	Health Management Information System
HPCL	High Performance Liquid Chromatography
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HRP	High Risk Pregnancy
HSS	Health Systems Strengthening
HTN	Hypertension
HVAC	Heating, Ventilation and Air Conditioning
HWC	Health & Wellness Centre
ICC	Internal Complaints Committee
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
IDSP-IHIP	Integrated Disease Surveillance Programme – Integrated Health Information Platform
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IFHRMS	Integrated Financial and Human Resource Management System
IFMIS	Integrated Financial Management Information System
IgM	Immunoglobulin M
IHMIS	Integrated Health Management Information System
ILR	Ice Lined Refrigerator
IM	Infrastructure Maintenance
IMNCI	Integrated Management of Newborn and Child Illnesses
IMR	Infant Mortality Rate
IPC	Infection Prevention & Control
IPD	In-Patient Department
IPHL	Integrated Public Health Laboratory
IPHS	Indian Public Health Standards
IQAS	Internal Quality Assurance System
IUCD	Intra Uterine Contraceptive Device
IYCN	Infant & Young Child Nutrition
JAS	Jan Arogya Samiti
JHI	Junior Health Inspector
JPHN	Junior Public Health Nurse
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KFT	Kidney Function Test
KMC	Kangaroo Mother Care
LAMA	Left Against Medical Advice

LaQshya	Labour Room Quality Improvement Initiative
LASA	Look Alike Sound Alike
LBW	Low Birth Weight
LCDC	Leprosy Case Detection Campaign
LDR	Labour, Delivery & Recovery
LED	Light Emitting Diode
LF-MDA	Lymphatic Filariasis – Mass Drug Administration
LFT	Liver Function Test
LIMS	Laboratory Information Management System
LLIN	Long-Lasting Insecticidal Net
LMIS	Logistics Management Information System
LOI	Letter of Intent
LSAS	Life Saving Anaesthesia Skills
LSCS	Lower Segment Caesarean Section
LSG	Local Self Government
LT	Laboratory Technician
MAA	Mothers' Absolute Affection
MAM	Moderate Acute Malnutrition
MaNTrA	Mentoring and Training for Health Providers
MAS	Mahila Arogya Samiti
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCCD	Medical Certification of Cause of Death
MCH	Maternal and Child Health
MCP	Mother and Child Protection
MDR	Maternal Death Review
MDT	Multi-Drug Therapy
MHA	Mental Healthcare Act, 2017
MHT	Mobile Health Team
MLC	Medico-Legal Case
MLHP	Mid-Level Health Provider
MMA	Medical Methods of Abortion
MMDSL	Meghalaya Medical Drugs & Services Limited
MMR	Maternal Mortality Ratio
MMSE	Mini-Mental State Examination
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MoU	Memorandum of Understanding
MPHW	Multipurpose Health Worker
MPW	Multipurpose Worker
MR	Measles Rubella

MRI	Magnetic Resonance Imaging
MTM	Makkalai Thedi Maruthuvam
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NAAT	Nucleic Acid Amplification Test
NABL	National Accreditation Board for Testing and Calibration Laboratories
NACP	National AIDS Control Programme
NAFLD	Non-alcoholic fatty liver disease
NBCC	New-born Care Corner
NBEMS	National Board of Examinations in Medical Sciences
NBSU	Newborn Stabilization Unit
NCDC	National Centre for Disease Control
NVBDCP	National Vector Borne Diseases Control Programme
NDCP	National Disease Control Programme
NFHS	National Family Health Survey
NHA	National Health Accounts
NHM	National Health Mission
NIC	National Informatics Centre
NICU	Neonatal Intensive Care Unit
NIDDCP	National Iodine Deficiency Disorders Control Programme
NIMHANS	National Institute of Mental Health and Neurosciences
NIRNAYA	Nava Kerala Integrated Referral Network for Advanced Diagnostics and Care
NLEP	National Leprosy Elimination Programme
NMHP	National Mental Health Programme
NOC	No Objection Certificate
NOHP	National Oral Health Programme
NP-NCD	National Programme for Prevention & Control of Non-Communicable Diseases
NPCBVI	National Programme for Control of Blindness & Visual Impairment
NPCCHH	National Programme on Climate Change and Human Health
NPCI	National Payments Corporation of India
NPHCE	National Programme for Health Care for Elderly
NPPC	National Programme for Palliative Care
NPPCD	National Programme for Prevention and Control of Deafness
NPPCF	National Programme for Prevention and Control of Fluorosis
NPPCL	National Program for Prevention and Control of Leptospirosis
NPPCSE	National Programme for Prevention and Control of Snakebite Envenoming
NPPMT & BI	National Programme for Prevention and Management of Trauma and Burn Injuries
NPS	New Pension Scheme

NPY	Nikshay Poshan Yojana
NQAS	National Quality Assurance Standards
NRC	Nutritional Rehabilitation Centre
NRCP	National Rabies Control Programme
NRT	Nicotine Replacement Therapy
NSCAEM	National Sickle Cell Anaemia Elimination Mission
NSSK	Navjaat Shishu Suraksha Karyakram
NSV	No-Scalpel Vasectomy
NTCP	National Tobacco Control Programme
NTEP	National Tuberculosis Elimination Programme
NVBDCP	National Vector Borne Disease Control Programme
NVHCP	National Viral Hepatitis Control Program
OAE	Otoacoustic Emissions
OBG	Obstetrics and Gynaecology
OCP	Oral Contraceptive Pill
ODK	Open Data Kit
OGTT	Oral Glucose Tolerance Test
OJAS	Online Job Application System
OOAT	Outpatient Opioid Assisted Treatment
OOPE	Out-of-Pocket Expenditure
OPD	Out-Patient Department
ORS	Oral Rehydration Solution
OSC	One Stop Centre
OT	Operating Theatre
OVP	Open Vial Policy
PBI	Performance Based Incentive
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PCTS	Pregnancy, Child Tracking & Health Services Management System
PEP	Post-Exposure Prophylaxis
PESA	Panchayats (Extension to Scheduled Areas) Act, 1996
PFMS	Public Financial Management System
PHC	Primary Health Centre
PHMC	Public Health Management Cadre
PICME	Pregnancy and Infant Cohort Monitoring and Evaluation
PICU	Paediatric Intensive Care Unit
PIMS	Personal Information Management System
PIP	Programme Implementation Plan
PLHIV	People Living with HIV
PLP	Performance Linked Payments
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PM-JAY	Pradhan Mantri Jan Arogya Yojana

PM-JJBY	Pradhan Mantri Jeevan Jyoti Bima Yojana
PM-SBY	Pradhan Mantri Suraksha Bima Yojana
PM-SYM	Pradhan Mantri Shram Yogi Maan Dhan Yojana
PMNDP	Pradhan Mantri National Dialysis Programme
PMOA	Para Medical Ophthalmic Assistant
PMS	Performance Management System
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PMSSY	Pradhan Mantri Swasthya Suraksha Yojana
PNC	Post Natal Care
POCSO	Protection of Children from Sexual Offences Act
POSH	Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013
POSHAN	Prime Minister's Overarching Scheme for Holistic Nutrition
PPE	Personal Protective Equipment
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPP	Public-Private Partnership
PPTCT	Prevention of Parent-to-Child Transmission
PRBC	Packed Red Blood Cells
PRC	Population Research Centre
PRI	Panchayati Raj Institutions
PRP	Platelet Rich Plasma
PSA	Pressure Swing Adsorption
PTV	Patient Transport Vehicle
PWS	Performance Work Statement
RBI	Reserve Bank of India
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive & Child Health
RDT	Rapid Diagnostic Test
RFID	Radio Frequency Identification
RFP	Request for Proposal
RH	Rural Hospital
RHS	Rural Health Statistics
RI	Routine Immunisation
RIG	Rabies Immunoglobulin
RKS	Rogi Kalyan Samiti
RKSK	Rashtriya Kishor Swasthya Karyakram
RMA	Rural Medical Assistant
RMNCAH+N	Reproductive, Maternal, Neonatal, Child, Adolescent Health & Nutrition
RMO	Resident Medical Officer
RMP	Registered Medical Practitioner
RNA	Ribonucleic Acid

RO	Reverse Osmosis
RoP	Record of Proceedings
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SAC	State Audit Committee
SAM	Severely Acute Malnutrition
SBA	Skilled Birth Attendant
SBCC	Social and Behaviour Change Communication
SDH	Sub-District Hospital
SDR	Surveillance and Disease Reporting
SHC	Sub-Health Centre
SHG	Self Help Group
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SLS	State Linked Schemes
SMHA	State Mental Health Authority
SN	Staff Nurse
SNA	Single Nodal Account
SNA-SPARSH	Single Nodal Account - Software Platform for Assistance, Resources & Scheme Handling
SNCU	Special Newborn Care Unit
SoE	Statement of Expenditure
SOP	Standard Operating Procedure
SPMU	State Programme Management Unit
SRB	Sex Ratio at Birth
SRS	Sample Registration System
STEMI	ST Elevated Myocardial Infarction
STG	Standard Treatment Guidelines
STP	Sewage Treatment Plant
SUMAN	Surakshit Matritva Aashwasan
SWAAS	Step Wise Approach to Airway Syndromes
TAT	Turn Around Time
TB	Tuberculosis
TBI	Team Based Incentive
TCC	Tobacco Cessation Centre
TD	Tetanus and Diphtheria
TDS	Tax Deducted at Source
Tele MANAS	Tele Mental Health Assistance and Networking Across States
TFR	Total Fertility Rate
THE	Total Health Expenditure
THO	Taluka Health Officer

TLD	Thermo-Luminescent Dosimeter
TMT	Treadmill Test
TNA	Training Needs Assessment
TOFEI	Tobacco Free Educational Institutions
ToR	Terms of Reference
TPT	TB Preventive Therapy
TSH	Thyroid Stimulating Hormone test
TVVP	Telangana Vaidya Vidhana Parishad
U5MR	Under 5 Mortality Rate
UAAM	Urban Ayushman Arogya Mandir
UC	Utilization Certificate
UDSP	Unified Disease Surveillance Portal
UHC	Universal Health Coverage
UHID	Unique Health Identification Number
ULB	Urban Local Body
UNDP	United Nations Development Programme
UNHS	Universal Neonatal Hearing Screening
UPHC	Urban Primary Health Centre
USG	Ultrasonography
USHC	Urban Sub Health Centre
UTI	Urinary Tract Infections
UWIN	Universal Immunization WIN
VBD	Vector Borne Disease
VED	Vital, Essential, Desirable
VHND	Village Health & Nutrition Day
VHSNC	Village Health Sanitation & Nutrition Committee
VIA	Visual Inspection with Acetic Acid
VPD	Vaccine Preventable Disease
WHV	Women Health Volunteers
WIFS	Weekly Iron & Folic Acid Supplementation
XV-FC	XV th Finance Commission



MANDATE & METHODOLOGY OF 17TH CRM

17th

MANDATE & METHODOLOGY OF 17TH CRM

Overview

The Ministry of Health and Family Welfare (MoHFW) emphasizes robust monitoring mechanisms to strengthen implementation and provide comprehensive support to programme interventions within the health system.

The National Health Mission (NHM) represents a comprehensive and coordinated initiative aimed at strengthening health system reforms across the country. In this regard, Common Review Mission (CRM) is undertaken annually by MoHFW across various states to assess the performance and effectiveness of national programmes implemented under the NHM. The CRMs undertaken to date have generated valuable insights into successful strategies and have given several significant mid-course corrections. During the year 2025-26, CRM field visits were conducted between 1st and 8th November 2025 across 14 States—namely Andhra Pradesh, Assam, Chhattisgarh, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Telangana, Uttarakhand, and Uttar Pradesh. These were followed by visits from 16th to 22nd November 2025 in two States (Bihar and Kerala), and subsequently from 23rd to 29th November 2025 in one State (Tamil Nadu).

Objectives

The objectives of the CRM include undertaking a rapid assessment of the implementation status of the NHM, its key strategies, and priority areas. The CRM seeks to analyse strengths and challenges related to health system strengthening and to identify trends in the progress of key health indicators, particularly with respect to coverage, equity, quality, and affordability at the state, district/sub-district, and community levels. It also aims to document innovations and best practices, assess the preparedness of states for the implementation of new initiatives, and review progress as well as coordination mechanisms with various development partners. In addition, the CRM assesses the implementation status of Ayushman Bharat–Ayushman Arogya Mandir (AAM) and the availability of the expanded package of comprehensive primary healthcare services at upgraded AAM-Primary Health Centres (AAM-PHCs) and AAM-Sub Health Centres (AAM-SHCs) across the states.

Terms of Reference of the 17th CRM

The Terms of Reference (ToR) for the 17th CRM were revised and restructured to comprehensively capture the ground-level realities faced by the public healthcare system in service delivery. These revisions focused on assessing the strengthening of ongoing programmes, the uptake of new initiatives, and state-specific achievements and best practices adopted to address existing challenges. In addition, information on demographic indicators, relevant Health Management Information System (HMIS) data, and district- and state-level health profiles was shared with the CRM teams prior to the field visits for aligning objectives, improving operational efficiency, and ensuring that on-field time is used effectively towards documentation of field practices for strong evidence to make informed documentation.

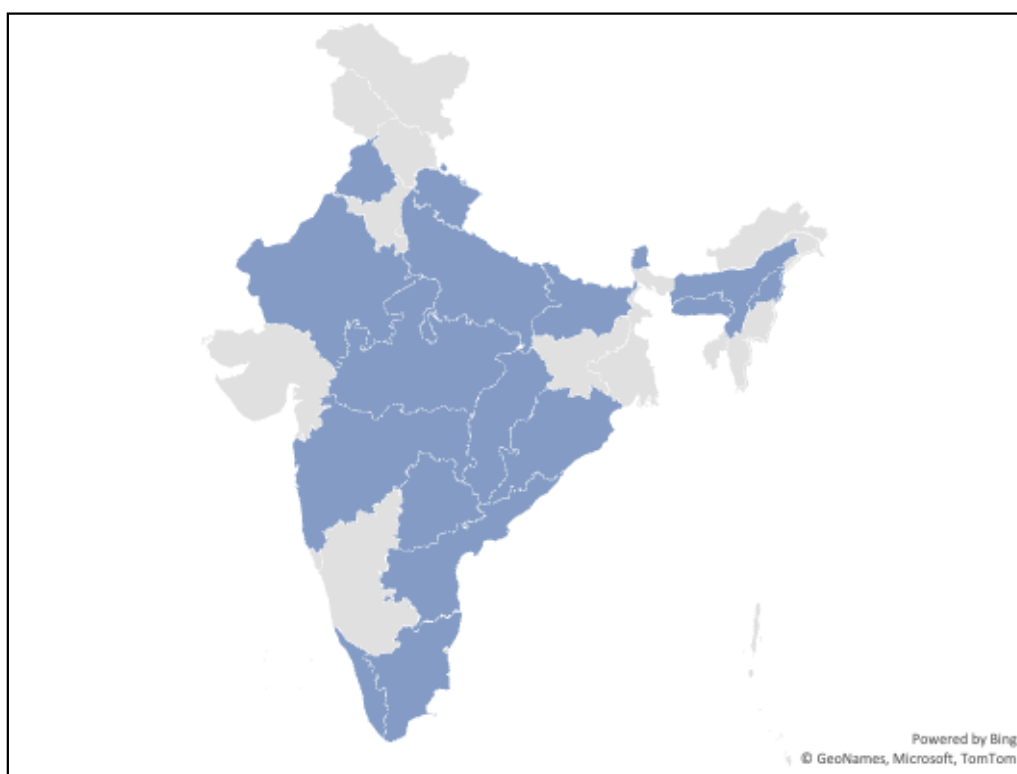
Geographical Coverage of 17th CRM

The 17th CRM covered 17 states including Andhra Pradesh, Assam, Bihar, Chhattisgarh, Kerala, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Tamil Nadu, Telangana, Uttarakhand, and Uttar Pradesh.

List of States and Districts Visited in 17th CRM

Sr. No	Name of State	District-1	District 2
1	Andhra Pradesh	Parvathipuram Manyam	West Godavari
2	Assam	Charaideo	Udalguri
3	Bihar	Munger	Saran
4	Chhattisgarh	Kanker	Mahasamund
5	Kerala	Kottayam	Kasargod
6	Madhya Pradesh	Mandsaur	Vidisha
7	Maharashtra	Nandurbar	Satara
8	Meghalaya	East Khasi Hills	North Garo Hills
9	Nagaland	Mon	Zunheboto
10	Odisha	Bargarh	Kalahandi
11	Punjab	Faridkot	Jalandhar
12	Rajasthan	Jhunjhunu	Nagaur
13	Sikkim	Mangan	Soreng
14	Telangana	Bhadradri Kothagudem	Sangareddy
15	Tamil Nadu	Salem	Tenkasi
16	Uttar Pradesh	Balrampur	Muzaffarnagar
17	Uttarakhand	Chamoli	Udham Singh Nagar

Geographical Coverage of 17th CRM



Team Composition

Each State was visited by a team of 10–13 members comprising a mix of the following:

1. Government Officials
 - a. Officials of the MoHFW, GoI

- b. Regional Directors of Health & Family Welfare
 - c. Officers from other Central Ministries and NITI Aayog
- 2. Public Health Experts
 - 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 IIMR, Tata Institute of social sciences (TISS), Post Graduate Institute of Medical Education and Research (PGIMER), Public Health Experts (IAPSM) from Medical Colleges including AIIMS and School of Public Health.
- 4. Population Research Centres (PRCs)
- 5. Consultants from various divisions of the MoHFW and NHSRC
- 6. Other Ministries & Departments – officials and Representatives from Ministry of Tribal Affairs, Ministry of Ayush, Ministry of Women and Child Development and School Education.

Methods

Prior to the field visits, the CRM teams were also provided reference documents with relevant secondary analysis for programme indicators across the National Health Programmes within NHM.

Teams were provided with background materials, including the CRM agenda, Terms of Reference, applicable guidelines, the latest MIS reports, factsheets, and survey reports such as RHS, SRS, NFHS, and HMIS. Additional reference materials comprised state- and district-specific reports and studies, data furnished by the states in accordance with the Terms of Reference, and relevant findings from previous CRM reports. The CRM teams were briefed at the state and district levels on the progress achieved across all NHM programmes. This was followed by field visits to selected districts over a period five to six days. Field interactions were systematically structured to commence at the community level and to progressively assess service delivery across successive tiers of the healthcare system—from Ayushman Arogya Mandir (AAM) to district and state levels—in both rural and urban settings, in accordance with the continuum of care framework.

Facility level assessments were conducted at District Hospitals (DHs), Sub District Hospitals (SDHs), Community Health Centres (CHCs), Urban Community Health Centres (UCHCs), AAM PHCs/ UPHCs, and AAM SHCs. Semi structured interviews were undertaken with frontline health functionaries, including ASHAs, Anganwadi Workers (AWWs), Auxiliary Nurse Midwives (ANMs), and members of Village Health, Sanitation and Nutrition Committees (VHSNCs), Mahila Arogya Samitis (MAS), and Jan Arogya Samitis (JAS). Community level interactions were conducted with beneficiaries and community representatives in two selected villages/slums. In addition, three Focus Group Discussions (FGDs) were held: one with ASHAs; one with community members from Scheduled Caste/Scheduled Tribe populations and other underserved hamlets/slums to assess access to and utilization of health services and related experiences; and one with Rogi Kalyan Samiti (RKS) representatives.



TOR-1 HEALTH SYSTEM STRENGTHENING

17th

TOR-1 HEALTH SYSTEM STRENGTHENING



Human Resources for Health

National Overview

A key strategy under the National Health Mission (NHM) is the strengthening of Human Resources for Health (HRH), that recognizes that a rationally distributed, adequately skilled and motivated health workforce is essential for delivering quality healthcare services. NHM supports States and Union Territories (UTs) by supplementing regular staff with contractual HRH and providing program management support. Additionally, NHM also offers significant flexibility in HRH planning and implementation, allowing each State to tailor solutions to their specific needs.

Key focus areas of HRH include the availability, rational deployment of staff, recruitment processes, effectiveness of state-level HRH policies, implementation of Human Resource Management Information Systems (HRMIS), and progress of training programs. Although several states have made progress in the availability of staff, rational deployment of the available staff still requires attention. States have also reported challenges related to long-term workforce retention, prolonged recruitment cycles, and issues in timely salary disbursement.

Availability of HRH

- Improvements in HRH availability were observed at the primary level across several of the states visited. However, secondary care facilities were reported to be functioning below their intended capacity level due to persistent gaps in the availability of specialists.
- Critical gaps in availability of specialists especially anaesthetists, obstetricians and gynaecologists, paediatricians, radiologists, surgeons, and physicians were reported in Assam, Bihar, Chhattisgarh, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Punjab, Rajasthan, Sikkim, and Uttarakhand.
- Uneven and irrational deployment of staff was also observed across Bihar, Nagaland, Odisha, Rajasthan, and Andhra Pradesh. In Bihar, it was observed that anaesthetists were posted at CHCs, but paediatricians or gynaecologists were not available as per IPHS norms, limiting the delivery of specialist services. In Odisha, the distribution of specialists across District Hospitals and CHCs reportedly did not correspond to

facility-level caseloads. In Sikkim and Rajasthan, operation theatres remained non-functional or underutilized due to the absence of anaesthetists, and infrastructure constraints, despite the availability of other specialists.

- Geographical disparities in HRH availability remain evident, with remote, tribal, and hard-to-reach areas in states such as Uttarakhand, Nagaland, Meghalaya, Sikkim, Chhattisgarh, Andhra Pradesh, and Assam continuing to face higher vacancies and retention challenges. Reluctance among specialists to accept rural postings, coupled with constraints such as inadequate staff quarters and basic amenities, particularly noted in Chhattisgarh, have further contributed to difficulties in retaining HR at peripheral facilities.
- To mitigate workforce shortages, Madhya Pradesh has deployed doctors with a one-year tenure bond across various facilities, ensuring the continuity of critical health services in underserved areas.

Management of HRH

- A dedicated HR cell at the state-level was reported in Nagaland, Uttarakhand and Meghalaya. Other states have a nodal officer for HRH with one or no consultant.
- Only a limited number of states, such as Madhya Pradesh, have formulated an HRH policy under NHM, while in other states, the HRH policy was currently under formulation.
- Recruitment delays have emerged as a recurring concern in Punjab, Chhattisgarh, Nagaland and Rajasthan. Centralised recruitment processes in Punjab and Rajasthan have led to prolonged vacancies, while Nagaland reported delays due to State Public Service Commission processes which are time-consuming.
- In contrast, innovative recruitment mechanisms were observed in certain states. Tamil Nadu's Medical Services Recruitment Board (MRB) has institutionalised streamlined merit-based recruitment across multiple cadres. Similarly, Andhra Pradesh has established the AP Medical Services Recruitment Board (APMSRB) to expedite vacancy filling. "You Quote- We Pay" scheme in some states has enabled faster specialist hiring through flexible salary negotiation.
- Timely salary disbursement plays a critical role in maintaining staff motivation and contributes to the smooth and efficient functioning of the health system. At the time of visit, delays in salary disbursement, particularly among contractual staff, were reported in Chhattisgarh, Telangana, Nagaland and Uttarakhand, often linked to the transition to SNA/SPARSH. In contrast, Rajasthan and Sikkim reported timely salary disbursement mechanisms.



- Inconsistencies in annual increments and performance-based incentives were also observed – in Telangana, contractual staff reported that they had not received annual increment for multiple years. In many of the states visited during this CRM, steps to strengthen insurance and social security measures for health staff were reported.
- A well-functioning HRMIS can help support many HR management functions and serve as a tool for more effective HR planning. Currently, its implementation remains uneven across the states visited. For instance, functional and well-utilised HRMIS platforms were observed in Kerala and Madhya Pradesh, while Punjab, Meghalaya, Sikkim, and Nagaland reported partial functionality or underutilisation.
- Digital attendance systems have been implemented in Andhra Pradesh, Kerala, and partially in Uttarakhand, whereas manual attendance systems continue in Punjab and Sikkim.

Capacity Building

- Gaps in training were widely reported across different cadres. Chhattisgarh reported a delay in trainings related to NCD management, VIA screening, family planning, and quality assurance.
- Induction and refresher trainings require further strengthening. Absence of structured induction training for newly recruited staff was reported in Uttarakhand, while findings from Andhra Pradesh indicate gaps in refresher trainings in critical clinical areas such as NSSK, Dakshata, emergency obstetric and neonatal care.
- In some states, including Assam and Madhya Pradesh, limited orientation of staff on the expanded package under Comprehensive Primary Health Care (CPHC) was reported, which may be contributing to suboptimal utilisation of services such as elderly care, mental health, palliative care, and rehabilitation. States including Kerala, Meghalaya, and Uttarakhand have prepared annual training calendars, implementation of the same varies. For examples, Meghalaya reported preparation of training calendars at the state level, but district-level gaps in execution observed.
- Some states have adopted innovative and focused measures for capacity building of HR. For instance, Meghalaya has signed an MoU with Tamil Nadu for specialist upskilling in CEmONC and LSAS and Uttar Pradesh has been operationalizing inactive FRUs through the ongoing Buddy-Buddy mentoring initiative.

Recommendations

- Districts should undertake comprehensive mapping of HRH to enable rational deployment of available staff and ensure that HR planning is evidence-based. States should prioritize filling of critical vacancies across all sanctioned posts, particularly for specialists. Local recruitment should be prioritised to improve retention.
- Task shifting strategies should be supported through regular short-term skill enhancing programs, supportive supervision, and clearly defined delegation of responsibilities to ensure efficient service delivery.

- States should develop robust mechanisms to ensure timely disbursement of salaries and incentives to maintain staff motivation.
- Introducing or expanding staff welfare measures like accidental and life insurance coverage, annual health check-ups, and similar employee benefits will help in creating a supportive and safe work environment.
- Training systems should be strengthened with particular emphasis on induction training for newly recruited staff and regular refresher trainings across all cadres.
- Internal Complaints Committees (ICCs), as mandated under the Prevention of Sexual Harassment (PoSH) Act, should be constituted and made functional at district, block, and facility levels to ensure a safe and supportive workplace environment.
- HR planning should be strategic and phased. Creation of posts under the regular cadre should be ensured to align staffing with IPHS 2022 norms. Setting up of a dedicated State Health Recruitment Board may be prioritized to streamline and fast-track the recruitment process of health cadres (regular and NHM) and reduce delays associated with general Public Service Commission processes.
- States should formulate and effectively implement a comprehensive Human Resource Policy, with clear guidelines for recruitment, deployment, training, performance appraisal, career progression, and retention.
- Dedicated HRH Cells should be established with suitably qualified staff. Smaller states where a full-fledged HRH cell under NHM is not possible due to budgetary constraints, existing staff may be appropriately trained to manage HR functions effectively.
- A strategy of bundling of incentives should be explored, combining measures such as provision of adequate staff accommodation and appropriate hardship allowances to attract and retain HRH in underserved and difficult areas.
- Objective and structured performance appraisal systems should be in place, aligned with defined performance benchmarks. Periodic self-review should also be a part of such systems to help staff build greater responsibility for their roles. Other than performance-based incentives, non-monetary recognition mechanisms such as commendation, training opportunities, and exposure visits should also be explored to motivate HRH.
- States should undertake systematic Training Needs Assessments (TNA) and develop training plan and Training calendars to ensure periodic skill enhancement of all cadres.
- Long-term workforce planning should be strengthened, considering HRH generation capacity, epidemiological transitions, demographic shifts, disease burden, health-seeking behaviour, and service utilisation patterns.
- States should have an HRH policy and HRH Strategic plan which is futuristic and takes into account the epidemiological and demographic shifts.

- States may prioritize the establishment or creation of Specialist and Public Health cadres to enhance secondary and primary care delivery.
- SIHFWs or equivalent bodies should be strengthened as nodal agencies for systematic capacity building.

State Specific Findings

Andhra Pradesh

- Andhra Pradesh Medical Services Recruitment Board (APMSRB) was established in the state to fill vacancies throughout the state under the HM&FW Department.
- Attendance Monitoring System through the Face Recognition System (FRS) was being used in the state, which has improved accountability across the workforce. However, the system cannot compensate for fundamental staff shortages in critical service areas.
- Uneven distribution and unavailability of critical clinical staff were observed. Vacancies among medical officers and specialist doctors were reported, particularly in remote and tribal areas.
- Staff continue to express reluctance in accepting rural or tribal postings, resulting in recurring vacancies and disruptions in continuity of care.
- Deployment of HRH was not as per patient load, leading to overburdening in some facilities and underutilization elsewhere. Staff nurses, especially those posted in labour rooms, were frequently rotated between departments, disrupting continuity of care.
- Motivation and retention challenges were observed, as contractual staff reported that increments have not been disbursed in the past 2–3 years which was leading to dissatisfaction among frontline workers.
- Across secondary care facilities in both districts, most of the workload, particularly in emergency and labour rooms was managed by contractual nurses and general duty medical officers. The specialized departments often relied on a small pool of overworked specialists.
- The lack of anaesthetists in secondary care facilities has led to referral of high-risk surgical cases, including C-section cases to tertiary care hospitals
- The NCD clinics were not able to provide complete screening and follow-up services due to unavailability of key human resources.
- There have been limited training and capacity-building efforts in the state over the past two years. No structured refresher training for Medical Officers, Specialists, or Program Officers has been conducted in key areas, including NSSK, Dakshata, emergency obstetric care, and neonatal care.
- Regular Continuing Medical Education (CME) opportunities were absent, particularly for specialists posted in secondary-care hospitals.

Assam

- Assam has made visible progress in ensuring the availability of key cadres at the primary care level, particularly Medical Officers (MOs), Community Health Officers (CHOs), staff nurses and multi-Purpose Workers (MPWs). The visited districts reflected a similar pattern, with facilities largely staffed as per norms to support delivery of primary care and outreach services.
- In tea-garden and char areas (sandbar/island settlements), MPWs and ASHAs continue to serve as the primary interface with the community, often covering large and difficult catchment areas while managing multiple programme responsibilities.
- Frontline workers in difficult geographies face significant operational pressures, particularly in tea-garden and tribal areas where ASHAs and MPWs cover large populations and manage extensive reporting requirements under constrained transport and connectivity conditions. While commitment remains high, supportive supervision, timely payments, and recognition mechanisms require strengthening to mitigate fatigue and sustain performance.
- From the community perspective, improved visibility of CHOs, ANMs and ASHAs along with better availability of doctors at AAM and PHCs was viewed positively. However, limited confidence in availability of specialist services, diagnostics and emergency services at higher facilities continues to drive reliance on private providers for chronic NCD care, complicated deliveries, and minor procedures.
- This perception is consistent with state reported data (HDI 2022–23), which indicates a substantial shortfall of specialists at CHCs and higher-level facilities. Against an estimated requirement of approximately 700 specialists at rural CHCs, only about one-fifth were currently in position.
- Field observations corroborated these gaps, with many CHCs and SDHs functioning without the full complement of specialists - particularly anaesthetists, paediatricians, physicians, and radiologists – thereby constraining emergency obstetric care, trauma care, and NCD management. For instance, SDH Sonari manages a heavy load of incomplete abortion and emergency medical cases despite not consistently having the full specialist and technical team in position. A notable shortfall of radiographers was also observed.
- In this context, it was observed that some secondary care facilities also face high outpatient and inpatient loads due to bypassing of lower-level facilities by patients, either due to habitual preference or limited confidence in service availability.
- HRH distribution remained uneven across the State, with facilities located near urban centres or along main roads being relatively better staffed, while remote, tribal and tea-garden areas report higher vacancies and greater dependence on contractual staff and visiting specialists.
- Some MOs at the PHC and UPHC levels continued to view their role primarily within a curative OPD framework, rather than in leading the full 12-package Comprehensive Primary Health Care model. As a result, the utilization of the expanded service

package remains limited, with facilities largely focusing on RMNCH and selected NCD services, while components such as elderly care, mental health, palliative care, oral health, rehabilitation were not consistently delivered to the community and some other CPHC components.

- The State had undertaken capacity-building initiatives through program-specific trainings, with monitoring supported through platforms such as SASHAKT. Although a significant share of MOs, CHOs, nurses and MPWs have received training in NCD and the expanded package of services, training coverage remains uneven across facilities and cadres.
- Field interactions suggested that continuous mentoring and supportive supervision were not consistent across districts. Some ASHAs were yet to receive orientation on newer initiatives under expanded health and wellness activities.
- It was reported that at CHC, SDH, and DH levels, managerial and administrative responsibilities were largely handled by clinicians in addition to their clinical duties, leaving limited time for leadership and mentoring.

Bihar

- Staff shortages were observed in both districts, especially in service delivery positions including medical officers, staff nurses, pharmacists, and lab technicians. High vacancies of specialists esp. in Obstetrics and Gynaecology, Paediatrics, and Anaesthesia were observed in CHC, SDH, and DH, which severely affected access to specialist services.
- Irrational deployment of staff was a concern in some facilities. In some CHCs, it was found that an anaesthetist was available, but positions of gynaecologist and paediatrician were vacant.
- Although the state has a cadre of community mobilisers at the district, and block level, more strengthening at the grassroots level is required to enhance their programmatic understanding.
- Earlier HRMIS was functional; however, at present, integrated HRMIS for all cadres including regular, contractual and outsourced HR was not available.
- No central or state level medical college was functional in either of the districts. A new nursing college was being planned in one of the districts for training nursing staff.
- The health facility staff had limited orientation about priority health activities under national health programmes. Further, staff nurses had not received Dakshata training.
- Training MIS was not adequately maintained at the health facility, block level, and district level.

Chhattisgarh

- It was observed that the state was taking positive measures to improve the availability and management of HR. These included the provision of differential remuneration and hardship allowance to attract and retain specialists in remote areas and leveraging support from medical colleges for clinical mentoring and strengthening of service delivery. Other good practices included the implementation of digital attendance system and the maintenance and regular updation of service books.
- The availability of key service delivery cadres such as MOs, ANMs, MPWs, and RMAs was observed to be adequate across the visited primary care facilities. CHO availability was reported to be above 95%.
- At the secondary care level, uneven distribution of staff was observed across selected CHCs. Significant shortages of specialists persist, with only about 20% of sanctioned specialist posts filled, resulting in gaps in service delivery.
- Recruitment processes were reported to be time-consuming with vacancies often remaining unfilled for 2-12 months, thereby impacting the continuity of service delivery.
- Retention of HR in remote and tribal areas remains a challenge due to inadequate staff quarters, limited availability of basic amenities such as water and electricity, and the difficult terrain.
- Delays of 3-5 months in the disbursement of salary and incentives were reported, particularly affecting CHOs and other HR engaged in outreach and community-level service delivery.
- Annual training calendars were found to be sub-optimally structured and inconsistently implemented, with a backlog of essential training reported in priority areas such as NCD management, VIA screening, CAC, Family Planning, and NQAS. The need for periodic refresher training was also highlighted.
- Staff also reported instances where despite having received training, they were unable to deliver services effectively due to shortages of supplies, logistics gaps, or limited supportive supervision at facility and district levels.
- Positive practices such as specialist differential pay, loyalty bonuses, exposure to mental health training (e.g., NIMHANS), and use of logistics management systems (PLP), were observed. Furthermore, digital attendance, service book maintenance, and academic/medical college support for service delivery were also noted.

Kerala

- Motivated Health HR was observed at all levels of facilities.
- The State was following its own norms instead of IPHS for staffing health workforce across the facilities.

- Programs were well managed and coordinated by District Programme Management Unit (DPMU) and Block Programme Management Unit (BPMU) in the districts.
- HRH planning and implementation ensured a well-distributed health workforce for quality healthcare services.
- State has a functioning HRMIS in place. A comprehensive overview of the human resources for health was available under the Department of Health Services (DHS) and related programs. It highlights the key indicators reflecting the availability, distribution, and Skills (based on training programs attended and their educational backgrounds) of medical personnel across different cadres and specialties, serving as a vital component in assessing the strength and efficiency of the healthcare delivery system.
- Biometric attendance was available till CMO level.
- Induction training was being conducted for new staff in the state, and the training of other health staff was also held on regular basis.
- State has vacant posts of specialists especially in rural areas.
- State has posted State Nodal Officers on deputation from regular cadre for fixed duration.
- At the State level, recruitments were conducted as per need, and vacancies are filled through the State public service commission.
- Apart from the regular cadre, the State has engaged contractual HRH through other funding sources.
- The performances of all employees was being reviewed by the respective supervisors, and further contract extension is based on the performance review.
- State has POSH committees, a maternity leave policy, leave policy (with provision of casual and earned leaves as per the norms) and grievance redressal mechanism in place.
- EPF is being provided to the employees whose salary is less than Rs. 15,000 per month.
- During the visit, it was observed that districts have adequate and quality infrastructure for training. It was also noted that the State and the districts have training plans which were being adhered to.
- There was no accounts/ finance staff available at the block level. In urban facilities, an accountant cum DEO was placed at every UPHC in the state.
- Finance staff have not received training in the last two years.

Madhya Pradesh

- The state has implemented a revised Human Resource for Health (HRH) Policy effective 1st April 2025, replacing the previous HRH Policy Manual 2021. The revised

policy emphasizes rational deployment, accountability, and performance-linked appraisal mechanisms.

- The Human Resource Health Management Information System (HRMIS) has been effectively implemented to streamline salary disbursement and HR-related processes, thereby improving transparency, timeliness, and efficiency in personnel management.
- To mitigate workforce shortages, the State has deployed doctors with a one-year tenure bond across various facilities, ensuring the continuity of critical health services in underserved areas.
- A severe shortage of radiologists persists across both districts. As an interim measure, the State is training Gynaecologists to perform basic obstetric ultrasonography.
- At the District Hospitals, vacancies were noted among key specialist positions including Anaesthesiologist, Surgeon, Radiologist, Pathologist and Orthopaedic Surgeon.
- Specialist vacancies were also observed at the Community Health Centres (CHC) and most CHCs were functioning primarily as Primary Health Centres (PHCs).
- The sanctioned human resources at AAM-SHC, AAM-PHC, AAM-UPHC, and AAM-USHC were not aligned with the IPHS norms.
- It was also noted that Medical Officers and Community Health Officers (CHOs) lacked clarity regarding the 12 expanded package services under the Comprehensive Primary Health Care (CPHC) approach.
- Despite prevailing human resource gaps, available staff were performing their duties with commendable dedication and commitment to maintaining uninterrupted service delivery.

Maharashtra

- The health workforce, across service delivery and programme management, was found to be highly motivated and dedicated, with many going above and beyond their specified roles and responsibilities.
- The State's HRH data reveals that three-fourths of the staff were in-place, however, this needs to be further analysed as the figures do not illustrate the disparities between the rural, tribal and urban facilities.
- With an urban population of more than 45%, Maharashtra has notified a separate Health Commissioner for urban recently, which was a welcome step.
- Availability of staff quarters was observed to ensure provision of round-the-clock services.
- Difficulties in recruiting and retaining doctors and specialists remains a key challenge across the state. While the State leverages doctors on bond to improve the availability of Medical Officers (MOs), a high attrition rate was reported across all levels with

the main reason cited as selection into PG courses.

- As a good practice, the Nandurbar district administration has empanelled private sector Radiologists to undertake USG scans at RH at a differential payment system.
- Satara district has taken some initiatives such as deployment of interns, and District Residency Programme (DRP) interns to address the challenges in the availability of doctors and specialists.
- State has a functional HRIS containing only personnel information (personal details and service book information). The HRIS was being used to process contract renewal orders, however, posting/ transfer orders, pay slip generation and other modules were not available on the system.
- Satara district has a digital system for attendance monitoring and application of leaves.
- Across several RHs and SDHs, rational deployment of staff remained sub-optimal, for e.g., facilities often having a gynaecologist available did not have an anaesthetist or paediatrician posted. Similarly, dental chairs were available, yet no dentists were posted at facilities.
- At the DH in both districts, counsellors were deployed programmatically under NCD, RKSK, ICTC, potentially underutilizing the staff. Even the district programme management posts were verticalized.
- Despite availability of in-house Laboratory Technicians (LTs) (contractual and regular), facilities largely depended on PPP laboratory services (HLL) operating in parallel. The in-house LTs only perform rapid diagnostic tests, hindering optimum productivity.
- The disbursement of salaries and incentives (including TBI and PBI) have been delayed by up to two months, impacting staff morale.
- It was reported that hardship allowances were not being provided to NHM staff, including the boat ambulance staff, in the tribal district of Nandurbar.
- Due to the unavailability of funds, minimal in-person trainings were conducted. The online trainings have led to lower retention, resulting in a significant knowledge gap.
- Due to the implementation of the PESA Act in Nandurbar district, under which only local candidates can be recruited to fill the vacancies in the district, concerns regarding the non-availability of suitable candidates were highlighted. For instance, a majority of the local candidates appearing for the ANM post did not pass in the competency tests. This knowledge gap has led to unfilled vacancies.



- Given the hard-to-reach areas and the difficulties in the geographic terrain in Nandurbar district, the team observed that the IPHS norms may not be suitable for the context for ASHAs and ANMs and instead a more relaxed habitation-wise norms may be considered.

Meghalaya

- Healthcare providers were motivated and committed, with a good reputation in the community. In some areas, they were staying in remote facilities to provide round-the-clock services.
- Mid-Level Health Providers (MLHPs) had been appointed in >90% of AAM in both districts and worked with a proactive approach to provide promotive and preventive services.
- They also did teleconsultations with MOs and dispensed the prescribed medicines accordingly.
- The sanctioned positions in the visited facilities were not as per IPHS 2022 norms.
- Human resource gaps were reported among lab technicians, pharmacists, and male multipurpose workers.
- Uneven distribution of HRH was observed, and staff attrition was very high in rural and remote areas. Staff were concentrated in urban areas, and shortages were prevalent in remote areas in North Garo Hills.
- Anaesthesia services were a bottleneck in both districts, with a requirement of visiting anaesthetists in remote blocks.
- Vacancy in specialists' posts under NHM had impacted service delivery. While in one of the districts, elective surgeries were conducted regularly, in the other district only essential surgical procedures were performed at CHCs due to limited surgeon availability.
- An HRH Cell was available at state level.
- POSH committee had been formed only at the state level.
- No weightage was given for NHM employees during recruitment (ANMs/ SN/ LT/ Pharmacists) under Regular cadre which needs to be looked into by the State.
- Annual increments and EPF payments were disbursed.
- Delay in release of incentives was observed for ASHAs and ANMs.
- Staff quarters were in poor and dilapidated condition. Further, in some areas, accommodation facilities did not exist.
- At present, the State does not have a standardized performance appraisal system for NHM employees.
- HRMIS was functional but was underutilized due to technical issues, internet

connectivity, and other organizational requirements for transitioning from manual to digital mode.

- Training Calendar was prepared only at the state level. However, gaps in training pertaining to some programmatic areas were identified.
- An MoU had been signed with the Government of Tamil Nadu in 2022 for upskilling doctors who are sent from Meghalaya for six months for specialized training in CeMONC, LSAS and Ultrasonography.
- State Midwifery training institutes have been identified, and training was undertaken in batches of 20 and 40 at respective institutes.

Nagaland

- Shortages of MO, nurses, and pharmacists were observed across health facilities in the districts visited.
- Some PHCs did not have a MO and were managed by ANMs and Pharmacist.
- Similarly, some HWCs did not have a CHO, and the facility was being managed by ANM and ASHA.
- Shortages were also observed in urban facilities. One of the visited UPHC was functioning only with a MO (Dental), limiting service delivery. Further, no sanitation staff were posted in the facility, and the ANMs were performing cleaning duties via roster, diverting them from core duties.
- Uneven staff distribution was also found in some facilities which affected service delivery in the districts.
- A specialist (surgeon) posted at a CHC having no anaesthetist or functional operation theatre.
- Seven MTS were posted in one SHC, while others operated only with a CHO and ANM.
- In one of the PHCs, there were 31 paramedical staff, including 16 medical attendants, but no MO.
- State does not have a separate specialist cadre. Under NHM, the post of specialists was advertised several times, but candidates opted for the district of Kohima and Dimapur only. There were no provisions for any hard-to-reach area allowance.
- State had a dedicated HR cell having officials with management qualifications (MBA in HR) in position.
- CHCs had a significant number of vacant positions due to delay in recruitment process by the State Public Service Commission.
- There was no provision of weightage for NHM staff while recruiting in regular cadre.

- Disbursement of salary and incentives was decentralized. There was no fixed date for releasing the salary.
- There had been a delay of 3 months in releasing salary in the State due to non-compliance with SNA SPARSH. Staff had received annual increment in the current financial year, and EPF was paid to eligible employees.
- State adopted CMHIS (Chief Minister Health Insurance Scheme) for its employees.
- Performance appraisal system was in place, but it was not linked to any monetary or non-monetary incentives.
- State did not have an established comprehensive Human Resource Management Information System (HRMIS). The PIMS (Personal Information Management System) platform was being currently utilized by the State (as indicated by HRH cell).
- Biometric attendance had been adopted since 2014 at the SPMU level only. However, there was no biometric monitoring system at the district and below level health facilities.
- Training gaps were evident, as many paramedical staff had not received orientation on the latest National Health Programme guidelines or on the use of digital platforms.

Odisha

- Human resource availability was found to be adequate at the primary care level, with all the sanctioned posts were filled in the NQAS-certified primary care facilities visited. However, the state needs to further strengthen service delivery at the CHC and DH levels by addressing the existing vacancies in specialist and paramedical cadres to ensure uninterrupted provision of trauma, psychiatric, neonatal care and other key services.
- In CHCs where specialists were currently posted, optimizing the availability of functional equipment and diagnostic services would enhance the effective utilization of specialist services and improve overall service outcomes.
- Irrational deployment of specialists across DHs and CHCs was also observed, resulting in a mismatch between available human resources and facility caseloads.

Punjab

- The State had adequate sanctioned positions for specialists, Medical Officers (MBBS), and pharmacists. However, the number of sanctioned posts was lower than the IPHS 2022 requirement for key cadres including MPW (M+F), Staff Nurses, and Laboratory Technicians. Facilities in both districts were aware of the sanctioned posts for their respective institutions.
- High vacancies were reported in the regular cadre, particularly for Specialists (49%), Medical Officers (MBBS) (37%), Pharmacists (46%), and Staff Nurses (35%). Under NHM, vacancies were also reported to be high against approved posts, including Specialists (45%), Medical Officers (64%), Pharmacists (65%), Lab Technicians (58%),

Staff Nurses (44%), and MPWs (42%). In both districts visited, the vacancy among the key HRH was high.

- The recruitment process in Punjab was centralized at the State level. Field interactions indicated significant delays in the recruitment cycle, adversely affecting timely deployment of human resources at district and block levels, particularly for critical service delivery cadres such as specialists, Staff Nurses, and MPWs (M+F). During the week of the visit, the State reported completion of recruitment of 703 Medical Officers and 50 MPW (F).
- Under District Hospital Strengthening, both districts were running DNB programmes /Diploma/ NBEMS courses. Both districts were utilizing PG residents and paramedical students in district hospitals. It was observed that DNB students and PG residents were actively involved in clinical service delivery at district hospitals. Their contribution was found to be significant in mitigating HR gaps.
- In both districts, essential posts under the District Programme Management Unit (DPMU) and Block Programme Management Units (BPMUs) were available. However, the role of State, District, and Block PMUs in supportive supervision and monitoring was reported to be suboptimal, affecting effective implementation and management of health programmes.
- Districts were found to be compliant with EPF provisions and TDS deductions for employees. No pendency was reported in the cases reviewed. The State reported compliance with minimum wage norms for few cadres such as laboratory technicians and lab attendants.
- Hospital Security Committees and Violence Prevention Committees were established at the district level. However, display of committee members and contact details was not found at facilities visited. Limited awareness regarding these committees was reported at district and sub-district levels. Constitution of POSH committees was not found to be in-place at facility levels.
- The State does not currently have a dedicated HR policy for NHM contractual staff.
- An annual appraisal mechanism was reported to be in place for both regular and NHM staff.
- An integrated Human Resource Management Information System (HRMIS) exists and covers multiple categories of staff, including regular and contractual. However, HRMIS functionality for contractual staff was reported to be incomplete. Key modules such as leave, training, and salary slip were not consistently updated or utilized for contractual employees.
- The State was implementing an individual insurance coverage and a group accidental insurance coverage through an MoU with Indian Bank. These insurance benefits were provided free of cost to employees, as no premium payment was required under the MoU arrangement. Maternity benefits were reported to be implemented as per prescribed norms.

- Staff attendance was found to be maintained through manual registers at facility level.

Rajasthan

- Most staff in the health facilities visited were from the regular cadre. It was reported that districts engage contractual staff through a committee chaired by the District Collector. Other sources of funds such as PMJAY were also used to engage contractual staff as needed.
- State had implemented service rules for contractual staff in 2022, bringing significant improvements in HRH management, including enrolment of all eligible staff under the New Pension Scheme (NPS) and coverage through the Mukhya Mantri Ayushman Aarogya Yojana.
- Salaries were decentralized, with disbursements mandated by the 5th of each month. Staff did not report any delays in salary disbursement.
- NHM staff were being integrated into the state's HRMIS (Raj Health), where mapping had been completed and development of NHM-specific modules was underway.
- A digital attendance monitoring system was functional up to the PHC and SHC-AAM levels in one of the districts, ensuring accountability and transparency.
- In case of staff misbehaviour or long absence, community level functionaries can file a complaint at the chief minister portal (e-Sampark Portal), by calling on a toll-free number (181) or using E-mitra portal.
- Human resource shortages emerged as a constant concern in both districts, with nearly 58% vacancies under NHM, particularly among Community Health Officers, specialists, radiologists, and laboratory staff. However, the team was informed that the state has recently advertised the posts of CHOs. The district team was also not aware of the provisions of in-sourcing specialists.
- Rational deployment of specialists was also a concern. At one sub-district hospital, a gynaecologist and surgeon were available, but no anaesthetist (on higher education leave) and GDMO were posted. ANMs were also posted at the district hospital level, resulting in increased responsibilities beyond primary care settings.
- The mismatch between infrastructure and staffing was notable—for instance, CHCs with radiographers had no X-ray machines.
- State must address the issue of acceptability of healthcare staff among the community especially male nurses. The team was given to understand that some facilities lacked adequate female nurses in labour rooms, causing discomfort among beneficiaries.
- The recruitment under NHM was centralized. However, staff reported delays in recruitment, which further exacerbated staff shortages.

- Selected capacity-building sessions were facilitated through the State Institute of Health and Family Welfare (SIHFW), Jaipur, ensuring uniform quality and adherence to state-level standards. While one of the districts had a well-structured and comprehensive training plan in place, the other faced issues in conducting trainings due to lack of dedicated training centres.
- The team mentioned that the trainings were mostly conducted between November and March, because of fund availability.

Sikkim

- The State had established a specialist cadre. Overall staffing levels across health facilities were noted to be adequate, mainly attributed to the State Government's 'One Family, One Job' policy, which has enabled consistent recruitment of paramedical and support staff across districts.
- Sikkim has made notable progress in deploying Medical Officers, CHOs, ANMs, and MPWs in line with IPHS norms. The paramedical and support staff were available in adequate numbers; however, there is a critical gap in availability of specialist positions, particularly paediatricians, anaesthetists, and gynaecologists.
- One of the district hospitals had an operation theatre, but it remains non-functional due to the unavailability of specialists. Despite having an ophthalmologist, the services were not being utilized due to a non-functional Eye Operation Theatre.
- Similarly, despite having a gynaecologist in place and a well-established labour room, C-sections and high-risk deliveries were not performed at the district hospital due to absence of an Anaesthesiologist and a Paediatrician.
- In District Soreng, CHOs were deployed rationally; however, vacancies persist for laboratory technicians and pharmacists in remote, geographically challenging Sub-Health Centres (SHCs).
- Geographical challenges were found to contribute to reluctance among specialists to accept long-term postings, resulting in higher absenteeism during harsh weather conditions.
- At the district level, the positions of District Accounts Manager and Finance & Logistics Consultant were filled, enabling continuity in core financial functions. However, several other sanctioned financial management positions remain vacant, and no recruitment process has been initiated for these posts.
- No delays were reported in the disbursement of salaries. The State has consistently implemented an annual 5 percent increment for staff across all cadres.
- A digital attendance monitoring system has not yet been implemented in Sikkim, and most rely on manual registers for their staff's attendance records.
- The HRMIS in the state was partially functional. Employee data entry has been fully completed, and the required modules were available on the portal. However, utilization remains limited to basic data storage, and the system is not yet leveraged

for routine HR functions such as transfers, posting decisions, leave management, or performance tracking.

- Performance appraisal mechanisms exist in Sikkim but were not uniformly implemented across all health facilities, particularly at the PHC and SHC levels.
- Regular induction and refresher trainings were being conducted across key programme areas, including RMNCHA+, NTEP, NVHCP, and NCDs. CHOs were observed to be well-oriented in the teleconsultation process and CPHC services.

Tamil Nadu

- The Medical Services Recruitment Board (MRB), established in January 2012, has institutionalized centralized recruitment of medical and paramedical personnel. This has shifted recruitment from a slower decentralized process to a streamlined merit-based mechanism, enabling faster filling of vacancies in key cadres. The MRB is headed by a chairman in the cadre of Additional Secretary to the Government and is supported by members from the Joint Director and District Revenue Officer (DRO) cadres. Since its establishment, MRB has recruited 42,258 candidates across 49 categories of posts (as of late 2025).
- The State currently had 4,146 specialists working across public hospitals. In Salem district, DH Mettur had relatively high specialist availability, with 7 gynaecologists, 3 paediatricians, and 3 anaesthetists.
- The State had adopted a policy of conducting deliveries mostly at District Hospitals and designated Comprehensive Emergency Obstetric and Newborn Care (CEmONC) centres.
- Despite overall availability of specialists, localized HR gaps were observed. For instance, at DH Tenkasi, only one staff nurse was posted for labour room duties, indicating constraints in service delivery at critical points of care.

Telangana

- The health system benefits from committed and hardworking frontline workers, nurses, medical officers, and support staff who continue to deliver services effectively despite high workloads and resource constraints.
- The health system in the state is supported by a large and diverse human resource pool under both NHM and the state's health departments - 20,442 regular cadre posts and 4,203 contractual posts are sanctioned under TVVP and DPH&FW in the state. Nearly 86% of the approved positions under NHM were reported to be filled at the time of the visit.
- However, it was observed that critical cadres such as staff nurses, medical officers, lab technicians and pharmacists show vacancies and, at the secondary care level, shortages of specialist doctors, particularly obstetricians, anaesthetists, and paediatricians, were also evident.

- At the primary care level, 2,930 MLHPs have been deployed out of the 3,206 sanctioned posts, supported through bridge courses.
- Delays in disbursement of salaries were reported, particularly among the contractual staff given pendency in processes under SNA SPARSH. It was observed that these delays had contributed to dissatisfaction among the HR and lowered their morale.
- Contractual staff at the visited facilities also reported that they were not receiving annual increments or performance-based incentives.
- Newly recruited staff reported receiving minimal orientation on clinical protocols, reporting systems, and facility processes. In-service staff similarly indicated limited refresher trainings, affecting adherence to standards and quality of care across facilities.

Uttar Pradesh

- Uttar Pradesh had a huge workforce under NHM but with many vacancies existing across different cadres. There was an overall shortage of specialists, Medical Officers, staff nurses, and ANMs across both the districts that were visited. However, the State was going through a large recruitment drive to plug these gaps.
- As reported, the state was already addressing over 10,000 vacancies in Human Resources for Health.
- 562 specialists have been appointed through the reverse bidding model.
- Human resources under national programmes continue to function in silos. Insufficient availability of skilled staff for safe delivery and newborn care was noted.
- As observed, HR related issues have led to limited availability of Critical Care Services (CCS) and Intensive Care Units (ICU) in the secondary care facilities. This has led to patients being referred to tertiary care facilities.
- The State has been conducting decentralized recruitment of medical officers and dentists at the district level.
- The State had also provided group term Life Insurance for the contractual employees with a coverage of Rs 30 lakh.
- Buddy-Buddy initiative was launched to operationalize inactive FRUs by mentoring EmOC/LSAS-trained Medical Officers at District Hospitals for six months before posting them to CHCs of their choice. So far, 353 doctors have been deployed at 185 FRUs, with another 36 currently undergoing training.

Uttarakhand

- Against Indian Public Health Standards (IPHS) requirements, shortage of Human Resources for Health (HRH) was observed affecting overall service delivery and underutilization of infrastructure at various levels of care. There was a lack of willingness to work in the remote areas leading to HRH shortfall in such areas.

- A significant number of in-service MOs were pursuing postgraduate education while drawing salaries against their MO positions during training. Their continued absence from active service creates ongoing HR shortages and challenges in retention.
- The state did not have a specialist cadre at present; however, it was being planned. A critical shortage of specialist doctors persisted in difficult areas directly impacting the availability and quality of secondary-level care services, including emergency and advanced clinical interventions.
- State had constituted HRH Cell where one position of programme officer was vacant at the time of visit. It was observed that HR consultant had the required qualification, in HR.
- There was no consolidated HRH policy at the State level, however, policies do exist for transfers, leaves, grievance redressals, etc.
- Prevention of Sexual Harassment (POSH) Committee was established, indicating compliance with legal mandates to ensure workplace safety and provide a grievance redressal mechanism for staff.
- Terms of References (ToR) for NHM positions for all cadre were prepared and available at the state level. As per State policy, there is no weightage given to NHM staff for regular recruitment at present in the state.
- Contract renewal of NHM staff and recruitment were being done at both the block and state level. The contract validity was one year.
- The recruitment of Specialists, Medical Officers (MO)- through monthly walk-in interviews and Community Health Officers (CHO) was conducted at the state level.
- The State was implementing “You Quote – We Pay” enabling the recruitment of specialists by allowing flexibility in salary negotiations to attract skilled professionals in the public health sector.
- Regular cadre recruitment was conducted through the State Public Service Commission along with walk-in interviews conducted by Directorate of Health.
- Disbursement of salaries and incentives had been decentralized to the District and Block level.
- Annual increment for the current financial year was in process and had not yet been implemented.
- Salaries of CHOs were released on time, however, backlog in Performance-Based Incentive (PBI) payments was observed which may reduce motivation and quality of service delivery.
- Incentives were also being deducted on account of non-achievement of Indicators (TB & Teleconsultation) as districts were still using 15 indicators to calculate PBI.

- Employee's Provident Fund (EPF) was provided for staff. Under the Atal Ayushman Uttarakhand Yojana coverage is being provided for secondary and tertiary healthcare services and life Insurance was available for all.
- Hard-to-reach allowances were provided for specialists, Staff Nurses & ANMs, with the aim of incentivizing deployment and retention in remote and underserved areas but not for MOs and PMU staff.
- Performance Appraisal was processed annually to assess the skills and achievements of healthcare workers in all districts.
- HRMIS was not functional in the state. While the process to develop HRMIS has been initiated, it could not be implemented due to operational issues with NIC and ITDA.
- State had planned to develop and implement HRMIS directly through third party preferably using the existing systems.
- Attendance monitoring through biometric system had been initiated by the State and directions were issued, but its implementation was limited to some districts. The state was also planning to initiate Geo-fencing and tagging for ensuring transparency and accountability in staff attendance for NHM-HR under HRMIS.
- For hands on skill enhancement, clinical trainings were conducted at District Hospitals (DH) to provide practical exposure and strengthen service delivery.
- Based on ROP approvals an annual training calendar is prepared to conduct all trainings in a timely manner. However, due to natural disasters, the trainings were delayed and could not be conducted as per the plan for the current year.
- For newly recruited staff, induction at the state headquarters was provided. Absence of Cadre specific induction training limits their understanding of specific roles in various National Health Programmes and in delivering services.
- While HRH integration was done for the Lab technicians, it was yet to be implemented for the other cadres. It was also observed that regular cadre staff nurses were reluctant to work in SNCUs, NBSUs, and other national health programmes under NHM.



PUBLIC HEALTH MANAGEMENT CADRE

17th

NATIONAL OVERVIEW

The Public Health Management Cadre (PHMC) represents a major structural reform designed to enhance governance, planning, and management capacities within the public health system. Acknowledging that clinical service delivery and public health management demand distinct and specialised competencies, the Government of India has proposed the creation of a dedicated PHMC to professionalise health administration and strengthen the effectiveness of programme implementation across states.

Historically, public health programmes at state, district, and block levels have been managed predominantly by Medical Officers alongside their clinical responsibilities. This dual role has frequently weakened administrative oversight, constrained the systematic use of data for informed decision making, and limited effective, inter-sectoral coordination, and systematic quality improvement. The establishment of the PHMC represents a policy response to these systemic challenges, seeking to enhance health system governance by delineating clinical and managerial functions and embedding trained public health professionals in clearly defined administrative and leadership roles.

Under the NHM, states are encouraged to establish a formal PHMC with clearly defined entry qualifications, structured career progression, and competency-based training frameworks aligned with national guidelines. The proposed cadre is expected to assume responsibility for critical health system functions, including health planning and budgeting, programme implementation, monitoring and evaluation, disease surveillance, supply chain management, and quality assurance, thereby strengthening managerial capacity and accountability across levels of the public health system.

The operationalisation of the PHMC is envisaged as a key reform to strengthen governance and accountability within the health system, enhance the efficiency and effectiveness of programme implementation, and institutionalise the systematic use of data for evidence-based decision-making. Additionally, it seeks to develop and sustain public health leadership capacity across state, district, and sub-district levels.

Overall, the PHMC constitutes a significant advancement in institutionalising professional public health management within India's health system and furthering broader systemic goals towards attainment of Universal Health Coverage.

KEY OBSERVATIONS

PHMC Fully Established / Relatively Strong Systems

- **Maharashtra** – Well-structured public health cadre with clearly defined promotional pathways and unified seniority system across District Health Officer, Civil Surgeon, and Specialist cadres.
- **Tamil Nadu** – The PHMC has been established, with alignment to Government of India guidelines currently in process.
- **Madhya Pradesh** – The PHMC has been instituted to strengthen governance and human resource performance; however, vacant positions persist.

PHMC Established at State Level but Limited at District/Sub-District Level

- **Odisha** – PHMC has been established at the state level; however, programme management at the district and block levels continues to be undertaken by Medical Officers performing dual administrative and clinical roles.
- **Meghalaya** – PHMC has been created at the state level, with no corresponding institutionalisation at district/subdistrict level.
- **Sikkim** – PHMC has been initiated; mapping of professionals underway; district-level capacity gaps persist. the PHMC has been initiated, and the process of professional mapping wa currently underway; nonetheless, significant capacity gaps persist at the district level

PHMC in Process / Early Stages of Operationalisation

- **Assam** – While a Task Force has been constituted, the cadre remains non-operational at present.
- **Chhattisgarh** – A Task Force has been established, with cadre formation presently in progress.
- **Telangana** – Policy directions were in place; however, the structural rollout has yet to be undertaken.
- **Nagaland** – Committee constituted and mapping completed; cadre establishment remains pending.

PHMC Not Established

- **Punjab** – No PHMC in place.
- **Rajasthan** – No PHMC constituted as per GoI guidelines; only teaching cadre established.
- **Uttarakhand** – No PHMC; Initial orientation and meetings held; however, prior gap analysis not acted upon due to leadership changes.

KEY CHALLENGES

- **Absence of Dedicated PHMC in Several States**
Resulting in weak public health leadership, fragmented programme management, and limited accountability.
- **Dual Burden on Clinical Staff**
In states like Odisha and Telangana, Medical Officers continue to manage programmes in addition to clinical duties, affecting supervision and inter-sectoral coordination.
- **Delayed Operationalisation Despite Policy Intent**
Task Forces/committees formed (Assam, Chhattisgarh, Nagaland, Telangana), but implementation timelines remain unclear.
- **Vacancies and HR Gaps**
Even where PHMC exists (Madhya Pradesh), significant vacancies affect service delivery.

- **Limited District-Level Institutionalisation**
PHMC largely concentrated at state level (Meghalaya, Sikkim, Odisha), with inadequate decentralised management capacity.
- **Leadership & Continuity Issues**
In states like Uttarakhand, change in leadership stalled PHMC progress.

KEY RECOMMENDATIONS

1. Policy & Institutional Measures

- States to prioritize; and formally notify and constitute the PHMC, where it is yet to be established (Punjab, Rajasthan, Uttarakhand).
- States to accelerate operationalisation where Task Forces or committees have already been constituted. (Assam, Chhattisgarh, Telangana, Nagaland).
- States should align their respective frameworks with the Government of India (GoI) PHMC guidelines. (Tamil Nadu, Telangana).

2. Phased Implementation

State to adopt a phased rollout approach for effective implementation:

- Phase I – State-level strengthening and policy notification.
- Phase II – District-level deployment of trained PHMC officers.
- Phase III – Block-level expansion and integration with health systems.

3. Role Clarity & Governance

- It is recommended that roles and responsibilities be clearly defined across key public health management functions, including planning and budgeting, data analytics and performance review, logistics and supply chain management, and supervision and quality improvement. Clear role delineation will strengthen accountability, enhance coordination, and improve the effectiveness of programme implementation across all levels of the health system. Clinical and managerial responsibilities to be institutionally separated to mitigate the dual burden on personnel.

4. Human Resource Strengthening

- Mapping to be undertaken for existing public health personnel (where pending).
- Vacancies to be prioritised and filled expeditiously, particularly in states with an established cadre.
- Structured career progression pathways to be developed and institutionalised.
- District-level capacity to be strengthened in planning, epidemiology, and data analytics.

5. Monitoring & Accountability

- To strengthen monitoring and accountability PHMC, states should undertake a set of coordinated actions. These include constituting or strengthening State Task

Forces, developing time-bound implementation roadmaps with clearly defined and measurable milestones, and institutionalising periodic reviews to systematically assess progress in PHMC implementation.

STATE SPECIFIC FINDINGS

Assam

- The State had already constituted a Task Force for PHMC, and operationalising this cadre would help strengthen planning, supervision and programme management in the coming years.

Chhattisgarh

- The state level Task Force was formulated for PHMC, however, it was still under process of formation

Madhya Pradesh

- State had established PHMC to strengthen governance, accountability, and performance in human resource management. However, a substantial number of vacancies across all cadres continue to affect the delivery of essential health services at various levels.
- As per State reports, 424 positions were in place against 727 sanctioned ones, thus leaving 303 as vacant.

Maharashtra

- The State had a strong public health cadre which is the backbone to the planning and implementation of public health programmes at the State and District levels.
- At present, the career trajectory after entering the system as Medical Officer under the public health cadre is given in the following figure

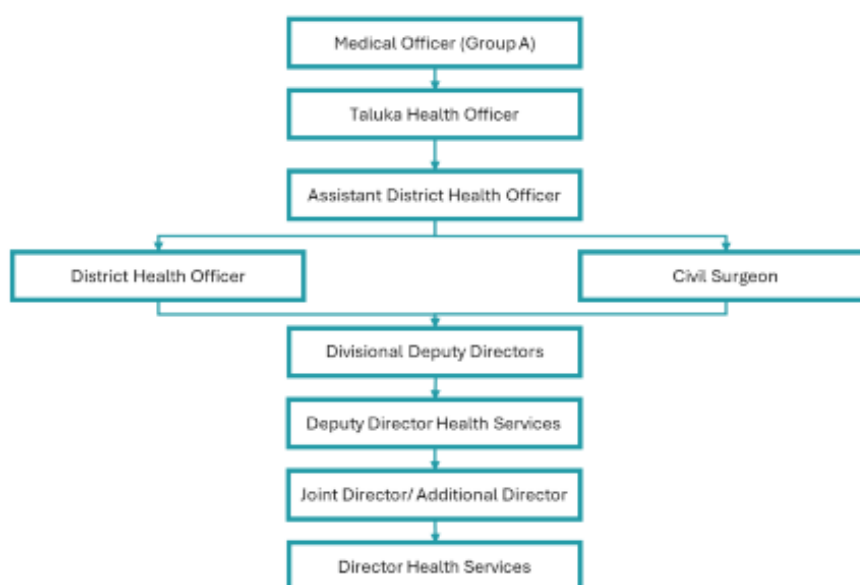


Fig. 6: Career trajectory of Medical Officers entering the Public Health Cadre

- The appointment of doctors as Medical Officers and their subsequent promotions were based on their educational qualifications. Medical Officers (MOs) are promoted in three cadres as per their qualifications. The District Health Officer Cadre is for Medical Officers with an MD (PSM) / DPH / MPH Degree
- Civil Surgeon Cadre is for Medical Officers with a Clinical Diploma / Degree
- Clinician Class – I Cadre is for Medical Officers with a Clinical Degree. (Specialist Cadre)
- The three cadres; DHO, Civil Surgeon, and Clinician, have common seniority for further promotion. Promotions proceed up the hierarchy to posts such as Deputy Director of Health Services, Joint Director of Health Services, Additional Director, and finally Director of Health Services.

Meghalaya

- PHMC had been created only at state level.

Nagaland

PHMC was not available in the State. However, State had formed a committee for augmentation of PHMC. Mapping of existing public health personnel had been conducted.

Odisha

- Dedicated PHMC was in place at the state level; however, at the district or block level, existing medical officers continued to shoulder programme-management responsibilities as BPHO in addition to clinical duties. This dual role constrained field supervision and inter-programme coordination.

Punjab

- PHMC had not been created in the State.

Rajasthan

- PHMC had not yet been constituted in the state as per the Government of India guidelines, and only teaching cadre has been established. At present, existing public health personnel are categorised into six groups: Specialists (2,976), Medical Officers (10,508), Nurses (36,774), Pharmacists (4,777), Laboratory Technicians (4,697) and ANMs/MPWs (22,818). Although these categories provide a foundational human resource structure, the absence of a formally established cadre limits the systematic development of public health management capacities across the state.

Sikkim

- Sikkim had initiated the creation of a PHMC and started mapping existing public health professionals.

- The dedicated cadre is still evolving, and district-level public health managers require capacity building in planning and data analytics.

Tamil Nadu

- PHMC had been created in state, and alignment with the Government of India guideline was under process.

Telangana

- PHMC in state was in the early stages of operationalization, with foundational policy directions in place but full implementation still pending. The structural rollout including defining roles, recruitment mechanisms, training pathways, and integration with existing health governance systems, was yet to be completed.
- At present, managerial and administrative responsibilities continue to be handled by clinical staff or general administrative officers, leading to workload imbalances and constraints in specialized public health functions.

Uttarakhand

- No dedicated PHMC was in place, and no mapping of existing public health personnel had been undertaken, resulting in inadequate managerial support for public health programs and weak governance structures.
- A meeting was held 2-3 years back and gap analysis was submitted, however due to change in leadership, no further progress has been made in this regard. The lack of PHMC continues to create a gap in public health leadership, planning, and program management.



INDIAN PUBLIC HEALTH STANDARDS (IPHS)

17th

NATIONAL OVERVIEW

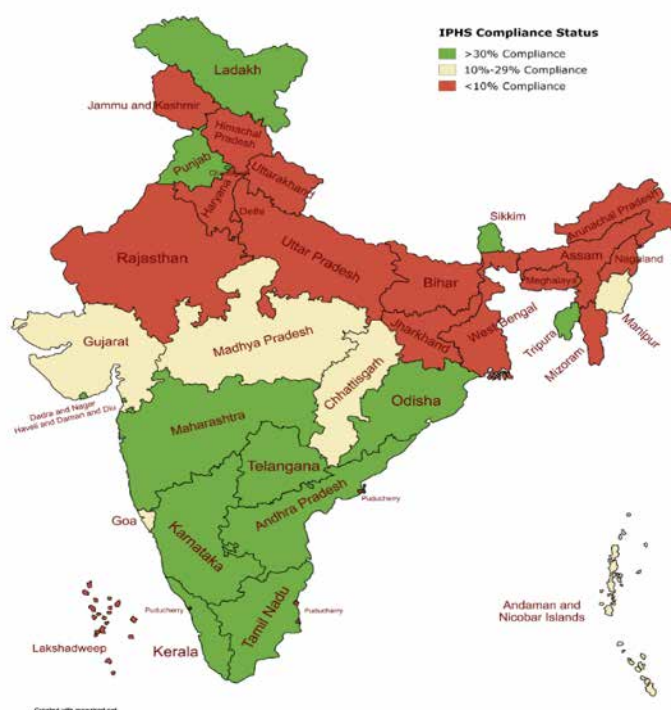
The Indian Public Health Standards (IPHS) are essential benchmarks that ensure the delivery of minimum essential services through public healthcare facilities, including District Hospitals, Sub-District Hospitals, Community Health Centres, Primary Health Centres, and Ayushman Arogya Mandir. These standards align with recent public health initiatives and are fundamental to our healthcare system. IPHS sets infrastructure, equipment, and human resources benchmarks, ensuring uniform service levels across all public health facilities. The guidelines outline essential and desirable services, helping states plan and meet these standards. By following these standards, facilities maintain consistent healthcare delivery and improve service quality.

MoHFW supports states and UTs by providing technical and financial support to address identified gaps and ensure that public healthcare facilities meet essential standards. The IPHS serve as a framework to evaluate facilities at all levels, contributing to improved health outcomes and increased public trust in the healthcare system.

As per the National Health Mission conditionality framework, states and UTs are committed to achieving IPHS compliance in 50% of healthcare facilities by 2025–26, with facilities required to score 80% or higher to be considered compliant. To support this process, the Ministry has developed an Open Data Kit (ODK) based digital tool and a web-based dashboard that facilitate assessments, enable rapid identification of gaps, and provide targeted support. The dashboard offers real-time updates, ensuring transparent and effective oversight while allowing stakeholders to make informed decisions and take timely corrective actions.

National Snapshot as of October 2025

As of 31 October 2025, 99.6% of public healthcare facilities had completed the IPHS self-assessment, of which 22.4% achieved compliance (scoring above 80%), while 38% were categorized as progressive with scores between 50% and 79%. A national snapshot reveals clear regional disparities, with southern and western states such as Kerala, Tamil Nadu, Karnataka, Telangana, Andhra Pradesh, Goa, and Maharashtra reporting relatively higher IPHS compliance levels (>30%), indicating stronger health system readiness and infrastructure.



Mid-range performers like Gujarat, Chhattisgarh, and Madhya Pradesh fall within the 10–29% range, while outliers such as Ladakh and Punjab in the north, along with Sikkim and

Tripura in the Northeast, demonstrate comparatively higher compliance than neighbouring states, highlighting pockets of better performance amid generally low regional trends. In contrast, much of the northern and eastern belt including Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Assam, and West Bengal remain below 10% compliance, reflecting significant gaps in facility standards.

KEY OBSERVATIONS

- **High assessment saturation but low full compliance**

Most States have achieved near-universal IPHS assessment coverage using the ODK toolkit; however, full compliance remains uneven. For instance, Telangana and Madhya Pradesh reported 100% assessment coverage, yet only 68.4% and 13% of facilities respectively were fully IPHS compliant (>80%), indicating that assessment completion has not uniformly translated into compliance.

- **Large concentration of facilities in aspirant and progressive bands**

States such as Assam, Rajasthan, and Uttarakhand show a high proportion of facilities clustered in the 25–69% score range. In Assam, only about 2% of facilities were fully compliant, while nearly half scored above 50%, reflecting partial readiness but persistent systemic gaps.

- **Primary-level facilities performing better than secondary care**

In Tamil Nadu and Telangana, Sub-Health Centres and PHCs demonstrated comparatively stronger compliance supported by initiatives such as AAM-HSC while District Hospitals and SDHs lagged, with only a small proportion crossing the 80% threshold.

- **Variation between ODK-reported scores and field observations**

In some locations, including parts of Andhra Pradesh, Rajasthan (Nagaur), and Meghalaya, minor variations were observed between ODK-based reporting and on-site findings. These were largely related to documentation practices, drug stock availability on the day of visit, biomedical waste management processes, and varying levels of awareness of IPHS norms among facility staff.

- **Uneven domain-wise performance**

Across States such as Maharashtra and Madhya Pradesh, infrastructure and basic service availability scored relatively higher, while diagnostics, drugs, human resources, and governance consistently emerged as weaker domains.

KEY CHALLENGES

- **Limited staff awareness and capacity on IPHS 2022**

Facility in-charges in Meghalaya, Nagaur (Rajasthan), and parts of Odisha were unaware of IPHS norms or the ODK toolkit, despite assessments being marked as completed on the portal.

- **Human resource shortages and misalignment**

States such as Chhattisgarh, Uttarakhand, and Assam reported significant gaps in specialist availability, laboratory staff, and support cadres, directly affecting service readiness and emergency care compliance.

- **Diagnostic and drug availability gaps**

In Maharashtra (Nandurbar), Chhattisgarh, and Uttar Pradesh, a substantial proportion of facilities scored below 50% in diagnostics and drugs due to non-functional equipment, limited test menus, and frequent stock-outs.

- **Infrastructure and IPHS version transition gaps**

Several States including Chhattisgarh and Madhya Pradesh continue to operate facilities aligned to older IPHS 2012/2016 norms, with incomplete compliance to IPHS 2022 standards on accessibility, zoning, patient safety, and climate resilience.

KEY RECOMMENDATIONS

- States should institutionalise random physical verification of ODK assessments and cross-validate scores with HMIS, e-Aushadhi, and diagnostic reporting systems.
- States to prioritise near-compliant facilities for rapid gains towards IPHS compliance.
- States such as Maharashtra, Tamil Nadu, and Telangana should focus on facilities scoring 70–79%, where targeted interventions in drugs, diagnostics, and HR can quickly increase the proportion of fully IPHS-compliant facilities.
- States to strengthen training and capacity-building on IPHS 2022. Refresher training on IPHS norms and ODK checklist interpretation is critical in states like Odisha, Meghalaya, and Rajasthan.
- States to address domain-specific gaps through targeted investments to expedite IPHS compliance. For states such as Chhattisgarh and Uttarakhand, focused investments in HR recruitment, diagnostic functionality, AMC/CMC for equipment, and biomedical waste management are essential to move facilities beyond the progressive category.
- States need to embed IPHS into routine planning and monitoring. States should translate IPHS findings into facility-wise and block-wise improvement plans, linked to NHM and PM-ABHIM funding, to ensure IPHS functions as a quality improvement tool rather than only a reporting requirement.
- States to strengthen secondary care facilities on priority for IPHS compliance. Given the consistent lag observed in DHs, SDHs, and CHCs across states such as Tamil Nadu, Telangana, and Assam, States should prioritise secondary-level facilities for infrastructure upgrades, specialist deployment, and quality system strengthening.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- Despite high scores for IPHS compliance reported for drugs and diagnostics in ODK-based assessments, several discrepancies were observed between the reported data and field conditions.
- Facilities often lacked complete documentation, had inconsistent stock records, or showed branding and waste-management gaps that were not captured in reported scores reflecting an absence of a structured mechanism for validating IPHS compliance through physical verification.

Assam

- State has institutionalised IPHS-based assessment across all levels of facilities and was using the state dashboards to track compliance. As per the compiled IPHS scores, 5,979 facilities have been assessed in the state. However, only about 2% of facilities were fully IPHS compliant, while around 48% of facilities have a compliance score of 50% and above. However, most facilities were still in the “aspirant” and “progressive” categories and have significant gaps to cover before they can be called fully compliant.
- Several facilities have good practices in cleanliness, display of citizen charters, availability of potable drinking water, and functional basic services, which were not always fully reflected in the way IPHS scores are used at the local level.
- At the state level, IPHS compliance varies by facility type; District Hospitals (DHs) and Sub Districts Hospitals (SDHs) are largely concentrated in the 50-79% only a small proportion fall in higher compliance bands was observed at CHC and PHC level, a large number of facilities fall in the 25-69% (progressive) range with only a proportion achieving full compliance. Similarly, most CHCs and PHCs fall within the 25–69% range.

Bihar

- None of the visited facilities was found to be IPHS 2022 compliant.
- Facility in-charge were not oriented about IPHS-2022
- District was yet to initiate the process of conducting IPHS-2022 assessment of health facilities.

Chhattisgarh

- IPHS 2022 guidelines were not uniformly followed in most facilities. State was still following the old IPHS norms, particularly in terms of infrastructure, proper zoning in labour rooms and adequate LDR beds.
- Staffing, service delivery, and documentation systems only partially comply with IPHS 2022 norms, with notable gaps in specialist and support staff availability,

essential drugs and diagnostics, and maintenance of data, SOPs, and essential service information displays.

Kerala

- 33% of health facilities were IPHS compliant in the State. State was requested to prepare the road map to fill the gaps found in assessment to meet the target to make 50% of health facilities IPHS compliant.

Madhya Pradesh

- A total of 12,626 health care facilities (100%) have been assessed for compliance with the Indian Public Health Standards (IPHS) across the State of Madhya Pradesh.
- Out of the total, 1614 (13%) of the health care facilities were IPHS compliant (score above 80%), and 6482 (51%) were progressive (50-79%).
- Domain-wise analysis of IPHS compliance indicated that while several facilities have shown improvement in basic infrastructure, service delivery, and record management, further efforts are required to achieve full compliance in areas such as human resources, quality assurance, and patient safety.

Maharashtra

- As per IPHS 2022 Gap Assessment: Across the state, about 20% of the health facilities have scored less than 50% and 22% facilities have scored between 50-69% on the compliance assessment. Approximately half (49%) of health facilities were IPHS compliant (i.e. have a score above 80%).
- A domain-wise analysis of the facilities revealed the percentage of facilities scoring less than 50% in each domain - 30% facilities in diagnosis, 35% facilities in drugs, 7% facilities in human resources, 24% facilities in services, 26% facilities in infrastructure, and 24% facilities in governance.

Meghalaya

- The health facilities at various levels (DH, CHC, PHC and SC) visited in both the CRM districts had gaps with regards to IPHS. The health functionaries were not aware of IPHS or ODK Toolkit.

Nagaland

- None of visited health facilities were IPHS compliant.
- The State had undertaken initial assessments and based on these, the action plan for phase wise gap filling was under process.

Odisha

- ODK toolkit training was provided to the facility in charge at all levels. Although there were gaps observed in the knowledge of staff for filling the checklist. e.g., an NQAS-certified facility, was marked NA for IPHS ODK assessment.
- There was an incomplete functional transition of services following the relocation of the DH, which led to temporary service disruption and overlapping functions with CHC Bargarh. Critical units such as the Blood Bank and CCU were not fully operational, limiting compliance with IPHS norms for emergency and critical-care readiness.

Punjab

- The districts reported that national and state-level online orientations on facility assessment for IPHS 2022 norms were conducted using the ODK toolkit. The IPHS ODK assessments for all health facilities have been completed.

Rajasthan

- Only 2.7 % Health facilities had more than 80% compliance score against the target of achieving 50% IPHS Compliance of all health facilities by December 2025.
- Most of the healthcare facilities assessed in the districts have completed the Indian Public Health Standards (IPHS) assessment. However, it was observed that the facility nodal officers in the visited facilities were largely unaware of the IPHS Open Data Kit (ODK) Toolkit.
- The number of tests performed at each level of health facility was way less as per the IPHS 2022.

Sikkim

- The facilities visited demonstrated partial compliance with the IPHS 2022. While both districts have made visible progress in strengthening infrastructure, service availability, patient safety, and information display systems, several areas require further improvement to achieve full IPHS compliance.
- Most PHCs, UPHCs, and AAM-SHCs in the two districts were functional as per the mandated timings, with essential outpatient services, basic laboratory tests, and pharmacy services in place. Citizen Charters, service timings, and departmental signages were found prominently displayed.
- Practices related to use of color-coded BMW bins, hand hygiene practices, availability of PPE, and adherence to infection prevention were observed to be good.
- Facilities meet many of the staffing requirements for ANMs, MPWs, and CHOs, but both districts face a significant shortage of specialists, particularly paediatricians, anaesthetists, and gynaecologists.

- The compliances such as AERB authorization, BMW authorization, and fire safety NOC were not upto the mark across facilities visited.

Tamil Nadu

- State had 54% facilities IPHS complaint, while 34.6% were progressive (score-50-79%), and only 11.3% were aspirant.
- Tamil Nadu exhibits a relatively strong performance in quality service delivery within the public health sector, with notable improvements in maternal health metrics and multisectoral health program implementations. It's progress aligns substantially with Indian Public Health Standards and National Quality Assurance Standards through initiatives ensuring emergency obstetric care availability, systematic quality audits, trained human resources deployment, and coordinated health interventions.

Telangana

The Baseline IPHS Assessment has been undertaken for 100% facilities. Total 68.4% facilities were IPHS compliant.

- Among the Secondary level facilities only 2 DH and 8 SDH have achieved more than 80% compliance, among the CHCs, only 13 CHCs (13.4 %) have achieved more than 80% compliance. Among PHCs show mixed results of 57.7% achieving compliant status of more than 80% score.

Uttar Pradesh

- Infrastructure across facilities only partially complies with IPHS norms, with notable gaps in building condition, essential amenities, equipment calibration, and availability of drugs and diagnostics.
- Availability of essential drugs and diagnostics remains below IPHS-mandated lists, particularly at the CHC, PHC, and SHC levels.

Uttarakhand

- Out of the 2,577 primary & secondary healthcare facilities of the state (SHC/PHC/CHC/SDH & DH) 99% have been assessed for IPHS compliance. Majority of facilities have been categorised as Aspirant as their scores lie between 25% -50%.
- Major challenges in achieving IPHS were related to high number of vacant positions and limited availability of trained staff.



FREE DRUGS SERVICE INITIATIVE (FDSI)

17th

FREE DRUGS SERVICE INITIATIVE (FDSI)



NATIONAL OVERVIEW

Access to essential medicines is a critical component of Universal Health Coverage (UHC). To ensure equitable, affordable, and quality-assured essential generic medicines, and to reduce out-of-pocket expenditure (OOPE) on medicines, the NHM launched the Free Drugs Service Initiative (FDSI) operational guidelines in 2015.

According to the National Health Accounts (NHA) 2013–14 report, 64.2% of India's total health expenditure was borne by households as out-of-pocket expenditure, with medicines accounting for a significant share. Over the years, the implementation of FDSI, along with other public health interventions, has contributed to a steady decline in OOPE on medicines. As per the latest NHA 2021–22 report, OOPE has reduced to 39.4%, reflecting the impact of improved access to free medicines in public health facilities.

The observations, major findings, and recommendations from the Free Drugs Service Initiative assessment across 17 States are summarized below.

KEY OBSERVATIONS

- Many States like Andhra Pradesh, Kerala, Odisha, Rajasthan, Sikkim, Tamil Nadu, and Telangana have established centralized procurement agencies through autonomous medical service corporations (e.g., TNMSCL, TGMSIDC, OSMCL, etc.), which facilitate procurement, quality assurance, supply chain management, thereby improving the availability of essential medicines in public health facilities across the State.
- All States have notified their Essential Drug Lists (EDLs) with facility-wise categorization. However, field observations indicate partial availability of EDL medicines, misalignment between State EDLs and IPHS EML, and limited awareness of the EDL among facility-level staff in some States.
- Several States have adopted digital inventory management systems such as DVDMS/ e-Aushadhi/State LMIS for drug procurement, indenting, and stock monitoring at the State level. In addition, many State LMIS platforms were integrated with the DVDMS central dashboard for efficient stock monitoring at the national level. However, challenges persist, including mapping of EML, incomplete rollout to peripheral facilities, delayed updating of stock or dispensing data, and mismatches between physical stock and digital records.

- In majority of the visited states, the availability of essential medicines up to the AAM-SHC level was found to be adequate, which would help to reduce out-of-pocket expenditure (OOPE) and improve service delivery. However, in some states, inadequate availability of NCD medicines and other essential medicines was observed, affecting the continuity of care.
- Gaps in storage and inventory management practices have been reported in several states, including limited adherence to FEFO/FIFO principles, inadequate management of expired or near-expiry medicines, and poor ventilation and temperature control in storage areas.
- In some States, such as Andhra Pradesh and Nagaland, drug distribution mechanisms were not fully demand-based, with reliance on centralized or push-based supply systems. This led to issues such as stock imbalances across facilities, and in certain cases, reliance on local purchase mechanisms to bridge supply chain gaps.

BEST PRACTICES

- To strengthen the last mile medicine delivery, the state of Tamil Nadu has launched a scheme “Makkalai Thedi Maruthuvam (MTM)” where Women Health Volunteers (WHV) distribute medicines to patients with chronic conditions.
- In the facilities visited in Tamil Nadu, a turnaround time of one day was observed for the supply of medicines to peripheral facilities, reflecting an efficient and responsive supply chain system.
- In Andhra Pradesh to reduce the travel burden long-duration dispensation of medicines for chronic conditions such as hypertension, diabetes, and thyroid disorders were followed; resulting in improved treatment adherence and reduced out-of-pocket expenditure (OOPE).

RECOMMENDATIONS

- States to ensure alignment of State EDL with IPHS EML to maintain uniform availability of essential medicines across facility levels.
- State to ensure display of EDL across the public health facilities and build community confidence in government medicines through consistent availability and counselling.
- States to strengthen DVDMS utilization up to the AAM-SHC level for real-time stock monitoring, indenting and dispensation.
- States to establish robust stock monitoring systems to minimize discrepancies between physical stock and State LMIS records.
- States to strengthen demand forecasting mechanisms and introduce data-driven cyclical indenting based on disease trends and seasonal variations.
- States to strengthen forecasting and buffer stock maintenance based on consumption trends, disease load, and seasonality.

- States to improve medicine transportation mechanisms, particularly for last-mile delivery to peripheral facilities, to ensure uninterrupted availability of medicines including for NCD, mental health, and other essential services.
- States to strengthen drug storage infrastructure with adequate shelving, ventilation, temperature control, and designated areas for quarantine, expired, and near-expiry medicines.
- States to ensure adherence to FEFO/FIFO principles, proper stock segregation, and systematic expiry monitoring across all facilities.
- States to conduct regular capacity-building initiatives for pharmacists and facility staff on inventory management, stock reconciliation, FEFO compliance, and record maintenance.
- States to introduce periodic drug-use and safety audits focusing on rational prescribing.

STATE SPECIFIC FINDINGS:

Andhra Pradesh

- The State has revised its EML in 2024 and developed facility-wise EMLs to support rational drug distribution across levels of care. Procurement and supply chain management were undertaken by the Andhra Pradesh Medical Services and Infrastructure Development Corporation (APMSIDC), providing an organized and autonomous mechanism for procurement and logistics.
- The E-Aushadhi platform has been implemented up to the AAM-SHC level and was integrated with the DVDMS central dashboard, enabling digital tracking of medicine stock availability across all level of public health facilities.
- Gaps between digital records and physical stock were observed due to delayed updating of dispensation data, particularly in facilities where pharmacist or dedicated data-entry support was not available, and in areas with poor internet connectivity such as parts of Parvathipuram Manyam.
- Consumption-based forecasting was not fully operational, as drug indenting largely follows state-level directives with periodic dispatches rather than facility-level consumption data. This has resulted in overstocking of certain medicines and shortages of others at some facilities.
- At the primary care level, most facilities reported adequate availability of essential medicines, and dispensing of medicine for long duration for diseases like hypertension, diabetes and thyroid disorders, which has reduced patient travel and has improved treatment adherence.
- State was ensuring the supply of medicines to patients through multiple channels (sub-centre supply, outreach services, Sanchar Chikitsa, Family Doctor programme and mobile medical units), however, they were not always reflected in the digital system, affecting stock accuracy.

- At secondary facilities, medicine availability and patient satisfaction were high in Chittoor, while shortages of selected medicines, including certain high-end antibiotics, thyroid medicines and psychotropic drugs, were reported in Parvathipuram Manyam, leading to out-of-pocket expenditure for patients.
- Drug storage practices were satisfactory in Chittoor, whereas space constraints, rented storage facilities and limited temperature control were observed in parts of Parvathipuram Manyam. In addition, regular stock reconciliation between physical inventory and E-Aushadhi records was not consistently practiced, affecting accurate forecasting and inventory management.

Assam

- The State has implemented the FDSI and the availability of essential drugs was generally good across AAM-SHC and PHC levels, with the State Essential Medicines List (EML) specifying 105 medicines for AAM-SHC and 172 medicines for AAM-PHC. Most facilities visited had the EDL displayed, and availability of key medicines was generally satisfactory.
- At AAM-SHCs and PHCs, most RMNCH drugs, antibiotics, analgesics and contraceptives were available at the time of the visit. Patients and providers reported that stock-outs of commonly used medicines have reduced compared to earlier, indicating improvement in the free drug supply system.
- Occasional shortages of some NCD medicines and psychotropic drugs have been reported, partly due to misalignment between the State EDL and IPHS EML lists, affecting the availability of certain items, particularly for mental health care.
- Community interactions indicated that patients value the availability of free medicines at government facilities. However, some patients with diabetes and other chronic conditions still prefer medicines from private pharmacies, citing concerns regarding the perceived effectiveness of government medicines, fear of future stock-outs and continued reliance on private prescriptions.
- State has established a fairly robust system for free drug availability at the primary-care level, as observed in districts such as Charaideo and Udalguri. However, alignment of the State EDL with IPHS EML, will ensure the consistent availability of NCD and psychotropic medicines leading to improved community confidence in government-supplied medicines, which will further enhance the effectiveness of the Free Drugs Service Initiative.

Bihar

- The State has implemented the FDSI across public health facilities, with medicines supplied as per the State EDL. During the visit, most facilities reported adequate availability of medicines, although some variations across facilities were observed. For instance, at APHC Bhati in Saran, 105 medicines were available against 147 medicines listed in the State EDL.

- The state has notified a facility-wise Essential Drug List (EDL), comprising 424 drugs at DH (303 rate contracted), 294 at SDH (229 rate contracted), 284 at RH (220 rate contracted), 291 at CHC (229 rate contracted), 278 at PHC (223 rate contracted), 174 at UPHC (146 rate contracted), 187 at APHC/AAM-PHC (153 rate contracted), and 147 at AAM-SHC/UAAM(123 rate contracted).
- DVDMS was being used across all visited facilities for monitoring drug stocks and managing the supply chain. However, due to delay in updating stock information, discrepancies between physical stock and DVDMS records were observed at several facilities, affecting the reliability of inventory data.
- Storage of medicines were generally satisfactory, with clear labelling of expiry dates on all medicines under FDSI, proper temperature maintenance, High-risk and LASA medicines were labelled and stored separately in all visited facilities. Additionally, no expired medicines were found in the visited facilities.
- Infrastructure gaps were observed in some drug stores, particularly at secondary facilities, where cracked walls, damaged flooring and improper carton arrangement affected safe storage and efficient inventory management.
- A QR code-based drug availability display system was operational at facilities, allowing the public to view available medicines thereby improving transparency. However, this system was not integrated with DVDMS, limiting its usefulness for real-time inventory management.
- The State has adopted a third-party logistics (3PL) model for drug distribution, with GPS-enabled vehicles transporting medicines from district warehouses to block and peripheral facilities, improving last-mile delivery across more than 12,800 health facilities in the State.
- Key gaps identified include mismatch between physical and digital stock records, need for rationalization of high drug inventory at the primary level, gaps in labelling/segregation of certain medicines, and ensuring secure storage of narcotic drugs in some visited facilities such as SDH Tarapur.

Chhattisgarh

- Implementation of the FDSI was observed across all public health facilities; however, compliance with Essential Drug List (EDL), FEFO and LASA norms was inconsistent. While EDLs were displayed and practices followed in some facilities, but adherence across PHCs and CHCs was not adequate.
- In NQAS-certified facilities, Look-Alike Sound-Alike (LASA) medicines were appropriately labelled, and First-Expiry-First-Out (FEFO) principles were being followed, with drugs stored in an organised manner.
- Availability of essential medicines at primary care facilities was limited. At AAM-SHCs, around 35–40 medicines were available against the prescribed 106 medicines, while AAM-PHCs had approximately 70–75 medicines available against the list of 172,

indicating partial compliance with the essential medicines list.

- No stock-out days were reported during the assessment period, and buffer stocks were maintained at all levels of care. However, shortages of some essential medicines were observed, including commonly used drugs such as Amlodipine, posing risks for continuity of care in chronic disease management.
- Lead time for medicine supply ranged between 2–10 days, reflecting variability in supply chain responsiveness across different locations. Furthermore, local purchase mechanisms were not utilized during shortages, causing service disruptions despite enabling provisions
- Stock management systems were uneven, with DVDMS/DPDMIS/DDMIS used for online indenting in some facilities; however, at AAM-PHCs/SHCs, stock management remained largely manual due to incomplete adoption of the system, limiting real-time stock visibility and forecasting.
- Drug storage practices varied across facilities. While warehouses were generally organized, several facility pharmacies had poor ventilation, temperature control issues, seepage or cracked walls, and expired fire safety equipment, affecting safe storage conditions.
- Expired and obsolete drugs were found stored in some facilities, indicating delays in removal and disposal mechanisms. Cold-chain monitoring for temperature-sensitive medicines was also inconsistent, with incomplete temperature logs observed.
- Pharmacist counselling and documentation practices were inconsistent, and most facilities lacked dedicated patient counselling spaces. However, prescribing practices generally adhered to generic nomenclature and Standard Treatment Guidelines (STGs).

Kerala

- FDSI was effectively implemented across all public health facilities in the State. Medicines are procured through the Kerala Medical Services Corporation Limited (KMSCL) using the Drug Distribution Management System (DDMS), with additional support from Local Self Governments (LSGs). The supply chain system was robust and well-functioning, contributing to consistent drug availability.
- The State Essential Medicine List (EML) was comprehensive and regularly updated every two years, with the latest revision in 2024. The State EML includes 866 drugs, which was higher than the IPHS norms, and facility-wise EMLs have been formulated, upto the AAM-SHCs.
- The State EML (including formulations) specifies 747 medicines for District Hospitals (DHs), 629 for Sub-District Hospitals (SDHs), 362 for CHCs, 296 for PHCs, and 36 for SHCs, reflecting a broad and stratified approach to drug availability across levels of care.
- The DDMS platform has been implemented up to AAM-SHC level, with online indenting functional at PHC level and above. Additionally, an MoU with Karunya Community Pharmacy was in place to ensure uninterrupted availability of chemotherapy drugs.

- Availability of medicines across facilities was generally adequate. During field visits, 35 of 106 drugs were available at SHC-AAM, 105 of 172 drugs were available at AAM-PHCs, and 157 of 300 drugs at CHCs, 212 of 318 at SDH and 253 of 381 at DH. NCD drugs were also being dispensed for approximately 15 days at AAM-SHCs.
- Despite strong overall availability, gaps were observed in relation to IPHS norms, with facilities reporting lower availability compared to prescribed standards.
- Drug storage and inventory management practices were appropriate, with adequate infrastructure for storage, monitoring, and dispensing. High-risk and Look Alike Sound Alike (LASA) drugs were properly labelled and stored separately.

Madhya Pradesh

- FDSI was successfully implemented across the State at all level of public health facilities. Madhya Pradesh Public Health Services Corporation Limited (MPPHSL) was the central procurement agency, which finalizes rate contracts for medicines and oversees procurement and supply chain management across the State.
- The State Essential Drug List (EDL) largely aligns with IPHS-2022 norms, with 530 medicines notified for District Hospitals, 448 for Civil Hospitals, 373 for CHCs, 299 for PHCs and 126 for SHCs. During the CRM visit, around 80% availability of EDL medicines was observed across the visited facilities.
- The E-Aushadhi digital platform was being used for procurement and supply chain management and has been implemented up to the Sub-Health Centre level, enabling tracking of medicine stocks and supply distribution.
- Availability of medicines varied across facilities. For example, 408 of 530 EDL medicines were available at DH Mandsaur, 376 of 448 at CH Shamgarh, 358 of 373 at CHC Nagri, 242–280 of 299 at PHCs, and 112 of 126 at AAM-SHCs. In Vidisha, 380 of 530 medicines were available at DH Vidisha, with lower availability at some CHCs, PHCs and SHCs.
- Stock-outs of certain essential medicines were reported, including vital drugs such as streptokinase (STK), sodium bicarbonate, methylprednisolone, diazepam and pentazocine, indicating gaps in supply continuity.
- The lead time for supply after procurement orders ranged from approximately 45 to 90 days, which contributes to supply delays and affects availability at facility level.
- Drug storage practices require strengthening in some visited facilities including the district drug warehouse at Mandsaur as it was found to have ceiling leakage and damp storage conditions, posing risks to safe medicine storage.
- Inventory management practices require improvement, including regular drug forecasting and physical stock verification, which were not being conducted consistently. In some facilities, LASA (Look-Alike Sound-Alike) drug lists were not properly maintained and EDL display was missing.
- At DH Mandsaur, the “Aushadi Mitra” application was being used at the drug distribution counter to record patient-wise dispensing and automatically update stock levels through

linkage with the E-Aushadhi system. However, the application was not integrated with the hospital electronic medical record system, requiring duplicate data entry.

Maharashtra

- The State implements the FDSI and has developed facility wise State EDL. However, all the EDL medicines were not available, but medicines required for patients based on facility disease burden and utilisation patterns were adequately available.
- Most facilities had the updated EDL available, although in few of the visited facilities in Nandurbar district it was not displayed publicly, limiting beneficiary awareness regarding available medicines.
- Stock-outs of certain essential medicines were reported across facilities in both Satara and Nandurbar districts, including shortages of Iron and Folic Acid (IFA) tablets.
- To address these gaps, facilities sometimes relied on local emergency procurement through JAS or RKS funds; however, such purchases were not consistently reflected in e-Aushadhi, resulting in an incomplete picture of actual stock positions.
- Drug inventory management practices were generally satisfactory, with no expired medicines found during the assessment period. High-risk and LASA medicines were properly labelled and stored separately, and Drug Distribution Counters (DDCs) were functional at all facilities.
- Essential medicines for NCD management (hypertension, diabetes and asthma) were adequately stocked at most facilities. In addition, Anti-Rabies Vaccine (ARV) and Anti-Snake Venom (ASV) were available across facilities, ensuring preparedness for emergency management.
- The State uses the e-Aushadhi platform for drug inventory management, which was operational across facilities for online indenting, stock tracking and drug distribution, and has been implemented up to the sub-centre level. However, unstable internet connectivity in remote areas lead to some AAM-SHCs still submitting manual indents, delaying the indenting process.
- A dual warehouse system was in use for drug distribution: warehouses under the Civil Surgeon supply medicines to secondary facilities, while those under the District Health Officer supply PHCs and sub-centres, ensuring decentralised supply chain management.
- Drug procurement was undertaken through a structured process, with block-level demand estimation based on EDL and available funds, approval by the District Planning Committee, and procurement through the GeM portal using a tendering mechanism.
- Key challenges include inconsistent medicine availability, incomplete updating of emergency local purchases on e-Aushadhi, connectivity issues affecting online indenting, and storage infrastructure gaps such as lack of fire safety equipment or power backup in some facilities. Strengthening forecasting, digital reporting and storage safety systems would further improve FDSI implementation in the State.

Meghalaya

- State Essential Drug List (EDL) contains over 1100 medicines, but it has not yet been standardized or rationalized according to different levels of healthcare facilities, leading to challenges in aligning drug availability with service delivery requirements.
- Drug storage conditions were inadequate at various levels. District warehouses and facility-level drug stores were found to be poorly organized, affecting efficient stock management and medicine accessibility at public health facilities.
- Cold chain storage for temperature-sensitive medicines was inadequate across several facilities, indicating gaps in availability of appropriate equipment and effective temperature monitoring systems required for safe storage.
- Stock management practices were weak, with both manual and digital stock records not being consistently maintained, resulting in poor visibility of inventory status.
- Expired medicines were observed in some facilities, and healthcare staff demonstrated limited knowledge of inventory management practices, including principles such as proper storage and stock rotation.
- However, emergency medicine trays were adequately stocked, ensuring availability of critical medicines required for emergency management.

Nagaland

- The State has notified its revised facility wise EDL in 2025, with 285 medicines for DHs, 238 for CHCs, 160 for AAM-PHCs and 86 for AAM-SHCs. However, the State EDL was not as per IPHS norms.
- Availability of essential medicines was inadequate across facilities, with essential drug availability ranging between 25 and 140, and stock-outs and irregular supply issues have been reported. Patients often had to purchase medicines from private pharmacies or through user charges, leading to out-of-pocket expenditure (OOPE).
- DVDMS has been implemented up to the PHC level but was not fully utilized for indenting or inventory management, largely due to lack of training of pharmacists and continued reliance on manual indenting systems, leading to discrepancies between DVDMS records and physical stocks at facility level.
- The State follows a PUSH-based supply mechanism, where medicines are distributed from the State warehouse to districts and then to peripheral facilities, rather than based on facility demand. SHC receive medicines directly from the CMO office at district level.
- Procurement systems remain weak, with no centralized procurement agency established in the State. Medicines are often procured manually through quotations and local purchase using untied funds or user charges for emergency procurement due to shortages.
- Drug storage and warehouse infrastructure were found to be poor, with the central drug warehouse in inadequate condition and some district stores having seepage, cracks, poor cleanliness and damp storage conditions. Inventory management practices were also weak.

- Management of expired and near-expiry medicines was inadequate, and the State has not yet notified a formal drug disposal policy. Psychotropic and narcotic drugs were not consistently stored under double-lock arrangements, indicating gaps in drug safety practices.

While NCD drugs and certain essential medicines (e.g., anti-malarials and emergency obstetric drugs) were available at some facilities, psychotropic medicines were largely unavailable at primary care levels.

Odisha

- State is implementing FDSI as NIRMAYA Scheme, managed by the Odisha State Medical Corporation Ltd. (OSMCL). They have developed an Essential Drug List (EDL) and it was well displayed across levels of public healthcare facilities.
- The DVDMS was operational across the State up to AAM-SHC level and was being used for drug indenting and monitoring of the supply chain, enabling digital tracking of drug stock.
- Availability of essential medicines was adequate at the primary-care level, although stock-outs of certain EDL medicines were reported at several visited facilities. For instance, at the District Hospital in Kalahandi, 75 medicines were out of stock out of 381 listed in the EDL, indicating gaps in supply reliability.
- Frequent stock-outs were attributed to delays in procurement and distribution processes and inadequate planning of indents, with the average lead time between indent submission and receipt of medicines being around 15 days.
- Drug storage and inventory management practices were generally good at the visited health facilities, with medicines properly labelled and organized, and expired and near-expiry drugs segregated. LASA medicines were also appropriately identified and displayed in all visited facilities. However, district drug warehouse storage conditions were not fully compliant with guidelines, particularly due to inadequate racks and shelving systems.
- Capacity for inventory management was observed among AAM-PHC staff, who were aware of ABC and VED analysis, although this practice needs to be strengthened and replicated across all levels of care.
- Adequate availability of the NCD medicines was observed in the visited facilities; however, all required dosage variants were not consistently available. Additionally, AYUSH medicines, were unavailable at the visited facilities despite the presence of AYUSH Medical Officers.
- Instances of local procurement of medicines (e.g., Telmisartan and other drugs in Bargarh district) were reported to address supply gaps. Additionally, improper disposal of expired drugs by the outsourced biomedical waste collection agency was also observed.

Punjab

- FDSI is successfully implemented and the State has notified its facility wise categorised EDL that includes 487 medicines for DHs, 362 for SDHs, 317 for CHCs, 202 for PHCs and 103 for SHCs. During the field visit, medicine availability was generally high, with approximately 466 medicines available at DHs, 341 at SDHs, 262 at CHCs, 109 at PHCs and 61 at SHCs.
- Availability of medicines procured through the State system was largely adequate, and no major stock-outs were reported at visited facilities. Facilities maintained buffer stocks, and no medicine-related out-of-pocket expenditure (OOPE) was reported during field visits.
- Digital drug logistics systems were operational, with e-Aushadhi integrated with the e-Sushrut system to update drug dispensing and track stock availability at DHs, SDHs and urban facilities. DVDMS was also used for stock management across the supply chain.
- Drug storage and inventory practices were satisfactory, with proper stacking and labelling of medicines, adherence to FIFO principles, segregation of Look-Alike Sound-Alike (LASA) medicines, and double-lock storage for psychotropic drugs. District drug warehouses maintained adequate stocks and mechanisms for monitoring near-expiry medicines.
- NCD medicines for hypertension and diabetes were available across primary and secondary care facilities and were typically dispensed for 30 days at primary care level. Emergency medicines such as Anti-Snake Venom and Anti-Rabies Vaccine were also available at relevant facilities.
- The State has established a local procurement mechanism through the “Local Medicine Demand Portal”, enabling facilities to procure medicines when required. Prescription audits were practiced across all secondary care facilities and Standard Treatment Guidelines (STGs) were available and implemented across facilities.
- Some gaps were noted at primary care facilities, where 109 of 202 medicines were available at PHCs and 61 of 103 medicines at SHCs, with remaining procurement under process. Additionally, folic acid tablets for the first trimester of pregnancy were unavailable, and only paracetamol syrup of 250 mg/5 ml strength, which is double the recommended 125 mg/5 ml, was available, with the recommended strength not found in any state warehouses.

Rajasthan

- FDSI is implemented across the State as Mukhyamantri Nishulk Dava Yojana (MNDY). Rajasthan has revised and notified a facility-wise Essential Medicines List (EML) in 2025, which includes dosage forms, strengths, and packaging details. The State EDL contains a large number of medicines with 1099 items for DHs, 1096 for SDHs, and 548 for PHCs, and facility-specific lists were implemented down to AAM-SHC level.
- Availability of essential medicines varied across facilities, with drug availability reported at 75% at DH Nagaur, 50% at SDH Jayal, and 63 – 80% at PHC/UPHC level, while AAM-

SHCs reported relatively adequate availability. Drugs were predominantly prescribed in generic names across visited facilities promoting rational and cost-effective drug use. The overall stock-out rate remained below 5% in the last three months, though NCD medicines (for hypertension and diabetes) were observed in low stock or out-of-stock at several visited PHCs and AAM-SHCs.

- The State has a centralized procurement system managed by Rajasthan Medical Services Corporation Limited (RMSCL), which undertakes procurement through e-tendering and rate contracts based on consumption and morbidity data. Facilities follow a three-month indenting cycle, with an average lead time of around 15 days from indent submission to receipt of medicines. A local purchase mechanism (up to 10% of the sanctioned budget) was also available at facilities to address emergency shortages.
- Digital drug logistics systems was operational through e-Aushadhi which is used at district drug warehouse level and the Integrated Health Management System (IHMS) which is being used at district sub store level for procurement and inventory management. Furthermore, effective rollout of DVDMS/e-Aushadhi at PHC level remains incomplete, limiting real-time stock visibility and affecting supply chain planning. Strengthening digital literacy and regular updating of stock data at peripheral facilities is required.
- Drug storage and quality assurance practices were generally satisfactory. District drug warehouses and facility stores were well organized with alphabetically labelled racks, segregated storage for near-expiry drugs, LASA medicine identification, and secure double-lock storage for narcotic medicines. Refrigerators and temperature-controlled storage facilities were available for thermo-sensitive medicines, and no expired drugs were reported during the previous three months; however, in some instances, temperature-sensitive medicines were observed to be stored in thermocol boxes, indicating a need to strengthen cold chain management practices.
- Rajasthan follows robust quality assurance mechanisms, including NABL-accredited laboratory testing of drug consignments before distribution, systematic ABC and VED analysis for forecasting, and 3PL logistics systems for transportation of medicines. Public display of medicine availability at facilities was also observed to enhance transparency and accountability.
- District drug warehouses had adequate infrastructure, including heavy-duty racks, walk-in coolers, quarantine areas for non-standard quality drugs, and separate sections for expired medicines, supporting safe storage and efficient supply chain management.

Sikkim

- The State follows a centralized procurement system with State EDL comprising 383 medicines categorised as Vital (56), Essential (250) and Desirable (77). Facility-specific EMLs have been developed, and the FDSI is operational across public health facilities.
- Significant stock-outs of essential medicines were observed. Out of the medicines listed in the State EDL, 124 items (Vital – 5 & Essential – 119) were unavailable, with nearly 47.6% of drugs in the Essential category reported as stock-out, indicating gaps in supply reliability.

- At the facility level, SHCs and PHCs reported shortages of several essential medicines, largely attributed to delays in supply from district stores and weak forecasting mechanisms.
- Forecasting was reported to be based on consumption and morbidity trends; however, the persistence of stock-outs indicated inconsistencies in quantification, highlighting the need for stronger adoption of ABC/VED analysis and clearer guidelines for facility-level local procurement.
- Inventory management systems remain weak, with limited use of digital logistics platforms. The rollout of DVDMS has begun but was not yet fully implemented, and stock management at many facilities continues through manual processes.
- Storage and cold-chain monitoring practices require strengthening. Temperature-sensitive medicines were stored in refrigerators, but temperature logs and monitoring mechanisms were not consistently maintained.
- Capacity gaps were observed among storekeepers and pharmacists, particularly in areas such as inventory documentation, expiry management and adherence to FIFO/FEFO principles, affecting effective stock management.

Tamil Nadu

- The FDSI was implemented and Tamil Nadu Medical Services Corporation Limited (TNMSCL), manages centralized procurement, storage, and distribution of medicines across public health facilities. The State has a comprehensive Essential Drug List (EDL) comprising 484 specialty medicines to support service delivery across different levels of public health facilities.
- Drug warehouses managed by TNMSCL were well maintained, EDLs were displayed properly and periodic prescription audits were in place to ensure rational drug use and transparency in medicine supply.
- The State has increased its drug budget and waived user charges in all public health facilities, supporting the provision of free quality medicines and reducing out-of-pocket expenditure for patients.
- Drug availability at primary care facilities was observed to be strong, with high availability of EDL medicines in visited facilities. Efficient logistics systems ensure rapid supply from district warehouses to peripheral facilities, with a lead time of about one day in Salem district.
- In urban areas, the “Makkalai Thedi Maruthuvam (MTM)” outreach programme supports last-mile drug delivery, where Women Health Volunteers (WHV) distribute medicines to patients with chronic conditions such as hypertension and diabetes.
- Patient awareness regarding availability of certain medicines such as insulin and CAD drugs was limited, even among patients already receiving treatment for hypertension and diabetes.

Telangana

- The FDSI was implemented across the State. They have established a centralized procurement system managed by the Telangana Medical Services and Infrastructure Development Corporation (TGMSIDC) using e-procurement from quality-assured GMP-certified suppliers. The State follows a unified EDL of 522 medicines, categorized for primary, secondary, and tertiary care levels to standardize drug availability across facilities.
- The drug supply chain was digitized through the e-Aushadhi platform, which enables online indenting, real-time stock visibility, and batch-wise expiry tracking. District Drug Warehouses function as logistics hubs, supporting storage, inventory management, and consumption-based distribution of medicines to health facilities.
- These systems have improved access to quality-assured medicines and reduced out-of-pocket expenditure (OOPE) for patients availing services at public health facilities.
- However, drug availability at CHC and Area Hospital levels was observed to be inadequate compared to the Essential Drug List, indicating supply and stock management gaps at secondary care facilities.
- e-Aushadhi was operational up to PHC level, and extension of digital indenting and inventory management to AAM-SHC level is required to improve last-mile stock visibility.
- Display of Essential Drug Lists and information on available services was inconsistent across facilities, limiting transparency and awareness among beneficiaries.

Uttar Pradesh

- The State has implemented the FDSI successfully and has recently revised their EDL. Newly added medicines were under procurement and Essential Drug Lists were displayed at the facilities; however, availability remained below IPHS-mandated levels at CHC, PHC, and SHC.
- Approximately 70–80% of essential medicines were available across facilities, and drugs under national health programmes were generally supplied free of cost. However, out-of-pocket expenditure (OOPE) persisted for medicines that were out of stock at facilities.
- DVDMS was operational for drug indenting, but its use for recording drug dispensation and consumption at peripheral facilities remains limited, creating gaps in real-time stock visibility.
- Knowledge of the EDL at facility level was limited, and instances of local purchase of branded medicines were observed where drugs were unavailable through the regular supply system.
- Drug storage practices were generally organized, with designated areas for near-expiry medicines and secure storage for narcotic drugs. However, some warehouses had infrastructure gaps such as inadequate racks, mixed storage of expired and active stock, non-functional walk-in coolers and lack of power backup.

- Inventory management practices require strengthening, particularly at SHCs where manual stock registers and local procurement were still used, and systems for stock verification, ADR reporting, and monitoring of high-risk medicines were limited.

Uttarakhand

- The State has notified its own Essential Drug List (EDL) for primary and secondary healthcare facilities. The State EDL includes 74 medicines for AAM-SHC and 135 medicines for AAM-PHC, while the list for secondary care facilities (CHC/SDH/DH) includes around 690 medicines.
- Availability of medicines against the EDL varied across facilities. At AAM-SHCs, 40–65 medicines were available against 75 medicines in the State EDL, while 54–80 medicines were available against 134 medicines at AAM-PHC level. At secondary facilities, availability ranged between 76 medicines at CHCs, 93–132 at SDHs, and 161–208 at DHs, indicating gaps in availability particularly at higher facilities.
- Updated Essential Drug Lists were not displayed in most of the visited facilities, limiting awareness among facility staff regarding medicines to be stocked as per the State EDL.
- Medicines for NCDs such as hypertension and diabetes were generally available, though shortages were reported in Udham Singh Nagar district. In addition, NCD medicines were dispensed for only 3–15 days instead of one month as recommended under NP-NCD protocols, affecting continuity of treatment.
- Stock-outs of commonly prescribed medicines were reported, and facilities were using emergency drug budgets for procurement of medicines such as Calcium, Vitamin-A, OCPs and Glimepiride. Insufficient stocks of ARV medicines were also reported in Udham Singh Nagar district.
- The State has implemented DVDMS (e-Aushadhi) up to the SHC-AAM level, but the system was primarily used for raising indents and not fully utilized for inventory management functions such as monitoring stock-outs, near-expiry drugs, and overall stock tracking. Limited capacity of facility staff in using the system was also observed.
- Drug storage and inventory practices require strengthening, as near-expiry medicines were not consistently stored separately and proper inventory management practices were not uniformly followed across facilities.
- State and district drug warehouses faced infrastructure limitations, including shortage of storage space leading to medicines not being stored properly as per the labelling, absence of proper temperature and humidity control, lack of air-conditioning, inadequate pest control measures, and shortage of staff for warehouse management.
- Transport mechanisms for drug distribution were weak, with no dedicated system for transporting medicines from state and district warehouses to facilities. Staff from district warehouses travelled to the State warehouse to collect medicines, while facility staff similarly travelled to the respective drug stores (PHC/CHC/DH/district) for receipt of supplies, affecting supply chain efficiency.
- A quality assurance mechanism for drug testing was in place, where samples from each batch of medicines (both centrally and locally procured) were tested and kept in quarantine until quality test results were received.



FREE DIAGNOSTIC SERVICE INITIATIVES (FDSI)

17th

FREE DIAGNOSTIC SERVICE INITIATIVES (FDSI)



NATIONAL OVERVIEW

Ministry of Health and Family Welfare (MoHFW), Government of India, under the National Health Mission (NHM), had launched the Free Diagnostic Services Initiative (FDSI) in 2015 with an objective to provide “Free of Cost” diagnostic services across the levels of public health facilities in order to reduce the Out-of-Pocket Expenditure (OOPE).

The revised guidelines released in 2019 recommend expanded packages of diagnostic tests (14 tests at Ayushman Arogya Mandir – Sub Health Centres (AAM-SHCs), 63 tests at AAM-Primary Health Centres (AAM-PHCs), 97 tests at Community Health Centres (CHCs), 111 tests at Sub-District Hospitals (SDHs) and 134 tests at District Hospitals (DHs). The service delivery framework is based on the ‘Hub and Spoke’ model for ensuring optimal resource utilisation.

States/UTs have adopted various combinations of service delivery modes, either through in-house, PPP, or mixed modes. High-volume, low-cost laboratory tests shall be undertaken through in-house capacities, while low-volume, high-cost advanced diagnostic tests may be provisioned through Public–Private Partnership (PPP) models.

Tele-radiology services provide access to imaging services at lower-level facilities (CHCs/SDH) that lack a specialist, such as a radiologist, for image analysis. Teleradiology services for X-rays include digitisation, transmission, and interpretation/reporting by a radiologist.

Free Diagnostic: Laboratory

Laboratory services have been implemented in all 17 visited States. Out of 17 states, 10 states (Andhra Pradesh, Bihar, Chhattisgarh, Kerala, Meghalaya, Nagaland, Sikkim, Tamil Nadu, Telangana and Uttar Pradesh) have FDSI implemented through the in-house mode, and remaining 07 (Assam, Madhya Pradesh, Rajasthan, Maharashtra, Odisha, Punjab and Uttarakhand) through the PPP/mixed mode.



Free Diagnostic: CT scan service

CT scan service has been implemented in 16 of the 17 visited States. Among these, 10 states (Andhra Pradesh, Assam, Bihar, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Uttar Pradesh, and Uttarakhand) have implemented the services in PPP mode and remaining 06 states (Chhattisgarh, Kerala, Meghalaya, Sikkim, Tamil Nadu, and Telangana) in In-house mode. The CT scan services were not implemented in the state of Nagaland.

Free Diagnostic: Tele radiology (Tele-reporting of X-ray)

Teleradiology services for X-ray reporting have been implemented in eight states out of 17 visited in CRM, i.e. Andhra Pradesh, Assam, Bihar, Kerala, Maharashtra, Rajasthan, Uttar Pradesh, and Uttarakhand. Kerala has been providing tele-reporting services in-house mode.

KEY OBSERVATIONS

- Availability of diagnostic tests as per the FDSI guidelines (2019) was found to be adequate in Assam, Andhra Pradesh, Kerala, Odisha, and Telangana.
- In-house sample transportation systems were available in Andhra Pradesh, Telangana, Kerala, and Chhattisgarh. Odisha, Assam, Madhya Pradesh, and Uttarakhand have implemented sample transportation through the PPP mode.
- Kerala's Nirnaya hub-and-spoke lab network ensures district-wide diagnostic coverage, with the Indian Postal Service facilitating sample transport between spoke and the central hub labs at District hospitals.
- Availability of reagents and consumables was inconsistent in Andhra Pradesh, Chhattisgarh, Meghalaya, Nagaland, and Rajasthan, with reports of shortages or irregular supply.
- Diagnostic services were provided free of cost in all the states except Kerala, Meghalaya, Uttarakhand, and Punjab, where user charges, i.e. out-of-pocket expenditure, were reported for selected diagnostic services.
- Tele-radiology services were found satisfactory, with turnaround time within 24 hours.
- External Quality Assurance System (EQAS) for laboratory tests were implemented only in the states of Madhya Pradesh, Kerala, Tamil Nadu and Uttarakhand.

RECOMMENDATIONS

- States are advised to strengthen the diagnostic services with the focus on ensuring availability of the test menu (80% and more) at each level of the healthcare facility as per the Free Diagnostic Services Initiative Guidelines.
- States of Uttarakhand, Maharashtra, and Punjab need to strengthen in-house capacities and switch over from PPP per sample model to a mixed model where low

cost-high volume tests are undertaken through in-house and low volume high-cost tests are outsourced to PPP service provider

- The diagnostics services should be provided free of cost to all beneficiaries availing the services at Public health facilities. User charges should be waived off from the States.
- States are advised to on-board on the existing central dashboard (DVDMS) for effective supply chain management of diagnostic reagents and consumables and preventing stock out.
- States need to establish a standard sample transportation system for assured linkages with the upcoming Block Public Health Labs (BPHL) & Integrated Public Health Facilities (IPHLs).
- States need to strengthen in-house capacities and switch over from PPP per sample model to a mixed model where low cost-high volume tests are undertaken through in-house and low volume high-cost tests are outsourced to PPP service provider.
- States are advised to implement the teleradiology services to enable digitisation, transmission, and remote reporting of Xrays from peripheral facilities, thereby improving diagnostic quality, reducing turnaround times, and addressing specialist shortages at the periphery.

STATE SPECIFIC OBSERVATIONS

Andhra Pradesh

- Availability of diagnostic tests varied across districts. Parvathipuram Manyam DH provided only 88 of the 136 tests due to shortages of microbiologists, reagents, and histopathology equipment.
- Laboratory and diagnostic linkages between AAM-SHCs, AAM-PHCs, and higher facilities were established.
- AAM conducted basic screening, with sample transport linkages in place for tests not available onsite.
- Referral linkages between AAM-SHCs and AAM-PHCs were mapped. However, the frequency of sample collection varied across districts.
- Chittoor district demonstrated consistent TAT for sample testing.
- Parvathipuram Manyam followed pre-fixed collection days due to the limited availability of laboratory technicians and transport support.
- True NAAT and CBNAAT laboratories were functional and operating in two shifts, with no sample pendency and maintained a 24-hour TAT for NAAT test results.
- X-ray services were available through fixed facilities and NGO-supported handheld units, with an average of 24 X-rays conducted per day.

Assam

- Routine laboratory diagnostic services were available at most AAM-SHCs and AAM-PHCs; however, their utilisation remains below prescribed norms.
- At the SHC–AAM level, only 7–10 of the 14 mandated tests were being conducted. At the PHC–AAM level, although all 63 tests were notified, only about 44–45 were routinely performed, with others referred or underused due to skill, workload, and equipment constraints
- At secondary and higher facilities, diagnostic services implemented through the PPP mode were found to be functional and offering an expanded test menu. However, utilisation remained suboptimal due to inadequate beneficiary awareness regarding the availability of free services, service delivery points, and report collection processes.

Use of DVDMS and other digital inventory management systems is affected by poor internet connectivity at the PHC level, limiting real-time visibility of reagent and consumable stock positions.

- Radiology services, including X-ray and CT, were available at DH Udalguri. The use of tele-radiology further contributed to reducing the turnaround time for reporting.

Availability of Diagnostics in Assam as per IPHS 2022			
Facility Type	Required as per IPHS	Available	Not Available
SC	14	10	4
PHC/UPHC	63	46	17
CHC	97	46	51
CHC/UHC FRU	97	62	35
SDCH	114	72	42
DH	134	123	11

17th CRM 1-6th November Assam
Source: State report

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Bihar

- The FDSI operated in-house, while services such as X-ray, CT scan, and MRI were provided through the PPP mode.
- There was a paucity of trained laboratory technicians, and calibration and maintenance records were not available
- There was a paucity of trained laboratory technicians, and calibration and maintenance records were not available.

Type of facility	Diagnostics as per IPHS 2022	No. of tests at facilities visited at Saran	No of tests at facilities visited at Munger
DH	134	80	58
SDH	111	39	41
CHC	97	49	45
PHC-AAM	63	42	34
SHC-AAM	14	14	13

- Quality control measures were not followed, and proper documentation of test records was lacking, with reports not being validated by a pathologist.
- Additionally, laboratory information management system was not observed at facilities.

Chhattisgarh

- Diagnostic services were available through the in-house mode.
- AAM-SHCs were providing approximately 9–10 tests against the 14 prescribed under FDSI norms. At the level of AAM-PHC and AAM-UPHC, 14-16 diagnostic tests were being conducted.
- Laboratory and radiology services, including CT scans, were available at secondary-level facilities. PPP diagnostic models and advanced services (such as CT, ventilators, and AERB-compliant equipment) exist at selected facilities, but their reliability was affected by reagent shortages and equipment non-functionality.
- Stock management systems were inconsistent, with continued reliance on manual registers and incomplete use of digital platforms for reagents and consumables.
- At the AAM-PHC level, gaps in test availability were primarily due to the prolonged non-functionality of laboratory analysers, exceeding six months in several facilities.
- Diagnostic data reporting was weak, with mismatches between registers and entries in HMIS, IDSP, and NCD portals, despite the use of ABDM-enabled registration.
- Sample referral and follow-up mechanisms were suboptimal, leading to delay in testing and weak linkage with NCD screening services.
- Staff competency gaps persist, particularly due to limited refresher training, inadequate hands-on exposure, and lack of mentoring for lab technicians, CHOs, and frontline providers.

Kerala

- The pathology services were available through mixed mode (i.e. PPP & In-house mode) at DH in the visited district, with user charges for APL and the cost to all beneficiaries.
- Diagnostic tests were available adequately in the visited AAM-UPHCs, CHCs and District hospitals in both districts.

- Procurement of reagents and consumables was done through the Hospital Management Committee(HMC) fund.
- Nirnaya (Nava Kerala Integrated Referral Network for Advanced Diagnostics and Care) is a hub-and-Spoke Lab Network that provides a standardised and quality diagnosis across the district.
- The Indian Postal Service is collaborating to transport samples from spoke labs to hub labs. Across the district, there were 23 Hubs, Labs and 82 Spoke labs.
- EQAS and IQAS were observed in all the visited health facilities
- X-ray services were available at Community Health Centres and above level of healthcare facilities. CT Scan and Ultrasound services were available at the district hospital level only.
- Test results were accessible via the state government's e-health portal, as well as through SMS or a mobile app
- Internal Quality Assurance was performed in most of the visited facilities.

Facility Level	AAM-SC	PHC/FHC	CHC	SDH/Taluka	DH/GH
Recommended as per FDSI-2019	14	63	97	111	134
Avg Availability in Kasargod	10	60	63	78	130
Avg Availability in Kottayam	12	60	62	66	162

Madhya Pradesh

- The state has implemented the free diagnostic services through in-house and outsourced modes under the wet lease model at DH.
- The PPP Service provider (Wet lease) was responsible for the supply, installation and maintenance of all pathological equipment, reagent and consumables.
- Internal & external quality assessment mechanisms were in place (CMC Vellore – monthly; AIIMS Delhi – quarterly)
- At district hospitals, 138 diagnostic tests were available, including 22 specialised/ rare tests, with a laboratory turnaround time (TAT) of 4–6 hours.
- At civil hospitals and CHCs, 80 tests were available, of which approximately 30 were conducted in-house, while the remaining 50 were referred to nearby hub laboratories through rider.
- At the AAM-UPHC level, 25 diagnostic tests were available, while AAM-SHCs were conducting approximately 15–17 tests.
- CT scan services provided in 51 districts and 2 Civil hospitals.

- The average cost of a plain CT scan varied across locations, with approximately Rs. 933 in Mandsaur and Rs. 764 in Vidisha.

Maharashtra

- Free diagnostic services under FDSI have been implemented across facilities through a mixed model, combining in-house operations with Public-Private Partnership (PPP) services .
- High dependency PPP laboratory services (HLL) were operating in parallel, despite the availability of in-house LTs (both contractual and regular).
- The PPP provider has deployed phlebotomists at the public health facilities for sample collection during OPD timings. These samples were subsequently transported to Mahalabs for testing and reporting. The in-house lab technician undertakes rapid diagnostic tests at the facilities.
- Barcode-based patient sample identification was found functional across facilities, and sample tracking records were available. Turnaround time for reports from the PPP provider was found to be within the expected 24-hour benchmark
- Procurement of reagents and laboratory consumables was being carried out through the district drug warehouse, and distribution was being monitored via the e-Aushadhi dashboard.
- Free X-Ray (up to CHC level) and CT scan services (DH) were available under PPP mode through Krishna Diagnostics
- Under the Tuberculosis diagnostic initiative, the state receives support from Mazgaon through a mobile diagnostic van equipped with portable X-ray technology and AI-based TB screening, enabling doorstep screening and early detection in hard-to-reach communities
- Despite the availability of diagnostic services, the overall range of tests at facilities remained below the IPHS-mandated standards

Facility Type	In-House	PPP	Total
AAM-SHC	6	1	7
AAM-PHC	12	43	55
CHC	15	43	58
DH	36	43	79

Meghalaya

- Pathology services were being provided through the in-house mode.
- Healthcare staff demonstrated limited knowledge of inventory management and proper storage practices.
- Display of diagnostic price list indicated that the diagnostics were not free. Variable prices for the same test were also observed in different facilities.

- The availability of slides, kits, and reagents for diagnostics was irregular, with frequent stockouts
- SoPs for diagnostic services were not available in peripheral facilities.

Range of diagnostic tests to be provided at each level of the facility as per free diagnostic services initiative under NHM

S. No.	Level of Facility	Number of diagnostic tests
1	Sub Health Centre-AAM	14
2	Primary Health Centre- AAM	63
3	Community Health Centre	97
4	Sub-District Hospital	111
5	District Hospital	134

Nagaland

- Diagnostic services were not available at all the visited facilities as per IPHS norms.
- At AAM-SHCs and AAM-PHCs, only 5–10 diagnostic tests were being conducted against the 14 and 63 tests recommended under FDSI guidelines, respectively.
- At DH Zunheboto, only 33 tests were conducted against the 134 required tests under IPHS norms. Although the TSH equipment was functional, it was not used because the reagents had expired and OPD doctors were not sensitised to the diagnostic tests available in the lab
- An additional test for scrub typhus was available up to AAM-PHC.
- Display of the number of diagnostic tests being undertaken was observed at facilities.
- Stock status of RDTs and consumables was not available on DVDMS and was reported to be under process of integration.
- Demarcated laboratory space was largely not available at AAM-SHCs, whereas all visited AAM-PHCs had designated laboratory areas.
- At NUHM UPHC, Mon, a demarcated laboratory space was available; however, tap water and drainage facilities were absent.
- The average TAT for tests conducted at IPHL was 12 hours which is as per the TAT recommended under FDSI guidelines.

Diagnostics (as per IPHS)	Availability at visited facilities
SC-14	5-7
PHC-63	10-12
CHC- 97	10-15
DH-134	33-35

Odisha

- Laboratory services were functional at both primary and secondary levels through both in-house and PPP modes.
- CT Scan facility (PPP mode) was available free of cost to the public with an average reporting time of approximately 2 hours.
- X-ray services were available at the visited secondary care facilities, except at one CHC in Kalahandi.
- Laboratory record keeping was maintained with UHID-based patient tracking and documentation of equipment, preventive and corrective maintenance. However, the staff interviewed were not fully aware of the maintenance and tracking processes.
- At CHC Bargarh, the absence of USG services curtailed the ability to conduct surgeries despite the presence of a surgeon.

Punjab

- FDSI services were implemented through a hybrid model comprising both in-house and PPP modes.
- Laboratories at DHs, SDHs, and CHCs were functional around the clock, while AAM-PHCs and AAM-SHCs provided diagnostic services during OPD hours.
- Dedicated NAAT laboratories for TB were operational, with three LTs deployed.
- RT-PCR laboratories were functional at Civil Hospital Jalandhar and DH Faridkot.
- The in-house diagnostic tests conducted were limited, with only 11 tests at Aam Admi Clinics (AAKs) and 20–25 tests at AAM-PHCs, CHCs, and DHs, while the remaining tests (approximately 70 investigations) were provided through PPP mode.
- MRI and CT scan services were available at District Hospitals through the PPP mode at subsidised rates.
- Aam Admi Clinics, largely co-located with AAM-PHCs and HSCs, were conducting up to 47 diagnostic tests through a hub-and-spoke model, with all diagnostic services provided free of cost.
- DVDMS was being utilised for stock management of diagnostics and consumables.
- Diagnostic tests were dispatched on the same day or the following day.
- Lab technicians were aware of sample handling, packing and transportation protocols and were following the same
- Most of the critical equipment have barcoding and were also calibrated

Rajasthan

- Diagnostic services were primarily implemented through the in-house mode, with selected specialised tests provided through PPP arrangements.
- Diagnostic services were lower compared to IPHS norms, except in SHC.

Facility Level	Tests Available	Tests as per IPHS
AAM-SHC	15	14
PHC	15	63
CHC	38	97
DH	69	134

- In Nagaur, sample transportation with barcoding was not established at any level, whereas in Jhunjhunu sample transportation system was functional, within acceptable limits.
- Sample collection timings at facilities were between 10 AM and 2 PM. Reporting TAT was approximately 4-5 hrs at DH, SDH and CHC. While PHC Ren reported a TAT of 2 hours.
- In Nagaur no LMIS for tracking laboratory consumables or reagents at PHC, SDH, and SHC levels, whereas in Jhunjhunu, LIMS was in place and functional.
- Tele-radiology system (PPP) for CT reporting was in place. DH was providing CT scan services through the PPP mode.
- Biochemistry and Haematology analyser were not available at PHC's visited
- In Jhunjhunu, VIA was unavailable, and staff were not trained to use it.

Sikkim

- Laboratory investigation services found to be functional up to the PHC level, with adequate availability of essential consumables and reagents.
- Sample collection, handling, and transportation systems were functional, and laboratory staff demonstrated awareness of standard operating protocols.
- Most PHCs had dedicated functional laboratory spaces providing essential diagnostics. However, space constraints, outdated equipment, and infrastructure gaps were reported in some facilities, limiting capacity to manage higher diagnostic loads.
- Radiological services, including X-ray and USG, were available only at District Hospitals in the visited district.
- EQAS for laboratories had not been initiated for any of the visited facilities.

- USG services were available at District Hospitals, resulting in increased travel time and out-of-pocket expenditure, especially for pregnant women requiring repeated ANC investigations and for populations in remote areas.
- No diagnostic availability at Polyclinics as diagnostic services for specialist care (radiology, biochemistry, and pathology) were concentrated at District Hospitals.

Tamil Nadu

- The state has implemented the FDSI services through an in-house mode.
- The state has developed its own In-house model of sample tracking and transportation (IELS) using barcodes. The State had rolled out the sample transportation system in Feb 2023. It has notified the number of diagnostic test availability at each level of the health facility vide G.O number 274.
- State Medical Corporation has a contracted rate for 111 lab reagents across all medical institutions under the programme. Additionally, a passbook system for laboratory reagents, similar to the drug delivery system, is in development to support efficient supply chain management.
- The program has significantly increased the number of basic laboratory tests conducted: from 29 to 63 in Primary Health Centres, 35 to 97 in Block PHCs, 53 to 111 in Sub District Hospitals, and 65 to 134 in District Head Quarters Hospitals.
- The state has also enrolled for the EQAS programme with CMC Vellore, Tata Memorial Hospital, Mumbai and AIIMS Delhi.

Telangana

- A free diagnostic pathology service was available through in-house (hub and spoke mode), providing 134 tests.
- Radiological services, including X-ray, ultrasonography (USG), ECG, 2D echocardiography, mammography, and CT scans was also available at CHCs and District hospital level as appropriate.
- Laboratory services at CHCs and Area Hospitals remain underutilised, functioning largely as sample collection points despite available resources.
- Sample rejections were observed, primarily due to the non-availability of reagents at facilities and coordination gaps between sample collection points and the Hub.

Uttar Pradesh

- The state had implemented the diagnostic (pathology) services through an in-house mode.
- The visited facility had availability of 80% and above diagnostic tests at each level of the healthcare facility as per the Free Diagnostic Services Initiative Guidelines.

- Availability of ultrasonography (USG) services at secondary care facilities was limited in Balrampur district, with only one designated provider catering to two facilities on scheduled days.
- Limited in-house USG capacity led to high dependence on private facilities (approximately 50–60 USG centres in the district), resulting in increased OOPE despite the issuance of e-Vouchers.
- X-ray services were available at CHC and above level of healthcare facilities.

Uttarakhand

- Diagnostics services were available in hybrid mode in the State, i.e., both in-house and Public-Private Partnership (PPP)
- PPP-based diagnostic services offered an expanded test menu (over 260 tests) with a TAT of less than three days.
- The number of tests available through in house laboratory was limited compared to the PPP mode. Sample collection timing for in-house laboratory testing was up to 11:00 am.
- At SHC-AAM, 7–12 diagnostic tests were available, and sputum samples for TB were collected.
- Under the PPP mode, 267 tests were available. At one visited facility, it was observed that 3 out of every 5 OPD patients were prescribed LFT, KFT, and Lipid Profile as routine tests regardless of their ailments, highlighting the need for a prescription audit to ensure rational use.
- No in-house laboratory or LTs available at the PHC-AAM visited, with diagnostics provided exclusively through PPP mode.
- External Quality Assurance (EQA) was being implemented for diagnostic services provided through the PPP mode.
- The visited PHC-AAM had no in-house laboratory, lab technicians, or diagnostic facilities, with services available only through the PPP mode. At PHC Pandukeshwar, diagnostic services were minimal, limited to a few rapid kit-based tests such as RBS, Hb, Cholesterol, and Uric Acid.
- User fees, as per the State rate list, were charged for OPD and diagnostic services at PHC-level and higher facilities. However, diagnostic services were provided free of cost for JSY, JSSK, PMJAY beneficiaries, and BPL households.
- Radiology services (X-ray, CT scan, and USG) were available through in-house mode at the district level, with tele-radiology support through PPP.
- Turnaround time for CT reporting was approximately two hours.



BIOMEDICAL EQUIPMENT MAINTENANCE AND MANAGEMENT PROGRAM

17th

NATIONAL OVERVIEW

Biomedical Equipment Management and Maintenance Program (BMMP) was launched in 2015 by the Ministry of Health and Family Welfare, Government of India under the National Health Mission (NHM). The program envisages providing support by outsourcing medical equipment maintenance comprehensively for all facilities to improve the equipment uptime and extend its useful life (functionality).

The implementation of BEMMP has helped in maintaining equipment uptime of 95% at District Hospitals, and diagnostics services in health facilities by making equipment available with 95% uptime, 90% at CHCs and 80% at PHCs across the states in the country. A total of 22 States/UTs have implemented the BMMP in PPP mode and 11 States/UTs through In-house mode.

In the 17th CRM, out of 16 states, **14** states have implemented BMMP through PPP mode (Andhra Pradesh, Assam, Bihar, Chhattisgarh, Kerala, Madhya Pradesh, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Uttar Pradesh, Uttarakhand) and **02** States through In-house mode (Meghalaya, Telangana).

KEY OBSERVATION

- Lifesaving and critical care equipment at the visited district hospital were functional and uptime was over 90%
- Dedicated Toll-free number was provided, and users were aware of the same, the complaint management system using toll free number was in use in Nagaland, Punjab, Uttarakhand, Maharashtra, Rajasthan, Odisha, Kerala.
- Inventory management by in-house management committee/BME was found lacking at the visited facilities.
- The user satisfaction for the states in PPP mode was positive.
- Preventive Maintenance and Calibration schedule for medical equipment was not undertaken as per schedule in the health facilities visited.



- The time-period for complaint resolution was varying in the States from 2 weeks to 12 weeks.
- Training of the biomedical engineers in high end medical equipment was found lacking.

RECOMMENDATIONS

- The dashboard needs to be updated on a regular basis.
- Preventive maintenance & Calibration should be done as per schedule for all medical equipment as per BEMMP guidelines.
- States need to review the asset value periodically for addition/deletion of equipment in the asset base.
- The availability of equipment should be as per IPHS-2022 and should be optimally utilised.
- Training and capacity building of BMEs needs to be strengthened.
- Hospital management committee at all DH/SDH/CHC level should be formed for improved inventory control.
- States should ensure undertaking equipment audit annually.



QUALITY AND PATIENT SAFETY

National Quality Assurance Standards (NQAS)

17th

QUALITY AND PATIENT SAFETY

National Quality Assurance Standards (NQAS)

NATIONAL OVERVIEW

The National Quality Assurance Standards (NQAS), under the Ministry of Health and Family Welfare (MoHFW), provide a comprehensive framework to strengthen institutional and clinical capabilities across public health facilities in India. Through well-defined standards, periodic assessments and structured certification processes, NQAS promotes patient-centric care, safety, accountability, and continuous quality improvement across primary and secondary healthcare systems. With the objective of achieving 100% National Quality Assurance Standards (NQAS) certification by December 2026, the Ministry of Health and Family Welfare (MoHFW) has set a national target across the country. In alignment with this goal, States and Union Territories are intensifying their efforts to meet the benchmark, thereby reaffirming the collective commitment to delivering high-quality healthcare services across the country. The current achievement of the 17 CRM states as on 28th February 2026 is mentioned in the table below:



S. No.	State	NQAS certified facilities	% of Achievement
1	Assam	2377	51.69
2	Andhra Pradesh	6581	55.03
3	Bihar	842	7.71
4	Chhattisgarh	2634	47.7
5	Kerala	510	7.92
6	Madhya Pradesh	2788	23.29
7	Maharashtra	936	7.91
8	Meghalaya	168	27.14
9	Nagaland	45	9.18
10	Odisha	2848	39.16
11	Punjab	1533	47.98
12	Rajasthan	1026	10.23
13	Sikkim	50	27.62
14	Tamil Nadu	3257	41.75
15	Telangana	1002	23.66
16	Uttar Pradesh	8446	38.02
17	Uttarakhand	62	2.8

KAYAKALP

Since the launch, there was a significant increase in the number of the participating health facilities and the number of facilities incentivised under the Kayakalp. The number of healthcare facilities participating in Kayakalp has increased from 750 facilities in FY 2015-16 to more than 1,34,000 facilities in FY 2024-25.

The number of facilities incentivized for Kayakalp increased from 97 in FY 2015-16 to 51707 in FY 2024-25.

The overall progress of 17 CRM States/UT is mentioned in table below:

State/UT	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25
Andhra Pradesh	5	14	66	171	496	1519	3022	3161	3541	5323
Assam	2	46	46	157	213	274	517	1000	1678	2043
Bihar	4	33	25	29	48	94	134	170	353	434
Chhattisgarh	2	50	94	108	274	380	480	852	1347	1948
Kerala	6	26	35	142	78	356	254	100	461	1010
Madhya Pradesh	9	43	63	90	267	220	396	780	1996	675
Maharashtra	5	81	305	366	369	396	927	1692	2179	2956
Meghalaya	1	21	28	25	27	26	38	30	40	114
Nagaland	2	15	20	33	25	51	61	104	118	144
Odisha	3	20	91	182	337	586	892	2414	3570	5339
Punjab	4	57	68	141	114	168	336	248	441	804
Rajasthan	4	46	151	205	489	1496	723	1475	2176	2082
Sikkim	0	15	6	13	12	17	49	123	120	163
Tamil Nadu	5	90	393	521	1171	1926	1769	2619	4762	6169
Telangana	5	90	133	225	353	291	444	735	876	982
Uttar Pradesh	11	37	116	184	351	690	1078	1423	2383	4714
Uttarakhand	3	11	16	46	65	64	95	137	174	201
Total	71	695	1656	2638	4689	8554	11215	17063	26215	35101

KEY OBSERVATIONS

- Most states have shown significant progress in NQAS certification. However, recertification and surveillance assessments were delayed because of focus on new certification to achieve the targets.
- Focus was needed on the post-certification sustainability and continuous quality improvement.
- NQAS-certified facilities demonstrated improvements in cleanliness, signage and patient amenities.



- SOPs, clinical protocols, and checklists were not uniformly available or consistently followed.
- Weak triage systems, inadequate emergency preparedness, and limited clinical audit mechanisms negatively impact patient safety.
- Improper segregation, transportation, and disposal of biomedical waste remain major concerns across states.
- Infection Prevention and Control (IPC) practices show inconsistent compliance.
- Vacant Quality Assurance Consultant positions delay implementation and monitoring of quality initiatives.
- Internal audits, surveillance visits, and QA committee reviews were irregular.
- Fire safety and BMW rules compliance remains a major gap in many states.
- Equipment maintenance, calibration systems, and laboratory quality assurance were weak, particularly at peripheral facilities.
- Delayed disbursement of NQAS and Kayakalp incentives affects motivation at the facility level.
- Funding gaps impact training, mentoring, periodic monitoring activities and sustenance of quality.
- Urban facilities were the least integrated into the NQAS framework.

CHALLENGES

- Shortage of HR and old infrastructure constraints was one of the key challenge in achieving the NQAS certification
- Lack of monitoring of the quality initiatives at state and district level remains a challenge
- Compliance with statutory and regulatory requirements particularly Fire NOC and BMW management rules emerged as a foremost challenge in most states.

RECOMMENDATIONS

- States needs to accelerate the process of state level certification and also focus on conversion of state certified facilities to national certification with in the period of state certification validity.
- Internal assessment of all the facilities is needed to be undertaken and facilities scoring 70% or more in internal assessment may be prioritised for NQAS certification.
- States should consolidate the gains made in NQAS certification by developing a time-bound roadmap for scale-up and sustenance of the quality certification, particularly at secondary and urban healthcare facilities.

- NQAS certified facilities should institutionalize continuous quality improvement mechanisms, including regular internal audits.
- Facilities which are Kayakalp, IPHS compliant, LaQshya and MusQan certified to be prioritised for NQAS certification.
- A robust review, monitoring and mentoring mechanism by DQAC and SQAC is to be ensured to achieve the targets of 100 % NQAS certification by December, 2026. The mechanism should also address the timely recertification and surveillance assessments for sustenance of quality standards.
- Priority should be given to expanding NQAS certification at CHCs, SDHs, DHs, and Urban facilities, with structured mentoring and supportive supervision.
- SOPs, clinical protocols, and checklists should be standardised, displayed, and strictly implemented across all facilities, with periodic compliance reviews.
- Emergency preparedness needs to be strengthened through standardised triage systems, functional crash carts, zoning and unidirectional flow in critical areas, and regular mock drills for disaster and fire safety.
- Biomedical Waste Management (BMW) is to be strengthened by ensuring proper segregation, colour-coded bin placement, linkage with CBWTFs, updated records, and regular staff training as per BMW Rules 2016. States may coordinate with State Pollution Control Board to find creative solution to address the issue in remote areas.
- Infection Prevention and Control (IPC) practices should be reinforced through periodic refresher training, designating an infection control nurse at DH/SDH level and regular on-site supervision.
- Vacant Quality Assurance Consultant positions should be filled on priority to lead quality initiatives.
- Fire safety compliance must be strengthened by ensuring Fire NOC, regular fire audits, staff training, and periodic mock drills across all facilities.
- Equipment maintenance and laboratory quality assurance systems are to be strengthened through regular calibration, preventive maintenance, AMC monitoring, EQAS/IQC enrolment, and proper documentation.
- Timely release of NQAS and Kayakalp incentives is to be ensured to sustain facility-level motivation and engagement and sustenance of quality certification.
- Adequate financial allocation should be ensured for training, mentoring and infrastructure gap-filling and continuous monitoring activities.
- Urban facilities and secondary-care institutions should be systematically integrated into the NQAS framework, with clear milestones, mentoring support, and monitoring mechanisms.

STATE SPECIFIC FINDINGS

Assam

- NQAS certification progress was more advanced at the PHC and Subcentre levels, while coverage at CHCs, SDHs and district hospitals remains limited.
- Field visits showed visible improvements, including display of citizen charters, service information boards, cleanliness, and basic infection prevention practices.
- Labour rooms and SNCUs demonstrated good clinical practices such as early initiation of breastfeeding, kangaroo mother care and routine new-born monitoring, indicating a growing culture of quality care.
- Communities reported better cleanliness, staff behaviour, and availability of services compared to before certification.
- SOPs, protocols, and checklists were not uniformly implemented.
- Emergency triage systems need strengthening, and mock drills for emergency/fire safety were infrequent.
- Infection prevention and biomedical waste management practices were inconsistent, especially in peripheral and tea garden facilities.
- Patient-centred elements—privacy, dedicated waiting areas, breastfeeding spaces, and grievance-redressal systems—require strengthening.
- Overall, Assam has built a strong foundation, but quality remains uneven and facility-specific rather than system-wide.
- The state should prioritise expansion of NQAS to secondary-level facilities, standardisation of clinical and safety protocols, and strengthening of patient-centred services under stronger district-level leadership.

Andhra Pradesh

- Andhra Pradesh's performance in quality assurance at the level of District Hospitals and PHCs was notable, where certification rates exceed the December 2025 targets reflecting strong leadership commitment, systematic monitoring and consistent support. However, facilities as Sub-District Hospitals, CHCs and UPHCs, lag behind in key processes required for NQAS certification.
- Many of these facilities display incomplete documentation, insufficient adherence to infection control protocols, gaps in triage processes, and inadequate biomedical waste segregation practices.
- Certification progress at the AAM-SHC level also requires attention. Though 75% of State targets have been achieved, the majority of certified facilities hold only state-level certification. Only 962 AAM-SHCs have attained national certification, and most

provide seven service packages instead of the full complement of twelve, as per the CPHC mandate.

- Recertification processes were also slow with only 5 out of 42 facilities in Chittoor due for recertification and none in Parvathipuram Manyam.
- Surveillance assessments, essential for ensuring continuous quality improvement, remain incomplete in several facilities.
- A major concern was the non-disbursement of NQAS and Kayakalp incentives for the past two years. Facilities reported a decline in motivation due to these delays. Additionally, newly posted Medical Officers, particularly those recently transferred, have not received orientation on quality assurance standards, leading to inconsistent understanding and implementation of NQAS protocols.
- The quality of care in secondary facilities across Andhra Pradesh has improved but remains uneven between districts. In Chittoor, hospitals demonstrated good adherence to clinical protocols, infection prevention practices, and documentation of patient vitals. Labour rooms and critical care units had clear SOPs displayed, and nurses were well-versed in protocol-driven care. Feedback mechanisms, including suggestion registers and patient grievance systems, were functional and routinely reviewed. Conversely, facilities in Parvathipuram Manyam showed gaps in process standardisation. Although infrastructure was functional, there were inconsistencies in hand hygiene compliance, case sheet documentation, and disposal of infectious materials. Quality assurance dashboards were maintained in Chittoor but either absent or incomplete in Parvathipuram.
- Certification efforts also showed asymmetry. While several secondary facilities were LaQshya-certified in Chittoor, progress toward NQAS milestones in Parvathipuram has been slow, with hospitals requiring significant capacity building and mentoring to establish documentation mechanisms, conduct gap assessments and prepare for state-level certification. Clinical staff in low-performing facilities was found motivated and receptive to improvement but limited by workforce shortages and inadequate exposure to quality frameworks.

Bihar

- Out of total 13,098 facilities in Bihar, 600 facilities were state certified, 90 were national certified and 199 were under assessment at the time of state visit. Despite these achievements, a significant proportion of healthcare facilities remain unevaluated or unprepared for certification, leaving room for quality improvement.
- In Saran, the Sadar Hospital and Sub-District Hospital were NQAS state certified and have applied for National certification. However, during the visit, it was observed that DH Saran needs a fire exit plan for certification.
- Dedicated post for quality assurance under NHM was vacant in Saran and Munger districts.

- A well-established Biomedical waste management system was available at all the facilities.
- Liquid waste management was in place in most of the health facilities.
- Lack of staff orientation and implementation of key quality assurance programs like SUMAN, LaQshya, and MusQan, which are critical for improving maternal, new-born, and child health outcomes was observed during the visit.

Chhattisgarh

- Quality initiatives under NQAS, Kayakalp, and LaQshya have improved processes in several facilities; however, post-certification monitoring and sustainability remains a challenge.
- A significant proportion of visited facilities were NQAS certified or preparing for certification, and many achieved Kayakalp scores above 70% and SUMAN notification, indicating progress in quality initiatives.
- Infection Prevention and Control (IPC) practices remain inconsistent, particularly in critical areas such as labour rooms, operation theatres, SNCUs, and emergency units, with gaps in triage systems, zoning, sterilisation, and autoclave compliance.
- Biomedical Waste Management (BMWM) shows partial compliance, with gaps in segregation, labelling, colour-coded bins, and continued reliance on deep or sharp pits at peripheral facilities.
- Quality monitoring systems—including internal audits, rapid assessments, surveillance reports, and post-certification follow-up—were irregular and insufficiently documented.
- Support systems for patient safety require strengthening, including laboratory quality control, equipment calibration, pharmacy stock management, fire safety preparedness, and functional patient feedback mechanisms.

Kerala

- Progress in NQAS certification remains slow in the state, with only about 17% of targeted facilities certified in Kottayam district and very limited certification in Kasaragod, where only one Family Health Centre was found certified. However, some facilities were assessed internally and in the process for the further assessment.
- The state follows a stringent approach of applying for NQAS certification only after achieving 90% scores, whereas minimum threshold is 70%. In the quality certification, the state is way behind to achieve the target provided by MoHFW.
- Biomedical Waste Management (BMW) systems were largely in place as per the guidelines.

Madhya Pradesh

- Referral systems for upward referrals were functional, but downward referral tracking

and follow-up remains a challenge. Teleconsultation was largely used for routine reporting, with connectivity issues affecting service quality.

- Quality assurance initiatives (NQAS, LaQshya, Kayakalp) have led to improvements in infrastructure, service delivery, and record management; however, gaps persist in BMW documentation, spill management, liquid waste handling, and overall patient safety systems.
- Support services showed variation in performance. Mechanised laundry and service coverage were relatively better in Vidisha, while Mandsaur reported deficiencies in linen management, dietary services, storage practices, supervision, and documentation.
- Service quality was constrained by human resource shortages, space constraints, weak clinical oversight, underutilisation of advanced technologies, and limited availability of specialised services such as palliative care and cancer screening.
- Biomedical waste management systems were largely in place, including colour-coded bins and linkage with CBWTF; however, gaps remain in documentation, staff training, needle-stick injury management, and liquid waste management practices.
- Although equipment availability and diagnostic services were adequate, biomedical equipment maintenance, calibration records, preventive maintenance systems, and fire safety preparedness needs strengthening. At the same time, innovative practices such as eco-friendly waste management initiatives have been observed in some facilities.

Maharashtra

- Progress in NQAS certification was slow, with only about 4% of targeted facilities certified. No facility in Satara achieved certification in FY 2025–26, and only one PHC in Nandurbar received state certification.
- Several facilities were in the pipeline for certification, with AAM-SHCs and PHCs undergoing internal assessments; the state also has a strong pool of trained internal, external, and virtual NQAS assessors.
- Biomedical Waste Management (BMW) remains inadequate across facilities, with improper segregation observed despite the availability of colour-coded bins.
- Infection Prevention and Control (IPC) practices were suboptimal, including reuse of single-use items in some facilities; however, good practices such as a daily colour-coded bed sheet system in Satara hospitals were observed.
- Patient-centred initiatives were in place, including a functional grievance redressal helpline (104), patient satisfaction forms, and separate registration queues for elderly persons, persons with disabilities, and ANC women at DH Satara.
- The state plans to accelerate quality certification through a special drive in aspirational blocks to improve NQAS coverage.

Top of FormBottom of Form

Meghalaya

- The progress of state in achieving quality certifications was very slow. Although the state has shown some progress over the last year in NQAS certification, it needs to be sustained and scaled up to meet the national targets. The pool of Internal Assessors, National Assessors and quality trained personnel may be used for gap-analysis and capacity building.
- Kayakalp initiative was ongoing in the state and was being implemented at all levels of facilities from District hospitals to AAM- SHCs.
- Biomedical waste management was not in accordance with BMW Rules 2016. Healthcare staffs were not regularly trained in BMW management. Sharp pits and deep burial pits were available at facilities. Facilities lack tie-ups with BMW management plants or CBWTF.
- Treatment of laboratory waste was not being done as Effluent Treatment Plants (ETP) ,were not available.
- Hygiene in kitchen and dietary services was not as per the norms. Patient-specific therapeutic diets like diabetic diet, antihypertensive diet, etc were not available.
- Grievance redressal desk or helpline was not available in any of the facilities visited.
- Fire safety norms and measures, and training of all staff on fire safety norms was not uniform at facilities.

Nagaland

- The state has 16 nationally certified and 32 state-certified NQAS facilities since FY 2023, and State/District Quality Assurance Committees were functional; however, none of the facilities in Mon and Zunheboto districts were NQAS certified.
- A few facilities have achieved state-level LaQshya (3) and MusQan (1) certifications, but none of the facilities in the visited districts have received either of the above mentioned certifications.
- Kayakalp participation was encouraging, with several facilities achieving compliant scores and awards; however, overall quality assurance mechanisms under NQAS, Kayakalp, and MusQan require strengthening.
- Key constraints affecting certification progress include limited training, infrastructure gaps, lack of Fire NOC for DH/CHC, funding constraints for monitoring and mentoring, and absence of district-level trainings.
- Biomedical waste management systems need strengthening, with all visited facilities relying on deep burial and sharp pits and lacking linkage with CBWTF.
- Service readiness showed variation like SNCU was functional in DH Mon but absent in DH Zunheboto, while the IPHL laboratory was functional with adequate capacity and surveillance linkages, though gaps remain in LMIS usage and optimal test coverage.

Odisha

- Quality assurance mechanisms require strengthening, as several facilities such as DHs and CHCs lack regular internal quality audits, documented patient-safety reviews, and systematic follow-up on identified gaps.
- Although NQAS and Kayakalp implementation has progressed, gaps remain in expanding NQAS certification to CHCs and SDHs, strengthening clinical audits, and ensuring adherence to LaQshya and Standard Treatment Guidelines, particularly in facilities with high caesarean section rates.
- Biomedical waste management and pharmacy safety practices require improvement, including instances of improper disposal of expired drugs by outsourced agencies and incomplete compliance with BMW authorization and linkage with CBWTF.
- Infrastructure and human resource constraints—including shortage of specialists and functional operation theatres at some CHC/SDH levels, and infrastructure gaps as per IPHS and NQAS requirements—continue to affect service quality and certification progress.
- The state has developed a structured roadmap to scale up NQAS certification, with district-wise targets, mentoring support, SQAC/DQAC review mechanisms, and focused planning in aspirational blocks.
- Significant investments under PM-ABHIM were strengthening the health system through Critical Care Blocks (CCBs), Integrated Public Health Laboratories (IPHLs), and Day Care Cancer Centres, improving emergency care, laboratory capacity, and access to cancer treatment services at the district level.

Punjab

- The state has made significant progress in NQAS certification, with 1,272 facilities certified (853 state-level and 419 national-level) as per the SaQsham portal, though state-level certifications were higher than national certifications.
- Quality-certified facilities have largely sustained service standards, and several facilities in both districts were undergoing recertification, indicating continued engagement with quality processes.
- District-level performance was notable, with 100 NQAS-certified facilities in Jalandhar and the District Hospital in Faridkot holding both NQAS and LaQshya certification.
- Quality governance structures were functional, with State and District Quality Assurance Committees conducting regular review meetings to monitor certification progress and address gaps.
- Kayakalp implementation was strong, with multiple facilities across Jalandhar and Faridkot districts receiving certification, reflecting improvements in cleanliness and facility upkeep.

- However, further improvements were required in cleanliness in some facilities and minor structural modifications in labour rooms to align fully with LaQshya and quality standards.

Rajasthan

- Progress in NQAS certification remains slow, with only a small proportion of facilities certified against the target of achieving 50% certification by December 2025.
- Vacant District Quality Assurance Consultant positions and irregular NQAS review meetings have affected implementation.
- Infrastructure and facility maintenance gaps were observed, including poor physical conditions in parts of District Hospital Nagaur and the need for sanitation and structural improvements.
- Quality assurance activities such as hand hygiene audits, infection prevention monitoring, biomedical waste management, and referral audits were not conducted regularly in many facilities.
- Although the state has developed a roadmap to accelerate NQAS certification, including internal assessments and virtual assessments through DQAC/SQAC mechanisms, stronger institutional leadership and dedicated QA teams are required to achieve targets.
- LaQshya and Kayakalp initiatives show some progress, with labour rooms certified in selected facilities and several CHCs and PHCs receiving Kayakalp commendations.
- Patient-centred quality mechanisms require strengthening. Limited awareness and utilisation of the Mera Aspataal feedback system, and gaps in patient satisfaction studies, SOPs, and documentation in several facilities were observed.

Sikkim

- Patient safety and infection prevention practices were satisfactory, with proper use of colour-coded BMW bins, availability of PPE, and adherence to hand hygiene protocols in most facilities. However, fire safety compliance and staff training require strengthening.
- Health facilities demonstrated good awareness of national quality programmes such as NQAS, Kayakalp, MusQan, and LaQshya; however, periodic review mechanisms by SQAU/DQAU and implementation in urban facilities remain limited.
- Service availability at primary care facilities was satisfactory, with 24×7 functional PHCs and AAM-SCs providing all 12 service packages; however, some services such as OT, SNCU, and NRC were non-functional at the District Hospital Mangan.
- Facilities maintained adequate documentation and record keeping, including OPD/IPD registers, referral registers, and nursing handover records, and basic patient amenities such as toilets, ramps, and waiting areas were available.

- Statutory and regulatory compliance remains a key gap, with pending BMW authorization, AERB approvals for radiology units, and fire safety NOCs in several facilities.
- Laboratory quality assurance systems require strengthening, as external quality assurance programmes had not been initiated in the visited facilities.

Tamil Nadu

- Tamil Nadu demonstrates strong performance in quality service delivery, particularly in maternal and child health outcomes, with initiatives aligned to Indian Public Health Standards (IPHS) and National Quality Assurance Standards (NQAS).
- Several facilities provide intra-partum and emergency obstetric care, supported by systematic quality initiatives such as maternal death reviews and quality certification processes, though gaps remain in meeting full IPHS compliance with standards, particularly in skilled human resource availability.
- The state has adopted multi-sectoral and evidence-based health approaches, such as the One Health strategy for rabies control, reflecting strong governance, coordination, and integration of public health services.
- Biomedical Waste Management systems were well established, with segregation at source using colour-coded bags, barcoding of chlorinated waste, and linkage with authorised treatment facilities ensuring safe disposal and improved accountability.
- The Integrated Public Health Laboratory (IPHL) model operates effectively on a hub-and-spoke system, strengthening diagnostic services and enabling faster reporting of results, including direct communication of reports to beneficiaries.
- Despite overall strong performance, variations in infrastructure, human resource availability, and service access across urban and rural areas highlight the need for continued investment in infrastructure strengthening, equitable service distribution, and capacity building at peripheral facilities.

Telangana

- Telangana has made significant progress in quality assurance, with 44% of AAM PHCs and 35% of AAM SHCs certified under NQAS, reflecting improvements in service standards and patient safety at the primary-care level.
- The state has shown strong performance under LaQshya, with multiple labour rooms and operation theatres certified, and 980 facilities achieving Kayakalp awards, demonstrating focus on cleanliness and facility upkeep.
- Peer assessments and structured mentoring mechanisms have been institutionalised, supporting continuous quality improvement across health facilities.
- However, sustenance of quality standards remains a concern, as some nationally certified facilities were not maintaining standards or applying for renewal after certification expiry.

- District-level planning for NQAS scale-up was limited, with absence of trained facility-level quality coordinators to support implementation and monitoring.
- Patient-centred quality systems require strengthening, including wider use of the Mera Aspataal feedback mechanism, improved cleanliness (especially washrooms), and uniform display of Citizen Charters across facilities.

Uttar Pradesh

- Quality of services at DHs, CHCs, and PHCs requires strengthening, mainly due to lack of refresher training on updated programmatic protocols and gaps in infection prevention and biomedical waste management practices.
- Around 40% of health facilities have achieved NQAS certification, indicating progress; however, further efforts are required to identify gaps and scale up certification across all levels of public health facilities.
- Nutrition Rehabilitation Centres (NRCs) were functional and well-equipped, with adequate human resources; however, stronger linkages with vertical programmes such as TB screening and testing are required.
- Training quality and follow-up mechanisms remain inconsistent, and many staff require refresher training and capacity building on SOPs and programme indicators.
- Community Health Officers (CHOs) require additional training, particularly in areas such as palliative care, cancer screening, and wellness services.
- Infrastructure utilization and facility maintenance require improvement, as some facilities were under-utilised and poorly maintained.

Uttarakhand

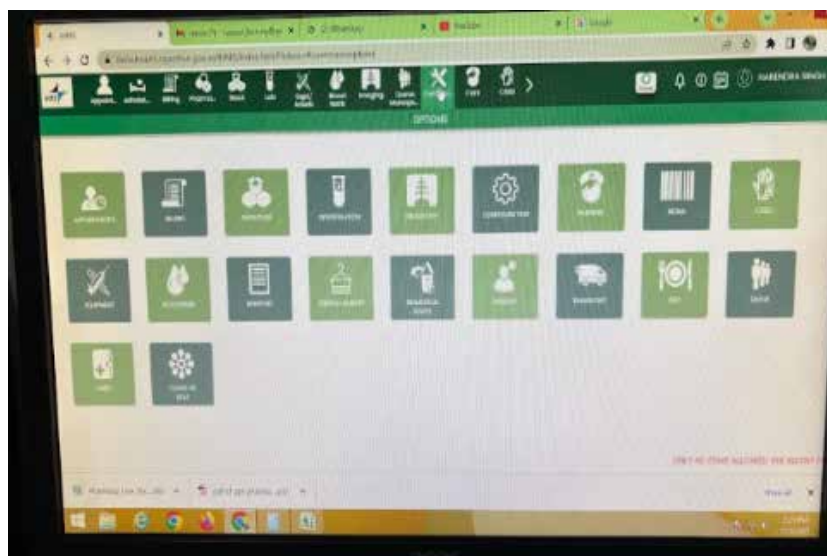
- NQAS certification coverage in the state remains very low, with only 47 facilities (around 2%) certified, indicating the need for accelerated efforts to scale up quality assurance initiatives.
- Some facilities have demonstrated progress, such as DH Gopeshwar achieving NQAS certification in 2024 and Kayakalp award in 2025, while DH Rudrapur requires recertification for NQAS and LaQshya.
- Quality governance structures were in place, including District Quality Assurance Committees and DH-level Quality Assurance Committees; however, the frequency of meetings and facility-level quality teams require strengthening.
- Human resource constraints affect quality programme implementation, as NHM Quality Managers were handling additional financial responsibilities, thus limiting focus on NQAS certification processes.
- Capacity-building initiatives have been undertaken, including state-level trainings on Internal Assessment and Kayakalp for medical officers, staff nurses, and CHOs.
- Biomedical waste management was implemented through PPP mode, but gaps remain in record maintenance and adherence to MoU provisions (especially in Chamoli district), particularly in ensuring timely collection of biomedical waste.



REVIEW OF IT APPLICATIONS

17th

REVIEW OF IT APPLICATIONS



NATIONAL OVERVIEW

To accelerate and strengthen the vision of Digital India, various designated IT portals have been implemented under NHM, to support service delivery documentation, tracking and monitoring of health programs at the field level. These digital platforms enable robust real time monitoring, improve data-driven decision-making and support in assessing the impact of interventions for the beneficiaries and the broader community. Broadly, NHM portals can be categorized into two types - portals capturing line-listed data of beneficiaries, such as RCH, PMSMA, ANMOL, U-WIN, PMNDP, IDSP-IHIP, NP-NCD, Nikshay, ANMOL, and e-Sanjeevani among others, which support service delivery by mapping longitudinal patient record, along with data aggregation platforms, such as HMIS and AAM portal, which are used for program monitoring, reporting of key indicators and decision-making at various administrative levels. Portals such as DVDMS and e-VIN support monitoring of supply chain management for drugs, vaccines, and diagnostics at national, state, and district levels.

In addition to the national portals, some States have additionally developed state-specific IT applications and portals based on local needs, such as CHO Soft in Rajasthan, *Swasthya Sewa Darpan* in Assam, BHAVYA in Bihar, and others. These systems have been developed to complement IT initiatives under NHM to streamline programme implementation. Some of these portals also cross-share data with the central portals for reporting and monitoring purposes.

The overall ecosystem requires adequate infrastructure (including internet connectivity), regular data entry and validation, capacity building of users, and adherence to data privacy and reporting protocols.

KEY OBSERVATIONS

- National IT platforms such as HMIS, RCH, NCD Portal, IDSP-IHIP, DVDMS, Nikshay and e-Sanjeevani were functional across most states, indicating widespread digital platform adoption.
- Few states were using state portals in addition to central portals, to support implementation of health programs e.g., Rajasthan is using IHMIS, Swasthya Sewa

Darpan in Assam, BHAVYA in Bihar, MTM and PICME in Tamil Nadu; Shaili, Nirnaya & E-Health in Kerala and e-Kavach in Uttar Pradesh.

- Data entry was being done across portals like HMIS, NCD Portal and RCH, however, delays in real time data entry was observed due to connectivity issues in states such as Telangana, Nagaland, Assam.
- Data quality concerns such as data mismatch between portal and physical records were observed in portals such as HMIS in Madhya Pradesh; NCD Portal in Meghalaya, Rajasthan & Uttarakhand
- Telemedicine platform e-Sanjeevani was available but underutilized across multiple states such as Uttar Pradesh, Bihar, Assam & Rajasthan.
- DVDMS/e-Aushadhi was implemented in most of the states. However, delays in uploading records on the portal was observed in states like Bihar.
- Internet connectivity and digital infrastructure was found to be better at secondary level facilities but weaker at primary level facilities.
- Data was being largely used for reporting purposes, with limited evidence of use for planning and decision-making in most of the states.



KEY CHALLENGES

- Poor internet connectivity at primary level facilities, resulting in delay real-time data entry was observed in states like Telangana, Nagaland, Assam and Meghalaya.
- Data quality issues including inconsistencies, over/under-reporting and mismatch with physical records was observed such as HMIS data mismatch in Uttarakhand and Maharashtra, and DVDMS stock mismatch was noted in Chhattisgarh.
- In states such as Maharashtra, Chhattisgarh & Bihar, gaps in the skills of staff in using digital platforms was observed.
- Underutilization of e-Sanjeevani platform was observed in Bihar.
- In states using both central and state applications, such as Tamil Nadu and Kerala, multiple unintegrated portals (e.g., NCD-MTM, HMIS, PICME) along with parallel physical registers lead to duplication of work, increased workload and staff fatigue and reduced time for service delivery, affecting data quality.
- Hardware and system-related issues including non-functional devices, slow portals were observed in states like Sikkim and Chhattisgarh.
- Weak monitoring, lack of comprehensive data validation mechanisms and limited IT support systems was a key challenge across most of the states.

RECOMMENDATIONS

- IT infrastructure & internet connectivity across health facilities should be strengthened to ensure streamlined and timely data entry for real-time utilisation.
- Integration of national and state portals should be prioritised to reduce burden and avoid duplication of work.
- Strengthening the utilization of various portals including e-Sanjeevani, PMNDP among others should be prioritised.
- Institutionalization of regular data quality audits and cross-verification between physical and digital records across portals.
- Periodic refresher trainings and capacity building for all cadres on portal usage and data quality should be ensured.
- Promote utilisation of data for active decision-making & health systems support by the health staff.

STATE-SPECIFIC OBSERVATIONS

Andhra Pradesh

- The digital ecosystem was robust, with widespread use of E-Aushadhi, PMNDP portals, face recognition-based attendance monitoring, and compliance with ANMOL and IHIP.
- Discrepancies were observed to be persistent between physical stock and digital entries due to irregular data entry in e-Aushadhi, particularly in areas with poor internet connectivity.
- Usage of the PMNDP portal was nearly universal at 99%, enabling consistent reporting and monitoring of diagnostic services.
- One of the most impactful practices observed during the CRM visit was the AP Hygiene App, which enables proactive malaria control through village-level surveillance.

Assam

- Multiple national platforms such as HMIS, RCH, NCD, DVDMS, e-Sanjeevani, along with State portal *Swasthya Sewa Darpan* were rolled out across the visited facilities.
- Internet connectivity remained a major bottleneck, affecting real-time data entry and causing delays in uploading data across facilities. Staff reported frequent delays in entering data into HMIS, NP-NCD and the AAM portal.
- IT platforms were being primarily used for reporting of data rather than decision-making. As a result, facility and block teams rarely use digital data proactively for local planning, follow-up of high-risk cases or stock management.
- e-Sanjeevani was functional but underutilized across most facilities.
- Stock reconciliation gaps were observed in DVDMS.

Bihar

- The state utilizes both central IT platforms such as Ni-kshay, IDSP, e-Sanjeevani, NCD, Ayushman Arogya Mandir portal, along with state specific ASHWIN Portal, BHAVYA portal to support health program implementation in the state.
- Data was being updated to the AAM portal regularly, however, gaps were noted in the real time and complete entry into the NP-NCD portal.
- IT infrastructure like desktop/laptop/tablet was available at all the health facilities and ASHAs were provided smartphones.
- Internet connectivity was observed to be a persistent issue across some of the visited facilities.
- State has a mechanism of a Data Validation Committee, which was functional at the facility level. However, this committee focused only on HMIS data reporting.
- e-Sanjeevani portal was found to be largely under-utilized.

Chhattisgarh

- National portals such as Nikshay, Nikushth, IDSP, RCH, AFHC, and DVDMS were implemented, however, partial use was leading to duplication and incomplete reporting.
- DVDMS/DPDMIS was used for online indenting in some facilities, but stock management remained largely manual at AAM-PHC/SHCs due to incomplete adoption of the system.
- Teleconsultation services through e-Sanjeevani were found to be available but required expansion.
- An ABDM-enabled HMIS (NextGen) has been implemented for OPD patient registration, enabling digital capture and management of health records.
- Digital platforms were available for surveillance and program monitoring, but absence of an integrated dashboard results in data being scattered across multiple portals.

Kerala

- State was using both central portals (IHIP, EVIN, UWIN, RCH, Nikshay, eSanjeevani, FPLMIS) as well as State developed portals (E-health, Nirnaya, and Shaili).
- It was observed during CRM visit that Shaili app used for NCD data entry was non-editable so ASHA could not correct, if any wrong entry is submitted. State may integrate with NP-NCD app to enable data flow at national level.
- AAM team members were handling multiple portals (~50 portals) along with physical registers, leading to high workload, staff fatigue, and reduced time for service delivery.

Madhya Pradesh

- The state is using a wide range of national and state-level IT applications/portals for entering programme-specific data at District/Block/Facility levels, including HMIS, NCD portal, IDSP, MP Aarogyam among others.
- The state-specific portal ANMOL Madhya Pradesh was not integrated with the RCH 2.0/ANMOL (National) portal due to ABDM non-compliance in ANMOL MP.
- During data verification, some discrepancies were found between the data reported on the HMIS Portal and the entries in the physical registers.
- The need for capacity building of staff at regular intervals, along with periodic review and monitoring of data quality was noted.

Maharashtra

- e-Sushrut portal was fully functional across all facilities till PHCs. Additionally, e-Aushadhi was being used till the PHC level, and in some areas even at the SHC level.
- Despite their functionality, gaps in the completeness and timeliness of data entry were noted, particularly in HMIS, RCH portal, and U-WIN portal, and e-Sushrut.
- In addition, there was a significant gap observed in staff training, particularly regarding portal usage and understanding of data definitions for each component.
- The “e-Suchi” platform being used in tribal districts such as Nandurbar serves as an important digital tool for capturing community-level socio-demographic data.
- Issues pertaining to e-Sanjeevani ID creation and utilization, as well as FPLMIS access were observed.

Meghalaya

- State was utilising most of the national portals except RCH and DVDMS. In place of DVDMS, State has its own application - MMDSL.
- Dedicated internet facilities were not available at health facilities; staff relied on personal connections for portal updates, with several areas lacking network connectivity.
- Data mismatch between registered in physical registers, digital portal vs actual count was noticed at most facilities.
- Access of Nikshay provided to all health facilities till AAM Level. Enrolment and monitoring of patient treatment being done through Nikshay portal/App.

Nagaland

- National portals such as HMIS, RCH, NCD, DVDMS, IHIP, U-WIN were being utilized by the state.

- Fix line internet connection like Bharat net was not available at any of the visited health facilities. Poor internet connectivity was observed as one of the major challenges in effective utilization of IT applications in all the visited health facilities.
- Limited use of DVDMS for indenting (primarily used for stock management) was noted. In most of the visited health facilities, the pharmacists were not trained in DVDMS portal.
- Data Quality Review on HMIS was quarterly conducted at the DH only.

Odisha

- Internet connectivity was available across secondary level facilities but remained limited in some primary facilities. ANMs were using their personal devices with internet access for data entry, which was reimbursed.
- The Nikshay portal and NCD app were being used inconsistently, limiting real-time reporting and patient follow-up.
- Regular HMIS data quality reviews were being conducted.
- Training on all IT applications was last provided to ANMs, CHOs, pharmacists, and nursing staff in December 2024.
- Teleconsultation efficiency issues due to delays were noted with the e-Sanjeevani platform.

Punjab

- State is using central portals such as RCH, HMIS, NCD, DVDMS, Nikshay, e-Sanjeevani along with multiple state-specific applications such as Mission Amrit App, E-Yog, ASHA portal, Flood Reporting, GIS mapping among others, were being used.
- In some of the visited facilities due to internet connectivity issue there was delay in reporting/difficulty in reporting was noted
- Resistance from ASHAs towards digital platforms was noted across the visited facilities in Faridkot, and they were only entering data in 3-4 applications.

Rajasthan

- National platforms including the RCH Portal, AAM Portal, PMSMA Portal, NCD Portal, DVDMS, Ni-Kshay, IDSP-IHIP, e-Sanjeevani, HMIS, and Ni-Kshay Aushadhi were found to be available and functional.
- A large number of state IT platforms (~35–40) complementing the national portals were also in place, including IHMIS, PCTS, OJAS, ASHA Soft, e-Upkaran, e-Aushadhi, Marudhar, RajHealth.
- It was reported from ASHAs that there were multiple apps for data entry, which increased workload and duplication of data entry.

- e-Upkaran software was being used for online inventory and identifying functional and non-functional equipment across health facilities.
- The Sashakt portal, intended for planning and monitoring of trainings, was not being used, and DVDMS had not been effectively rolled out at the primary-care level, impacting drug stock visibility and supply-chain efficiency. e-Sanjeevani was also being underutilised.

Sikkim

- HMIS and e-Raktkosh were functional, with partial rollout of DVDMS.
- Strong district-level infrastructure was present, but internet connectivity was observed to be a major concern, especially in the far-flung, hilly, and remote areas where network stability was inconsistent.
- Portal-specific issues were observed (U-WIN OTP failure, NCD data flow gaps, AAM image upload issues). Slow performance of FPLMIS affected usability.
- Regular training for HMIS portal was being provided. However, a key challenge observed was training for especially drug and inventory management.
- Need for integration and improved system performance was identified.

Tamil Nadu

- Regular reporting was being done on multiple IT platforms such as PICME, Nikshay portal, NCD-MTM, e-RaktKosh, HMIS, IHIP, and HMIS-3.0; however, a Data Validation Committee at State/District/Facility level was needed to review data across portals.
- Teleconsultation was available at AAM through the e-Sanjeevani platform.
- FPLMIS was functional with trained staff; physical stock matches digital records, with no recent stock-outs.
- High-Risk Pregnancy (HRP) tracking was being done through PICME and HMIS-3.0, enabling systematic identification and real-time follow-up from ANC to postnatal care.

Telangana

- National portals (HMIS, IHIP, DVDMS/e-Aushadhi) were functional across facilities.
- Poor internet connectivity at PHC level was affecting real-time reporting on HMIS and IHIP.
- A critical issue identified was the continuation of dual data entry practices in NCD (Non-Communicable Disease) portals, with parallel entries being made at both State and National levels.

Uttarakhand

- Multiple portals (HMIS, NCD Portal, DVDMS, Nikshay, e-Raktkosh, AAM Portal) were in use.
- Data inconsistencies were observed in HMIS (e.g., NBSU/NRC reporting without facility availability). Data mismatch between Physical & online records for NCD portal, Viral Hepatitis portal was also observed.
- State has issued directions for District & Block level Data validation committees to be formed to strengthen data quality.
- The need for refresher training was observed for DEOs and other health staff on IT portals.

Uttar Pradesh

- Both central portals such as DVDMS and state portals such as e-Kavach were implemented in the State. However, data quality gaps were noted between field records and portal reporting, across portals including HMIS.
- The state-developed UDSP portal reported only 20 diseases compared to 50 outbreak-prone diseases under IDSP/IHIP, resulting in under-reporting against programme requirements.
- Limited use of data for programmatic decision-making was observed.
- Utilization of digital platforms was found to be inconsistent — e-Sanjeevani required strengthening, some of the AAM centres under-reported NCD cases and e-Raktkosh was not fully extended to blood storage units.



LEGAL FRAMEWORK & ACCOUNTABILITY

17th

LEGAL FRAMEWORK & ACCOUNTABILITY

NATIONAL OVERVIEW

Legal framework in India is a comprehensive framework aimed at standardizing healthcare delivery, protecting public health, ensuring ethical practices, and safeguarding vulnerable populations. These regulations are critical in ensuring the rights-based services to the patients. There are several key legislations regulating the healthcare establishments and services as per the provisions of the specific Acts. As part of the monitoring mechanism, CRM teams assessed the implementation of health regulations under various Acts and Rules. This comprehensive review provided valuable insights into successful strategies and gaps in implementation, as well as the enforcement of legislative provisions.

The Clinical Establishments (Registration and Regulation) Act, 2010 (CEA) mandates the registration and regulation of all clinical establishments (hospitals, clinics, diagnostic centres, etc., across government and private sectors) to prescribe minimum standards for facilities, services, and treatment guidelines. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, (PCPNDT Act), prohibits sex selection before or after conception and regulates prenatal diagnostic techniques (such as ultrasound) strictly for detecting genetic or other medical abnormalities. The Medical Termination of Pregnancy Act, 1971 (MTP Act), significantly amended in 2021, legalizes safe abortions under specified conditions to reduce unsafe procedures and maternal mortality. The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 (COTPA) prohibits smoking in public places (with limited exceptions), bans direct and indirect advertising/promotion/sponsorship of tobacco products, restricts sales to minors and within 100 yards of educational institutions. The Mental Healthcare Act regulates mental health establishments, prohibits certain treatments without consent, establishes Central/State Mental Health Authorities and Review Boards for oversight, and emphasizes community-based care, decriminalization of suicide attempts, and protection of rights during admission and treatment. Collectively, these Acts reflecting India's efforts to balance regulation, patient protection, and public health improvement.

Overall, the legal framework and governance structure across states was observed to be largely institutionalized and streamlined. Some States have adopted the Clinical Establishments Act (CEA), while others have enacted their own Acts to regulate clinical establishments. Institutional mechanisms under the PCPNDT Act were found to be functional in almost all states, however, gaps persist in implementation and compliance. Inconsistent documentation of consent in Form 'C' under the MTP Rules was observed in several facilities. There was limited clarity among service providers regarding provisions of the Mental Healthcare Act, 2017, and other health-related legislations, largely due to the absence of structured orientation or training programmes on legal frameworks. While awareness of key provisions such as disability certification, birth registration, confidentiality norms, prohibition of sex selection, and mandatory signages under COTPA was generally satisfactory, strengthening systematic training, compliance monitoring, and documentation practices is essential to ensure uniform and effective implementation of health-related legal Acts.

KEY OBSERVATIONS

1. Clinical Establishments (Registration and Regulation) Act, 2010

The Clinical Establishments Act (CEA) has been enacted in most of the states, but implementation varied across states. Bihar has enacted the Act with State Council and District Registration Authorities constituted though online streamlining remains pending. Odisha follows a robust online Clinical Establishment Management System for registration and renewal. Tamil Nadu follows its own State Act (1997), regulating both public and private establishments through an online system. In Chhattisgarh, CEA implementation in District Hospital Kanker was not observed. Nagaland reported CEA in place but without detailed documentation. Rajasthan has notified the Act; however, operational clarity and awareness at district level were limited. Overall, while institutional mechanisms exist in most states, digital transparency and uniform enforcement require strengthening.

2. PC & PNDT Act, 1994

Institutional mechanisms under PC & PNDT were largely functional across states. Andhra Pradesh, Odisha, Punjab, Tamil Nadu, Sikkim, Uttarakhand, and Assam have constituted Supervisory Boards and Advisory Committees, with periodic meetings being conducted. Odisha undertakes SRB trend analysis using HMIS data, and Tamil Nadu reported prosecutions and enforcement actions. However, gaps were observed in Meghalaya (Board last met in 2021), Madhya Pradesh (mandatory signage not displayed), Uttar Pradesh (renewals pending in some facilities), and Assam (need for prominent display of Act provisions signed by facility in-charge). Community awareness remains uneven, and enforcement challenges persist in certain districts.

3. Medical Termination of Pregnancy (MTP) Act, 2021

Most states reported availability of trained providers, MVA/EVA equipment, MMA kits, and reporting formats (e.g., Odisha, Punjab, Sikkim, Andhra Pradesh, Tamil Nadu). However, inconsistencies in documentation and Form 'C' compliance were observed in several facilities. In Assam, MTP cases increased from 556 (Apr–Sep. last year) to 652 (current year), reflecting a 20% rise, highlighting the need to strengthen family planning counselling and contraceptive access. In Nagaland and Meghalaya, limited training and documentation gaps were noted. In Rajasthan and some other states, awareness among peripheral staff was inadequate. Clear display of MTP provisions and improved documentation practices are required.

4. Rights of Persons with Disabilities Act, 2016

Most states were issuing disability certificates through designated medical boards. Bihar demonstrated a structured validation process with interdepartmental camps. Tamil Nadu and Uttarakhand follow systematic issuance processes. However, in Chhattisgarh and Meghalaya, beneficiary awareness about certification procedures was limited, and accessibility gaps (ramps/wheelchairs) were noted. Rajasthan's implementation remains largely district-centric, limiting outreach in rural areas.

5. POSH Act, 2013

Awareness of the POSH Act varied. Bihar has yet to constitute Internal Complaints Committees (ICCs) in several facilities. In Madhya Pradesh and Rajasthan, committees were either partially formed or lacked documentation and staff awareness. Chhattisgarh and some other states reported existence of committees but indicated the need for training on statutory norms. Strengthened orientation and monitoring of ICC functioning is required across states.

6. Medico-Legal Care Protocols & One Stop Centres

States such as Tamil Nadu, Odisha, Uttarakhand, Maharashtra, Assam, and Karnataka reported functional 'One Stop Centres' (OSC) with defined protocols. Tamil Nadu's 'OSC' in Tenkasi was well-integrated with helplines and support services. However, in Bihar, Rajasthan, and Tripura, although centres existed but training of staff on medico-legal protocols remains inadequate. Jhunjhunu (Rajasthan) showed better structured medico-legal care at higher facilities but lacked dedicated spaces at primary level.

7. COTPA, 2003

COTPA implementation showed mixed progress. Andhra Pradesh reported strong enforcement with over 36,000 penalties under Section 4. Odisha and Punjab have active District Tobacco Control Cells with regular trainings and signage compliance. Uttarakhand reported issuance of challans and awareness programs. However, enforcement gaps were observed in Bihar (poor signage, tobacco shops near facilities), Rajasthan (weak implementation at schools and primary level), Maharashtra (improper utilisation of penalties), and Chhattisgarh (need for stronger awareness despite tobacco-free signage). Enforcement in rural areas remain inconsistent across states.

8. Registration of Births and Deaths Act

Digital registration systems were functional in Odisha, Maharashtra, Uttarakhand, Tamil Nadu, Punjab, and Sikkim. However, training and community awareness gaps were noted in Rajasthan and Meghalaya. In some states, procedures for private and home deliveries require improved clarity and dissemination.

9. Biomedical Waste Management Rules, 2016

BMW compliance varied significantly. Bihar reported outsourcing to private provider, (SYNERGY) for waste management. However, Madhya Pradesh reported missing barcoding, non-submission of annual reports, and non-functional STP/ETP systems. Rajasthan and some facilities in Chhattisgarh faced gaps in documentation, transport systems, and PPE compliance. While some states demonstrated structured systems, consistent monitoring and training remain critical.

10. Mental Healthcare Act, 2017

Most states have notified State Mental Health Authorities and Rules (e.g., Andhra Pradesh, Odisha, Punjab, Uttarakhand, Tamil Nadu). However, operationalization at district level remains weak in several states, including Rajasthan, Tripura, Chhattisgarh, and Meghalaya. Infrastructure gaps, shortage of trained professionals, and limited integration at PHC level were common challenges. Awareness among frontline staff requires strengthening

KEY CHALLENGES

- Inconsistent implementation and compliance of public health legislations across states and peripheral facilities.
- Deficiencies in statutory documentation, including improper maintenance of PCPNDT and MTP records.
- Non-display or irregular display of mandatory licenses, certifications, and legal signages at facilities.
- Limited awareness and understanding of key legal provisions among healthcare providers.
- Lack of structured and periodic legal training and refresher programmes for staff.
- Weak enforcement and monitoring systems, including low conviction rates and irregular inspections.
- Partial compliance with AERB and radiation safety norms, including inadequate monitoring mechanisms.
- Shortcomings in Biomedical Waste Management systems, including infrastructure and reporting gaps.
- Weak coordination between health authorities and enforcement agencies.
- Irregular functioning of statutory committees and absence of systematic action tracking.
- Inadequate grievance redressal systems and medico-legal preparedness, including gaps in MCCD reporting.
- Limited and inconsistent IEC efforts on key legal and public health issues.
- Infrastructure deficiencies affecting regulatory compliance, including lack of disability-friendly access.

KEY RECOMMENDATIONS

- States to integrate awareness of key public health legislations (PCPNDT, MTP, COTPA, CEA, Mental Healthcare Act, AERB norms, BMW Rules, Birth–Death Registration, Disability Act, POSH, HIV Act) into routine service delivery and community health promotion activities.
- States to establish structured and periodic training programmes for all cadres (MOs, nurses, ANMs, CHOs, LTs, radiology staff, administrators) covering legal provisions, documentation standards, medico-legal protocols, and compliance requirements.
- There is a need to strengthen state and district-level monitoring through quarterly legal compliance reviews under SHS/DHS, with documented action points and follow-up of statutory committee meetings (PCPNDT, SMHA, Advisory Committees, etc.).

- States to ensure timely renewal and prominent display of all mandatory registrations and licenses (PCPNDT, MTP, AERB, CEA, BMW, Fire NOC), along with functional grievance redressal systems at facility level.
- States to improve enforcement mechanisms through regular inspections, record verification (Form-F, MTP consent forms), fast-track legal follow-up, and stronger coordination with police and judicial authorities, particularly under PC & PNDT and COTPA.
- States to ensure full compliance with AERB and radiation safety norms, including issuance of TLD badges, maintenance of exposure logs, appointment of Radiation Safety Officers, and periodic safety audits.
- States to strengthen Biomedical Waste Management through operational STP/ETP systems, regular audits, staff training, mock drills, barcoding, and timely submission of statutory reports.
- States to intensify COTPA enforcement and tobacco control measures through regular drives, inclusion in crime review mechanisms, and targeted IEC on tobacco and Gudakhu (a form of smokeless Tobacco) addiction.
- States to enhance public awareness through multi-platform IEC campaigns on safe abortion services, prohibition of sex selection, suicide prevention, disability rights, and other legal provisions.
- States to strengthen MTP services by prioritising provider training, ensuring proper consent documentation, and improving family planning counselling to reduce unintended pregnancies.
- States to improve Medical Certification for Cause of Death (MCCD) reporting and digital birth–death registration through focused training and monitoring.
- States to ensure disability-friendly infrastructure in all facilities and maintain adequate supply chains for essential medicines, diagnostics, PPE, and safety equipment to support statutory compliance.

STATE SPECIFIC OBSERVATIONS

Assam

- PCPNDT, MTP, BMW, AERB act displays were not placed prominently.
- MTPs reported have shown an increase- last year (Apr-Sep) it was 556 MTPs and this year for same period was 652 (20% increase).

Andhra Pradesh

- PCPNDT Act - Implementation of the PCPNDT Act in Andhra Pradesh was observed with the State having constituted Appropriate Authorities and Advisory Committees at both district and sub-district levels. All ultrasound facilities have been registered, and statutory bodies meet regularly for monitoring and review. Despite this, conviction

rates remain low, reflecting gaps in field-level enforcement, evidence collection, and timely follow-up of suspected violations. The State needs stronger surveillance, regular inspections, and focused capacity building for district teams to strengthen compliance with the Act.

- **MTP Act** - The State has conducted orientation trainings for Medical Officers on provisions of the amended MTP Act, and MTP pills were available up to PHC level. However, the utilisation of MTP services remained low, partly due to insufficient awareness among frontline providers, limited availability of trained personnel at peripheral facilities, and hesitation in offering services due to medico-legal concerns. There is a need for clear operational guidance to ensure safe and timely provision of MTP services at the appropriate levels of care.
- **COTPA Act** - The Cigarettes and Other Tobacco Products Act (COTPA) is enforced well in Andhra Pradesh. During the reporting period, more than 36,000 individuals were penalised for violations under Section 4, reflecting the commitment to reduce public smoking. Awareness activities and enforcement drives have been conducted at schools, public institutions and urban centres, however, compliance in rural areas remains inconsistent, and periodic enforcement varies across districts. Strengthening coordination between health, police and education departments, along with community-focused IEC, is essential to ensure uniform enforcement across the state.
- **Mental Health Act** - Under the Mental Health Act, the State has notified the State Mental Health Authority and Mental Health Review Boards. State Mental Health Rules were notified, and the SMHA draft regulations have been circulated to members, with views and suggestions consolidated and the final report to be submitted to the chairperson for Government orders.

Bihar

- **Clinical Establishment Act (CEA)**: The Clinical Establishment Act has been enacted in the state, with the State Council and District Registration Authorities constituted in both districts. However, further streamlining through an online portal remains pending.
- **PC & PNDT Act**: The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act supervisory board has been constituted at the state level, with regular meetings being conducted. Facilities in both districts displayed information on the Act. No cases under the PCPNDT Act were registered in either district.
- **Medical Termination of Pregnancy (MTP) Act, POSH Act, and Medico-Legal Cases**: Committees for the MTP Act and other medico-legal frameworks have been formed at both state and district levels, with meetings held sporadically. However, for the POSH Act, the Internal Complaint Committee was yet to be constituted, reflecting a critical gap in ensuring workplace safety for healthcare staff.
- **Bio-Medical Waste Management Rules (2016)**: Biomedical waste from facilities was being managed by private agency ensuring compliance with waste collection and disposal protocols.

- Rights of Persons with Disability Act: Disability certificates were being issued at district hospitals in both Saran and Munger districts. A structured validation process by medical experts is in place, and interdepartmental camps were conducted for issuing certificates.
- COTPA (Cigarettes and Other Tobacco Products Act): There was a significant lack of implementation of COTPA across facilities as 'No-smoking Area' signages were observed in only a few locations. Monthly review meetings on COTPA compliance were not held in any facility, Tobacco spitting and the presence of tobacco-selling shops near healthcare facilities were common, reflecting poor enforcement.

Chhattisgarh

- Facilities possess valid USG/X-ray licenses, but licenses were not displayed, and mandated radiologist details and grievance information were missing.
- Tobacco-free signage and counselling rooms were available, but overall COTPA enforcement and staff awareness require strengthening. But, it was observed that people were addicted of Gudakhu (a smokeless tobacco-based paste).
- Birth and death registration was being updated online with well-maintained certification records, yet legal documentation and public disclosures remain incomplete in several facilities.
- AERB licenses were available for radiology equipment, but PPE quality testing was not documented and CT operators lacked TLD badges.
- Disability and medical fitness certification processes were systematic:
- Requirements under PCPNDT, AERB, and other regulatory acts were partially fulfilled and display norms, grievance mechanisms, and record-keeping were not consistently followed.
- State Supervisory Board under PC PNDT was constituted and meetings were being held. District Advisory committee meetings were also being held regularly.
- POSH committees existed, but need training on statutory norms.

Kerala

- State has implemented Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PCPNDT Act), Medical Termination of Maternity Act, 1971 (MTP Act) Clinical Establishment etc.
- All visited facilities were observed to be compliant with provisions of PC&PNDT, COTPA Act.
- Kerala Public Health Act, 2023 has established public health governance framework with defined roles for State, District and Local Public Health Officers.
- MTP services were available at the GH (only till 12 weeks) and Medical College level (till 24 weeks), and the facilities were approved as per the MTP Act. However, utilisation remain low.

- Mapping of all functional/non-functional equipment under BEMP had been undertaken.
- The State has implemented IEC activities in local language and which was observed to be effective in creating awareness.
- One stop centres to register Medico Legal cases were functional providing counselling services to the victims and records were also maintained.
- Registration Desk for Births and Deaths were available at the facilities and were functional between 10 AM to 12 AM.
- All the visited health facilities were "No Smoking Zone" as per the COTPA ACT, 2003.

Madhya Pradesh

- PCPNDT Compliance: Mandatory signage prohibiting sex determination was not displayed, and the prescribed format for PCPNDT display was not followed. DQAC meetings were being conducted, and adequate awareness of the PC&PNDT Act and MTP Act was observed among Medical Officers and support staff in Vidisha district
- Biomedical Waste (BMW) Management - Bar-code entries were not recorded in the BMW logbook. The annual BMW report was not submitted to the State Pollution Control Board and had not been uploaded on the designated-online portal. BMW authorization has been granted for all CHCs and PHCs, except AAM Sub-Centres in Vidisha. The STP and ETP were found non-functional and not connected to all infectious discharge points.
- Employee Health and Safety - Vaccination: Hepatitis-B and Tetanus immunization was not uniformly ensured across regular and contractual staff involved in patient care and biomedical waste handling.
- Fire Safety - A designated Fire Safety Officer was not identified. Several buildings were found without valid Fire NOCs in Mandsaur. Fire NOCs were available at CHCs and PHCs in Vidisha
- Service Delivery - OPD services for OBGY and Paediatrics were functioning in the new MCH Wing without the required NOC compliance at District Hospital Mandsaur.

Maharashtra

- The registration of births and deaths was conducted at every level of healthcare facilities. At the SHC, the registrations were being managed through the local gram panchayat office. Above SHC, registrations were typically handled by a Data Entry Operator (DEO) using the CRS Portal.
- Medical Officers have been trained to conduct post-mortems at the primary care level in identified PHCs in both districts.
- At the facility, the use of ultrasound machines was being strictly adhered to the Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) Act.
- Information regarding MTP Act was not displayed outside facilities in both the districts.

- The facilities did not have adequate signage displayed inside the facility premises on tobacco control.
- In Satara district, it was observed that the penalties collected under the COTPA Act 2003 at SDH Karad were being used for activities rather than depositing them into the Treasury, without required approvals.

Meghalaya

- Implementation of Pre-Natal Diagnostic Techniques (PCPNDT) Act was found to be lacking at facilities offering USG services, and the State Supervisory Board last met in 2021. There was a need for refresher training for Primary Health Care staff regarding the Mental Health Care Act, 2017. Furthermore, only some facilities provided ramps, wheelchairs, and walkers, necessitating improvements to ensure a differently abled friendly environment.
- All facilities (90) providing ultrasonography services were registered under PCPNDT Act & no case has been registered in last 1 year.
- MTP (Medical Termination of Pregnancy) act, 1971- RMPs were aware of recent amendments in the Act but only few Medical Officers were trained to conduct MTP.
- Under Medicolegal care protocol for rape and sexual violence cases 'One stop centres' established by WCD and were functional as per protocols.
- The cigarettes & other Tobacco products (Prohibition of advertisement and regulation of trade and commerce, production, supply and distribution act 2003, (COTPA) was being implemented in the state and signages were available. Tobacco free educational Institute (TOFEI) guidelines were being implemented in the state in all districts.
- Registration of Births & Deaths Act 1969- Birth & Death certificates were being issued by the facilities (CHC) in both the districts including home deliveries.
- Mental Health care Act, 2017- State has notified mental health authority and review boards.
- Clinical Establishment Act- Online registration was available at state level with check at district level, DHS (Medical Institutions).
- Rights of Persons with Disability Act 2016- Disability certificates were being issued to the patients by State Resource Centre of Disability Affair (SRCDA). Only some facilities were having provision of ramps, wheel chairs and walkers to ensure differently abled friendly environment.

Nagaland

- The Clinical Establishment Act (Nagaland Health Care Establishment Act) was adopted by the state in 2010.
- PCPNDT: The State Supervisory Board was in place and its meeting has been convened once in the last year. Appropriate State level authorities have been appointed consisting

of 3 members. Advisory committees both at State and District level had also been formed.

- MTP Act: In both the districts, majority of MOs were not fully aware of the provisions under the MTP Act and its recent amendments. Refresher training on the MTP Act were planned to be conducted in 4th Quarter of FY 2025-26 in the Mon district.
- Medico-Legal Care Protocol for Rape and Sexual Violence Cases- one stop centre with defined SoPs were available only at the DH. The standard protocols were followed in prosecution for Rape and Sexual violence cases as per POCSO Act for victims below 18 yrs of age and for others as per the Bharatiya Nyaya Sanhita (BNS), 2023.
- The Mental Healthcare Act, 2017- State Mental Health Authority and Mental Health Review Boards was formed and State had notified the State Mental Health Rules. State Mental Health Authority (SMHA) had conducted one meeting in the last one year. However, the Minutes of SMHA meetings were not available.
- Registration of Births and Deaths Act, 1969- Registers for entering Birth & Death were available till PHC level. Home deliveries were being issued birth certificate through the Statistics office.
- POSH: No awareness was found about the act at the District level.
- COTPA- Regular enforcement drives by District Tobacco control cell team were undertaken and violators were fined as informed by DH officials however no record of any penalty through challan was found. All education institutes in Nagaland declared Tobacco Free and teachers empowered to act as Enforcement Officers in their jurisdiction to enforce COTPA 2003 Section.
- BMW Management: Biomedical waste was effectively managed. Non-chlorinated colour-coded plastic bags were used for waste disposal however the cultural practice of handing over of delivered placenta to the family was prevalent across the visited facilities.

Odisha

- PCPDNT Act 1994 - To ensure the effective implementation of the PC PNDT Act, the State Supervisory Board has been constituted. Periodical trend Analysis of Sex Ratio at Birth was being done from HMIS, CRS to identify hotspots. IEC/BCC strategy/campaign on awareness about the act, and against the practice of pre-natal determination of sex and female feticide was being undertaken. Though, Training of staff is needed on a regular basis.
- Medical Termination of Maternity Act 1971 (MTP Act) - Odisha has officially gazette notified MTP Forms I, II, and III and implement them across the State to support women requiring abortion services beyond 24 weeks. The State also established Medical Boards in 12 Maternal and Child Health (MCH) institutions, with their formation duly notified in the State Gazette. Equipment (MVA/EVA), drugs MMA kits along-with MTP reporting formats were readily available in respective facilities.

- Medico-legal Case - Total 1216 cases reported on MLC during the last 6 months preceding CRM visit. 7 facilities reported MLC Cases during 2025-26. During 2024-25, Total 2288 cases reported from 9 facilities.
- The Cigarettes and Other Tobacco Products Act 2003 (COTPA) - All health institutions have been declared Tobacco-Free Zones. “No Smoking Area – Smoking Here is an Offence” signage was displayed at all levels of health facilities, from AAM to DH. The District Tobacco Control Cell (DTCC) was conducting regular training sessions for staff and officials to strengthen implementation of the COTPA Act.
- Registration of Births and Deaths Act 1969 - All health facilities registered birth & death certificates through the online web portal (<https://www.birtheath.odisha.gov.in/>). For community/Home delivery, MPHW(F) filled up the birth form & submitted it to the concerned Medical Superintendent for issuing the birth certificate online within 15-21 days.
- The Mental Health Act 2017 - The state has notified the mental health authority & mental health review board. The state has also notified state mental health rules.
- Clinical Establishments Act, 2010 - All the private hospitals registered through Clinical establishment Act 2010 in [http:// cemso.nic.in](http://cemso.nic.in) web portal.

Punjab

- PCPNDT Act - State Supervisory Board meeting was convened in the last year (2024-25). State has undertaken an IEC/BCC strategy/campaign on awareness about the act, and against the practice of pre-natal determination of sex and female foeticide. State was using online registration portal for PC&PNDT. Districts have appropriate authorities appointed and have advisory committees but no recent meeting noted in last 6 months. State is also implementing ‘Balri Rakshak Yojana’ scheme to improve sex ratio, stabilize the population of the state of Punjab and reduce infant mortality.
- MTP Act - The facilities had trained doctors (as per the MTP Act), MVA/EVA equipment, MMA drugs and MTP reporting formats.
- The Cigarettes and Other Tobacco Products Act, 2003, (COTPA) was implemented in the districts and across the health facilities. “No Smoking Area - Smoking Here Is An Offence” signages were displayed. District tobacco cell was active and conducted regular awareness through IECs and conducted trainings.
- Registration of births and deaths occurring at the hospital were diligently registered and home deliveries were also issued birth certificate.
- State had notified ‘State Mental Health Authority’ and Mental Health Review Boards but no recent SMHA meetings were noted in last 6 months.
- Punjab Clinical Establishment Act, 2020 is being implemented and provides the registration and regulation of public & private hospitals, clinics, maternity homes etc.
- Disability certificates were issued in the District Hospital level at Faridkot.

Rajasthan

- PCPNDT Act - State has developed an online registration portal, which has strengthened transparency and regulatory oversight. The state has undertaken mapping of districts and blocks with low child sex ratio through the Pregnancy and Child Tracking System (PCTS), helping identify vulnerable geographical pockets. Community interactions indicated that residents generally hold a positive perception regarding the prohibition of sex determination, and IEC materials on PCPNDT were found extensively displayed at AAM and AWCs, suggesting that awareness efforts were visible and consistent.
- MTP Act - Staff at the District Hospital demonstrated awareness of the legal provisions. DH team was familiar with the protocols, indicating adequate understanding at secondary-level facilities. However, no information was available on availability.
- Medico-Legal Care Protocol for Rape and Sexual Violence Cases CHC and DH maintained designated medico-legal care spaces equipped with a team consisting of a gynaecologist, female physician, jurist and a female constable, ensuring that examination and sample collection were conducted in a structured manner. A total of 35 cases under IPC Section 370 were recorded in 2025, reflecting utilisation of the medico-legal system.
- POSH committees at the level of CMHO has been constituted, however, the details regarding the committee members or its awareness among the healthcare staff was observed to be lacking in Nagaur district.
- Mental health ACT 2017- Rules governing the authority has not been notified by state.
- COTPA – ‘No-smoking’ signage was not displayed at the AAM and UPHC but were adequately displayed in common areas at the District Hospital. District Tobacco Control Cell (DTCC) trainings were not observed at the primary-level facilities. ASHAs demonstrated awareness of tobacco cessation referral pathways and reported referring community members to District Hospital for services.
- The State has notified the Clinical Establishments Act (CEA) in 2013.

Sikkim

- PCPNDT Act, 1994 - The State Supervisory Board had convened meetings in the past year, and minutes were available. Mapping of low Child Sex Ratio districts and IEC/ BCC efforts on sex selection prevention have been initiated. Appropriate Authorities and Advisory Committees were functional, and development of an online PC&PNDT registration portal was in process. Community awareness was uneven, requiring continued outreach.
- MTP Act, 1971 - Most facilities had trained providers with functional MVA/EVA equipment, and MMA drugs. Awareness of amended provisions, especially gestational limits, privacy requirements, and reporting obligations varied across providers. MTP reporting formats were available, though consistency in documentation and adherence to legal procedures needs strengthening.

- Medico-Legal Protocols for Rape and Sexual Violence - Facilities have maintained designated spaces or linkages with 'One Stop Centres' for medico-legal care. Standard procedures for examination, evidence collection, and chain of custody exist, though implementation practices differ across facilities. Strengthening staff training and inter-departmental coordination will enhance compliance and service quality.
- Enforcement of COTPA, 2003 - Mandatory "No Smoking Area" signage was displayed in most facilities, though uniform compliance with prescribed formats requires attention. District Tobacco Control Cells have conducted trainings; however, coverage remains variable. Strengthening the monitoring mechanisms can improve overall enforcement at facility level.
- Registration of Births and Deaths Act, 1969 – Health facilities had systems for timely registration of births and deaths with the designated registrar. Procedures for community-based or home deliveries were in place but not uniformly understood by beneficiaries. More awareness efforts are required to ensure consistent access to certification processes.
- Mental Healthcare Act-The State Mental Health Authority and Mental Health Review Boards have been notified, along with relevant State Mental Health Rules. Meetings have been held in the past year, and action points documented. Strengthening follow-up and operationalization at district level remains an area for improvement.
- Clinical Establishments Act, 2010 - Mechanisms for registration and regulation of private health facilities were functional at state and district levels. However, publicly available information regarding compliance status and enforcement actions remains limited. Improved digital transparency would enhance accountability and regulatory oversight.
- Rights of Persons with Disabilities Act, 2016 - Disability certificates were issued through designated medical boards, following prescribed procedures. Awareness among community members regarding eligibility and certification processes varied. Strengthened communication through frontline workers can improve access to entitlements.

Telangana

- The review of the legal and accountability framework within the health system indicates that critical legislative instruments including the Pre-Conception and Pre-Natal Diagnostic Techniques (PC-PNDT) Act and the Medical Termination of Pregnancy (MTP) Act were being implemented across health facilities.

Tamil Nadu

- Clinical Establishments regulation - The State has the Private Clinical Establishments (regulation) Act, 1997 and has not adopted the Central Act which regulates government hospitals also. Under the TN Act, the Joint Director of Medical and Rural Health Services as the competent authority to perform functions under the Act. The act regulate Allopathic, Indian Systems of Medicine as well as Homeopathy. Certificate once granted

is valid for 5 years. The application is done online, response to objections is physical and the list of certified facilities was available on the website.

- PCPNDT - District Advisory Committee was in place and had 7 meetings since January 2025 and the minutes of meeting were available. Two prosecutions were held in the last 5 years in Tenkasi out of which one hospital was closed; and in the other, the machine was sealed.
- Registration of Birth & Death act - The certificates were issued only if birth or death happens in the hospital. For the rest, Local Self Governance Institutions issue certificates.
- The Mental healthcare Act - Medicines and services were available at District Hospital and General Hospital. A committee was in place for deliberating on implementing Advance Directive, Nominated Representative etc.
- Disability Act - Public health facilities were issuing disability certificates. The District Hospital and General Hospital holds biweekly medical board with four specialists and two optional specialists
- MTP Act - Only Obstetricians performed MTP as part of State policy. Hence, the trainings were offered only to Obstetricians.
- One Stop Centre in place with WCD support in Tenkasi district was operational since 2022. The site moved to district hospital premises in 2024. There were 13 staff working in the Centre (Psychologists, Social worker, etc.). The Centre is linked to 181 women helpline, de-addiction Centre, livelihood mission, child line etc. Inmates were kept for a maximum of 10 days, and if there is additional requirement, arrangements were made with Sakti Sadan, which works under WCD. 716 persons with varying requirements were served.

Uttar Pradesh

- Governance compliance exists for COPTA, PCPNDT, and MTP, but issues remain in facility specific AERB approvals, incomplete AMC/CMS mapping, gaps in SOPs, BMW management, and incident reporting mechanisms.

Uttarakhand

- PCPNDT Act - State Supervisory Board constituted and meeting held in August 2025. Mapping of districts/blocks/villages with low child sex ratio has not been undertaken by the State. IEC/BCC activities were conducted by the State on awareness about the act. Thirteen appropriate Authorities have been appointed and 13 Advisory Committees (at both state & district) constituted to assist the Appropriate Authority. However, last District Advisory Committee meeting held in Chamoli two years back. Currently, the state has not developed the online registration portal for PC & PNDT.
- Mental Healthcare Act, 2017 - State has notified a State Mental Health Authority and Mental Health Review Boards. State has also notified the State Mental Health Rules in July 2023. In the last one year, only one meeting held by the State Mental Health Authority.

- Rights of Persons with Disability Act, 2016 - Issuance of Disability certificates through a board (constituted under the chairpersonship of CMO with all relevant specialties) as per requirement and social welfare department on a fixed day of a month. Awareness on obtaining disability certificate is through outreach campaigns 'Sarkar Aapke Dwar', Janta Darbar and through Block Development Committee and Social Welfare department.
- Medico-Legal Care Protocol for Rape and Sexual Violence Cases - Victims of rape cases usually arrive with police to facilities for further examination. Medical report is handed over to police. However, in case it results in pregnancy, MTP of such cases done as per MTP act.
- Registration of Births and Deaths Act, 1969 - Birth or death certificates for births and deaths occurring in government hospitals (DH, SDH, CHC, PHC) were issued by that facility within one week of birth or death. The Registrar (Births & Deaths) is the officer in-charge of these facilities. However, for births and deaths occurring in private hospitals, the Registrar (Births & Deaths) of the Municipal Corporation/Town Panchayat/Gram Panchayat in the respective area issues birth & death certificate. Birth certificates for home deliveries and death certificate for home deaths issued by the Registrar (Births & Deaths) of the Municipal Corporation/ Nagar Panchayat/Gram Panchayat in the respective areas.
- COTPA - COTPA implemented. Challans issued 1393 for Chamoli and 948 for Udham Singh Nagar. Percentage of persons counselled for ill effects of tobacco against target was 27% for Chamoli and 29% for U.S. Nagar. School awareness program conducted for Chamoli were 24% and for U.S. Nagar were 54%. College awareness program conducted for Chamoli were 66% and for U.S. Nagar were 40%.



**INDIA COVID-19
EMERGENCY RESPONSE
AND HEALTH SYSTEM
PREPAREDNESS PACKAGE:
PHASE-II (ECRP-II)**

17th

OVERVIEW:

Phase-II of Emergency Response and Health System Preparedness Package (ECRP-II): was approved by the cabinet on 08th July 2021 amounting to Rs. 23,123 Crore with a central share of Rs.15,000 Crore and a state share of Rs.8,123 Crore. To provide support to Central hospitals agencies and to States/UTs Governments to augment their existing response to the second wave and the evolving pandemic, including at district and sub-district levels in peripheral facilities. The ECRP-II has the Central Sector (CS) and Centrally Sponsored Schemes (CSS) components. The scheme aimed to accelerate health system preparedness for immediate responsiveness for early prevention, detection, and management of COVID-19, with the focus on health infrastructure development including for paediatric care and with measurable outcomes.

Under CSS components of the ECRP-II, a total of Rs.12,740.22 Crores released to the States/UTs as the central share. The CSS components include support to States/UTs level through NHM Framework with a State Share as is applicable in NHM.

Under the Central Sector (CS) components of ECRP-II, a total of Rs.1508.59 Cr has been released to the central institutions/agencies. The activities are implemented using existing mechanism of Central Procurement Division (CPD), Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), NCDC, Central Hospitals and Public Health Division and Allied Health Services division of the MoHFW.



KEY OBSERVATIONS

1. Infrastructure Created but Not Fully Operationalised

- A large proportion of ECRP-II investments in infrastructure: paediatric care units, ICUs, field hospitals, MCH wings, laboratories, and oxygen systems have been physically completed across several states. However, many facilities remain partially or fully non-functional due to lack of staffing, equipment maintenance, governance arrangements, or operational planning.
- Examples include non-functional paediatric ICUs, RT-PCR laboratories, unused ventilators, and completed buildings awaiting commissioning or repurposing. In

some locations, facilities constructed during the pandemic have experienced reduced utilization following service reallocation or changing clinical demand, resulting in underutilized infrastructure.

2. Human Resource Gaps Limiting Service Delivery

- Operationalization of critical care infrastructure is frequently constrained by shortages of trained personnel, particularly ICU-trained nurses, paediatric specialists, laboratory technicians, and technical staff. Even where infrastructure and equipment were available, absence of skilled human resources affected the service delivery.

3. Underutilization of High-Value Equipment and Diagnostics

- High-cost medical equipment such as ventilators, RT-PCR machines, biosafety cabinets, oxygen infrastructure, and ICU systems remain underutilized in multiple districts largely due to lack of maintenance contracts, absence of consumables, non-functional components, or lack of trained operators.
- Diagnostic infrastructure created for pandemic response was not fully integrated into routine surveillance systems or public health laboratory networks. Sample referral mechanisms from peripheral facilities were weak, resulting in limited testing volumes and sub optimal utilization of molecular diagnostic capacity.

4. Weak Integration with Health System Functions

- Several ECRP-II components were not fully integrated into routine service delivery, referral systems, or surveillance frameworks. Referral linkages between CHCs, PHCs, and higher facilities remain weak in some districts, affecting utilization of paediatric and critical care units.
- Similarly, tele-ICU hub-and-spoke models were not always implemented as intended, and health information systems were partially operational or delayed due to technical or administrative challenges. In some cases, newly created infrastructure functions in isolation rather than as part of district-level service networks.

5. Delays in Commissioning, Procurement and Civil Works

- Although significant funds have been released, delays persist in completing civil works, handing over facilities, initiating procurement, and commissioning services. Some construction projects remain incomplete, while others were finished but not operational due to administrative or logistical delays.
- Fund utilization varied significantly across states and districts, with both under-utilization and delayed expenditure reported. Pending utilization certificates and incomplete work-in-progress projects risk affecting timely implementation within the scheme's validity period.

6. Maintenance and Sustainability Concerns

- Maintenance of infrastructure created under ECRP-II was inconsistent. Oxygen plants, ICU equipment, ventilators, and diagnostic platforms require regular servicing, calibration, and AMC arrangements, which were not uniformly in place.

- Inadequate planning for recurring costs such as staffing, consumables, utilities, and maintenance poses risks to long-term sustainability. Without integration into routine health system budgets, some facilities may remain operationally fragile.

KEY RECOMMENDATIONS

1. Prioritize Operationalization of Created Infrastructure

- Develop time-bound action plans to operationalize all completed facilities, including paediatric ICUs, laboratories, and MCH wings.
- Ensure infrastructure is integrated into routine service delivery and referral networks.

2. Strengthen Human Resource Planning and Capacity Building

- Recruit and deploy adequate numbers of trained personnel for ICU, paediatric, laboratory, and critical care services.
- Institutionalize structured training programmes in emergency care, ETAT, critical care nursing, and equipment operation.

3. Ensure Utilization and Maintenance of Equipment

- Establish comprehensive AMC and maintenance systems for all high-value equipment.
- Ensure continuous availability of consumables, reagents, and spare parts.

4. Strengthen Referral Systems and Service Integration

- Standardize referral pathways between primary, secondary, and tertiary facilities.
- Fully implement tele-ICU hub-and-spoke models and specialist mentoring systems.
- Integrate ECRP infrastructure with district emergency response and clinical care pathways.

5. Improve Financial Management and Implementation Efficiency

- Accelerate completion of pending civil works and commissioning processes.
- Strengthen financial monitoring to ensure timely utilization of funds.

6. Strengthen Monitoring, Data Systems and Accountability

- Establish standardized indicators for utilization of paediatric units, ICUs, laboratories, and oxygen infrastructure.
- Accelerate implementation of HMIS and digital reporting systems.
- Use data for periodic performance review and course correction.

7. Strengthen Public Health Preparedness and System Resilience

- Integrate laboratory networks with surveillance platforms for early outbreak detection.
- Strengthen climate and environmental health preparedness where relevant.
- Enhance multi-sectoral coordination for emergency response.

- Build institutional mechanisms for continuous preparedness beyond pandemic response.

State-specific Observations

Assam

- At the state level, the team observed that Assam has received substantial support under ECRP II, PM-ABHIM and XV Finance Commission (Health Grants) for strengthening primary care, public health and critical care.
- As on 30-10-2025, under ECRP-II, the total approved resource envelope of ₹812.46 crore (GoI share ₹731.22 crore and matching State share ₹81.24 crore) has been fully received. Expenditure of ₹518.10 crore has been incurred so far, accounting for 64% utilisation of the total funds.

Bihar

- 32-Bedded Paediatric Care Unit in Munger was fully functional operating 24×7 staffed by 1 Paediatrician, five Staff Nurses and other paramedical staff. Bed occupancy was low, and not aligned with district paediatric morbidity. Paediatric ICU has been established but remains completely non-functional. Nursing staff was inadequate for a 32-bedded unit and was not aligned with the IPHS norms. Paediatric ICU was non-functional due to lack of ICU-trained staff. There were weak referral linkages with CHCs and PHCs. The proper referral protocols were not being implemented. There was limited monitoring of service utilization, outcomes and quality-of-care indicators.
- A 20-bedded Nutrition Rehabilitation Centre (NRC) was fully functional and a 12-bedded Paediatric ICU was ready and expected to become operational within two weeks in Saran district. The paediatric ward was planned to function in full capacity once ICU services start as the building was recently handed over (within the last 5 months).
- 100-Bedded Field Hospital in Munger district currently houses District Physiotherapy Unit & 'BHAVYA Command & Control Centre'. Inpatient services were not currently provided as new Model Hospital has recently been operationalized in the district, catering to most of the clinical services. Field hospital in Saran District has been successfully converted into a 70-bedded MCH facility. The 24×7 services were available at the facility catering to around 300 deliveries and around 500 OPD every month.
- RT-PCR Laboratory- The lab was currently performing only Dengue ELISA (3–4 tests/day) in Munger while it was closed and not in use at the time of visit in Saran district. In Munger district the RT-PCR lab was not being utilized, despite availability high value equipment including Biosafety cabinets, Deep freezer, RNA extraction system, 2 RTPCR machines, ELISA washer units, ILR. Additionally, minimal IDSP-linked referral or surveillance testing was observed.

Chhattisgarh

- The unspent balance under ECRP-II needs to be settled, and pending WIP civil construction works require early completion, as the Emergency COVID Response Package (ECRP-II) is valid up to December 2025–26.
- Under ECRP-II, in SNCU ventilators were received but were not in use and AMC was also not done.
- The utilization of funds under ECRP-II for Kanker was 63% and for district Mahasamund it was 100%.

Madhya Pradesh

- Under ECRP II, major infrastructure projects were completed but operationalization challenges remain such as the non-functional MCH wing at DH Mandsaur.
- In the visited districts, all the sanctioned components were found to be completed, However, MCH wing was yet to be made functional at DH Mandsaur.

Nagaland

- Preparedness, response and challenges were observed with reference to ECRP II. In Zunheboto district hospital, 28 ventilators and other equipment which were sanctioned through ECRP II but not being used may be shifted to other higher facilities for their utilization.
- 30 bedded Paediatric Care Units construction at NHAK & Dimapur was under progress. In all DHs (including Noklak) 10 bedded ICU project with additional support from e-Gov. has been made functional. In each DHs ICUs, 5 to 10 beds were available, out of which 2-3 beds were reserved for paediatrics in a Hybrid ICU Mode.
- Under the 10 Bed ICU project NHAK is functioning as the Hub (CoE) for Tele-ICU across other DHs (a total of 11 including Noklak) as the spokes.
- 11 District Hospitals as spokes and NHAK (MC) as the Hub have been connected with internet-web based access. Around 5-8 Tele ICU consultations were held per month.
- Medical Gas Pipeline System was available and piped oxygen delivery was in place at the DH. The PSA Plant capacity was 500 LPM
- HMIS was functional at DH in both the districts. The modules were being prepared and training of health staff on HMIS was under process.

Punjab

- Under ECRP preparedness, the State is implementing ECRP-II projects, through which facilities such as LMO plants and NICUs have been operationalized.

- In Faridkot district, as district hospital was 1.5 kms away from Faridkot Medical college & Hospital, dedicated Paediatric Care Units, SNCU, DU was established there.
- These were supported with functional oxygen supported beds.
- Liquid Medical Oxygen (LMO) was available at the DH/CHCs in both the visited districts.
- Continued proper maintenance of these oxygen plants must be ensured.

Rajasthan

- Under ECRP II, the state has utilized 76.96% of the approved funds, with Rs 1133.04 crore spent out of Rs 1472.28 crore approved fund. An additional Rs 312.20 crore was already committed for ongoing works (to be completed by December 2025), and Rs 27.04 crore remains as savings.
- Work for dedicated paediatric units was completed for 81 units out of 86 and it was in progress for 5 units. Similarly for 50 & 100 bedded field hospitals, work for most was completed and was in progress for remaining.

Sikkim

- At the District Hospital (DH) Mangan, piped gas supply was available, and all functional beds were equipped with piped oxygen support, ensuring uninterrupted oxygen delivery within the facility. However, hybrid ICU beds and dedicated ICU facilities were not available in the district. In District Soreng, no District Hospital has been established, and therefore ICU and HDU services were also unavailable.
- With respect to telemedicine integration under the Paediatric Centre of Excellence model, teleconsultation services were currently being provided from the PHC to sub-centres, whereas the recommended hub-and-spoke model requires the District Hospital to function as the central hub with lower facilities as spokes. This misalignment limits the intended specialist-led teleconsultation flow from higher to lower facilities.
- HMIS was being implemented at the District Hospital Mangan, enabling the facility to capture and report routine service delivery data. However, due to the absence of ICU facilities, real-time reporting of ventilator-supported admissions, ICU discharges, or ICU mortality was not applicable.

Telangana

- The facilities had an established and operational paediatric unit that is providing essential child health services, including inpatient care, basic emergency management, and routine monitoring. The unit was staffed and equipped to handle common paediatric conditions, ensuring continuity of care and timely clinical interventions for newborns, infants, and children.

- Although oxygen-supported beds were available within the facility, but were insufficient to meet potential surge demands, particularly during seasonal peaks of respiratory illnesses or emergencies.
- The limited availability of oxygen-enabled infrastructure restricts the facility's ability to manage moderate to severe cases requiring continuous oxygen therapy, indicating a need for further expansion of oxygen points, concentrators, and related maintenance systems.
- Challenges remain in terms of sustaining trained human resources, ensuring full operationalisation of climate-resilient infrastructure across all districts, integrating climate surveillance with local early warning systems, and securing dedicated budgets for long-term climate-health actions. Strengthening last-mile implementation, community awareness, and multi-sectoral convergence will be essential for achieving comprehensive climate and environmental health resilience under ECRP-II.

Uttarakhand

- Approval accorded for 18 dedicated Paediatric Care Units off which construction was completed for most of the units, however handover was yet to be done. Procurement and supply of equipment was in process. Budget for operationalization of 15 Paediatric Care Unit provisioned and approved in NHM in mid-term review and planned to be proposed under NHM in FY 2026-27. Out of 15 such units, 8 were 32 bedded and 7 were 42 bedded.
- For Paediatric Centre of Excellence (CoEs), AIIMS Rishikesh has been identified as hub with 13 districts as spokes but tender process was yet to be completed.
- -Total 471 Additional ICU Beds were approved under ECRP-II and have been made functional with 100% achievement.
- For implementation of Hospital Management Information System (HMIS), attempts have been made to coordinate with CDAC Mohali & was to be named as e-Shushrut. However, it was still in process and yet to be implemented due to frequent change in leadership.
- Fund request under ECRP-II (Chamoli District) for a 50-bed CCB (sent 17.06.2025) remains unprocessed despite scheme validity till December 2025



NHM FINANCING

17th

NHM FINANCING

NATIONAL OVERVIEW

Healthcare financing is a critical determinant for an effective and responsive health system. Since the inception of the NHM, including its earlier iteration as the National Rural Health Mission (NRHM), the Ministry of Health and Family Welfare (MoHFW) has released ₹3.92 lakh crore up to FY 2024–25¹. In recent years, central releases under NHM have increased, amounting to, ₹32,997 crore in FY 2023–24² and ₹36,120 crore in FY 2024–25³. Ensuring efficient, timely and judicious utilisation of these funds is essential for strengthening service and improving health outcomes. To strengthen the efficiency of fund flow across districts, blocks, and healthcare facilities, states are encouraged to adopt the Single Nodal Account (SNA) framework, which enables improved monitoring, accountability, and transparency in fund utilization.

Funding under the National Health Mission (NHM) is guided by Programme Implementation Plans (PIPs) prepared by the states, which enable decentralised planning based on local health needs and priorities. The financing pattern under NHM follows a shared arrangement, with a 60:40 Centre-State contribution for most States, a 90:10 for hilly and North-eastern States, and 100% Central funding for Union Territories without legislatures.

NHM Financing supports a wide range of interventions, including Health System Strengthening in rural and urban areas, Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCH+A), and programs for Communicable and Non-Communicable Diseases.⁴ These investments are central to improving access, quality and equity in public health services.

As per the National Health Accounts (NHA) Estimates for 2021–22, Government Health Expenditure (GHE) among the CRM-visited States ranged from 6.6% to 14.1% of total General Government Expenditure (GGE). Meghalaya reports the highest share (14.1%) relatively lower shares are observed in Punjab (6.5%) and Telangana (6.9%). A similar pattern is observed when assessed as a share of Gross State Domestic Product (GSDP) indicating interstate variation in prioritization of health expenditure.

While overall public expenditure on health has increased over time, inter-state variations in allocation and utilization patterns persist. This highlights the need for strengthening financial planning, monitoring, and utilization mechanisms to ensure optimal use of available resources.

¹https://nhsrcindia.org/sites/default/files/202601/NHM%20Central%20allocation%20Release%20and%20Expenditure%20till%20FY%202025-26_PM-ABHIM%20tab.pdf

²https://nhsrcindia.org/sites/default/files/202601/NHM%20Central%20allocation%20Release%20and%20Expenditure%20till%20FY%202025-26_PM-ABHIM%20tab.pdf

³https://nhsrcindia.org/sites/default/files/202601/NHM%20Central%20allocation%20Release%20and%20Expenditure%20till%20FY%202025-26_PM-ABHIM%20tab.pdf

⁴<https://www.pib.gov.in/PressReleasePage.aspx?PRID=2154166&reg=3&lang=2>

Table 1: Government Health Expenditure across the States as per NHA 2021-22

State	Government Health Expenditure (GHE)		
	% of GSDP	% of GGE	Per Capita Rs.
Andhra Pradesh	1.5	9.4	3,129
Assam	2.3	9.4	2,753
Bihar	2.5	9	1,320
Chhattisgarh	2.2	10.3	2,940
Kerala	1.7	9.7	4,338
Madhya Pradesh	1.6	8	2,083
Maharashtra	1.2	9.1	2,872
Meghalaya	5.9	14.1	7,690
Nagaland	3.4	8	5,490
Odisha	2.1	10.7	3,067
Punjab	1.1	6.6	2,300
Rajasthan	1.8	9.4	2,755
Sikkim	2.1	9.8	7,800
Tamil Nadu	1.3	9	3,410
Telangana	1	6.9	3,007
Uttar Pradesh	1.8	8.5	1,497
Uttarakhand	1.6	9.3	3,946
India	1.84	6.12	3,169

Source: *National Health System Resource Centre (2024). National Health Accounts Estimates for India (2021-22), New Delhi, Ministry of Health and Family Welfare, Government of India.*

Out-of-pocket expenditure (OOPE) in India, has shown a gradual decline, supported by key NHM interventions, such as Comprehensive Primary Health Care under Ayushman Bharat, provision of free essential medicines, free diagnostics, improved access through ambulance and patient transport services, and disease control programmes. These measures have contributed to improved financial protection and access to healthcare.

The majority of CRM-visited States report out-of-pocket expenditure (OOPE) below the national average of 39.4% of Total Health Expenditure (THE) as per National Health Accounts (NHA) Estimates for 2021–22. However, higher OOPE levels are observed in Uttar Pradesh (63.7%) and Kerala (59.1%).

Field observations indicate that out-of-pocket expenditure persists in several states due to factors such as non-availability of essential drugs and diagnostics at public health facilities, continued user charges for selected services, and delays in beneficiary payments. Addressing these gaps remains important for further reducing financial burden on households.

Table 2: Out-of-Pocket Expenditure across selected states as per NHA 2021-22

State	Out-of-Pocket Expenditure (OOPE)	
	Per Capita (Rs.)	% of THE
Andhra Pradesh	3,834	52
Assam	1,180	27.6
Bihar	984	41.3
Chhattisgarh	1,419	29.2
Kerala	7,889	59.1
Madhya Pradesh	1,739	43.3
Maharashtra	3,184	38.1
Odisha	2,133	37.1
Punjab	3,668	57.2
Rajasthan	2,048	37.1
Tamil Nadu	2,280	34.6
Telangana	2,449	37.6
Uttar Pradesh	3,014	63.7
Uttarakhand	1,560	26.9
India	2,600	39.4

Source: National Health System Resource Centre (2024). National Health Accounts Estimates for India (2021-22), New Delhi, Ministry of Health and Family Welfare, Government of India.

KEY OBSERVATIONS

1. Single Nodal Account (SNA) Implementation

SNA-SPARSH has been implemented across most states at the state and district levels, with several states (e.g., Odisha, Meghalaya, Chhattisgarh) extending implementation to Block/CHC level. In several states, the system has been recently operationalised or was in early stages of rollout. However, in some states (Punjab, Sikkim, Telangana, Uttarakhand), operationalisation at district and block-level remains in progress. PFMS integration was largely functional, however challenges persist in the form of workflow delays, rejection of bills, multi layered approval processes, continuation of parallel system (e.g., physical bank accounts below CHC level), and incomplete integration with state IFMIS platforms.

2. Utilisation of Matching State Share of Kind and Infrastructure Maintenance (IM) Grants

Several states have initiated the process of opening separate State Linked Schemes (SLS) with 0:100 sharing patterns; however, operationalization and utilization remain pending in many states (Punjab, Rajasthan, Chhattisgarh, Uttarakhand, Madhya Pradesh, Bihar). A few states (Meghalaya, Kerala) have operationalized the SLS accounts and implemented the SOP.

Delays were primarily procedural, including creation of budget heads, treasury approvals, and alignment with state financial systems, which constrains utilization of matching state share.

3. Process of Fund Refund of Unspent Central Share

Most states have refunded unspent central shares to the Consolidated Fund of India as per DoE guidelines. States such as Punjab, Meghalaya, and Andhra Pradesh have reported with compliance with refund provisions. However, in certain states, including Bihar and Chhattisgarh, the refund process was pending or under reconciliation due to transition-related and accounting adjustments under SNA-SPARSH.

4. Refund of Interest Earned in SNA

Compliance with refund of interest in SNA accounts has improved across states. Several states, including Kerala, Rajasthan and Andhra Pradesh, have deposited accrued interest to respective Consolidated Funds. However, in some state's documentation gaps and delays in submission of supporting certificates were observed.

5. Prerequisite & Process Flow of 1st Mother Sanction

Most states have fulfilled key conditionalities, including submissions of (UCs, FMRs, Fund Position Statements, refund of interest) enabling receipt of the first Mother Sanction under NHM. States such as Kerala, Rajasthan, and Andhra Pradesh demonstrate timely compliance with these requirements. However, in some states including Bihar, delays were observed due to pending state share provision, audit related issues, or technical onboarding gaps.

6. Steps for Initiating the Daily Payment File

States were at different stages of operationalizing daily payment file processes under SNA-SPARSH. State such as Rajasthan, Andhra Pradesh have initiated actions towards decentralised workflows. However, in several states, including Bihar, Chhattisgarh, and Sikkim, processes such as user IDs activation, maker-checker systems, and system-based payment initiation remain under progress.

7. Direct Benefit Transfers (DBT) Payments

DBT payments under JSY, ASHA incentives, FP, and NTEP were operational across most states; however, delays and pendency have been observed following transition to SNA-SPARSH.

Integration gaps between scheme portals and State financial systems (e.g. NI-KSHAY, and IFMIS) have led to pendency at validation and checker levels in states such as Bihar, and Andhra Pradesh. In Tamil Nadu, payments continue through PFMS due to integration constraints, resulting in delays. Data validation issues (incomplete bank details, limited Aadhaar linkage in Odisha) and fragmented payment structure for ASHA incentives (e.g., Maharashtra) further contribute to delays and administrative burden.

8. Human Resources in Finance

Vacancies in key finance positions (DAM, BAM, Finance Consultants) persist across several states, particularly at district and block levels, as observed in Chhattisgarh, and Madhya Pradesh.

Capacity building on financial systems (SNA-SPARSH, PMS, PM-ABHIM) remains limited in states such as Kerala and Chhattisgarh, affecting system adoption and compliance.

9. Central Release under Infrastructure Maintenance (4064)

Most states have submitted Utilisation Certificates (UCs) and Audited Statement of Expenditure (ASEs) up to FY 2023–24. However, delays in audit report submission have led to withholding of IM grants in some states such as Telangana and Bihar. States such as Rajasthan and Nagaland demonstrate timely compliance and receipt of IM funds.

10. Auditing and Internal Control Mechanism

While statutory audits were completed in some states, delays persist in others, including Punjab, Meghalaya, Chhattisgarh. Concurrent audits remain weak or non-functional in states such as Bihar, and Chhattisgarh. Issues related to TDS compliance, reconciliation gaps, and non-presentation of audit reports before Governing Bodies were observed in some states like Maharashtra.

11. Implementation of Progress Monitoring Mechanism

PMS portal usage varies across states. In states such as Maharashtra and Kerala, expenditure updates were not regularly reflected, limiting real-time monitoring. Geo-tagged documentation under PM-ABHIM remains pending in some states, including Kerala, and sub-district reporting remains inconsistent across multiple states.

12. Cost of Care

States with robust provision of free drugs and diagnostic services, such as Tamil Nadu, and Kerala, reported low OOPE. However, in several states, such as delays in beneficiary payments and system-led constraints continue to contribute to financial burden. For instance, delays in DBT related payments have been observed in states such as Odisha, while procurement and system-related challenges affecting service delivery were noted in Chhattisgarh.

13. NHM Fund Utilisation

Fund utilisation varied significantly. Some states such as Nagaland and Tamil Nadu demonstrate strong utilization. In contrast, states such as Assam and Meghalaya show low utilisation due to delays in sanctions, procurement processes, treasury bottlenecks, and capacity constraints at district and facility levels.

KEY CHALLENGES

- Technical issues such as workflow delays, bill rejections, multi-layered approval processes, incomplete decentralization below the CHC level, and partial integration

with state IFMIS, and absence of maker-checker IDs continues to delay smooth functioning of SNA-SPARSH.

- Delays in operationalization of SLS accounts, including creation of budget heads and treasury approvals, constrain timely utilization of matching state share and may lead to underutilization of available funds.
- Delays in reconciliation between State Health Societies and implementing agencies, along with inconsistent record-keeping and delays in submission of supporting documentation, affect timely verification of financial transactions and delay completion of fund flow processes, including refunds and utilisation following issuance of Mother Sanctions. Inconsistent record-keeping and delays in submission of supporting documentation affect timely verification and compliance with prescribed financial requirements.
- Dependence on timely provision of state share, audit completion, and treasury processes delays activation and utilization of funds following issuance of mother sanctions.
- Delays in operationalisation of daily payment workflows, centralised routing of bills, incomplete activation of user roles, and treasury processing timelines lead to payment backlogs and affect timeliness of fund disbursement.
- Integration gaps between scheme portals and State financial systems, along with issues in beneficiary data validation and transitional challenges during SNA rollout, result in delays in DBT payments and affect timely transfer of benefits to beneficiaries.
- Vacancies in key finance positions and limited capacity building on financial systems affect compliance, reporting quality, and effective utilisation of funds.
- Delays in completion of statutory audits and submission of required documentation, impact timely release of Infrastructure Maintenance grants and affect programme implementation.
- Delays in statutory and concurrent audits, along with gaps in reconciliation and compliance tracking, affect financial accountability and overall financial oversight.
- Delayed updates in PMS and inconsistencies in reporting across levels limit real-time financial visibility and affect monitoring of programme progress.
- Delays in beneficiary payments, continuation of user charges for certain services, and system-level constraints contribute to higher out-of-pocket expenditure.
- Delays in procurement and civil works, pending advances, salary disbursement delays, and gaps between planning and execution affect pace of expenditure under NHM and PM-ABHIM and overall programme performance.

RECOMMENDATIONS

- States to expedite full operationalisation of SNA-SPARSH across all levels and eliminate parallel bank accounts to ensure a unified and efficient fund flow system;

strengthen automated reconciliation and error-tracking systems.

- States to operationalise SLS accounts with a 0:100 sharing pattern on priority and ensure the timely release of the matching state share to enable optimal utilization of funds.
- States to strengthen periodic reconciliation mechanisms and ensure timely refund of unspent central share through prescribed portals.
- States to ensure timely refund of interest accrued in SNA account to the respective consolidated funds.
- States to strengthen district-level documentation capacity to facilitate timely processing of Mother Sanctions.
- States to prioritize and decentralise bill processing workflows; enable bulk upload functionality; ensure real-time rejection codes and status tracking in IFMIS to streamline payment processes.
- States to strengthen integration of IFMIS with scheme specific portals, consolidate ASHA incentive payments, and prioritise clearance of pending JSY and beneficiary liabilities to improve DBT efficiency.
- States to fill all vacant finance positions on priority and institutionalise structured capacity building SNA-SPARSH, audit compliance, and financial reporting.
- States to ensure timely submission of pending ASEs and UCs; ensure compliance-linked release and strengthen component-wise expenditure tracking.
- States to prioritize and complete statutory and concurrent audits within timelines; constitute Audit Committees; ensure audit reports are placed before Governing Bodies; strengthen TDS compliance and reconciliation processes.
- States to mandate monthly updating of expenditure in PMS; strengthen linkage of utilisation with programme priorities and ensure geo-tagged reporting under PM-ABHIM.
- States to ensure uninterrupted availability of free drugs, diagnostics, and ambulance services and rationalise user charges to minimise out of pocket expenditure.
- States to accelerate settlement of advances and civil works; streamline salary disbursement processes conduct regular district-level utilisation reviews to improve absorption capacity and strengthen alignment between planning and expenditure through regular utilization reviews.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- SNA SPARSH was being implemented under NHM from 28.10.2025 at the State and District levels with rollout at block level under process. The state has received the

first Mother Sanction of ₹229.33 crores (29.08.2025) and provision of matching State share under IM and Kind Grants is under process. Under PM-ABHIM, first mother sanction of Rs. 41.20 Cr was received on 09.05.2025.

- Utilisation of Matching State Share under NHM was under process, with opening of a separate SLS (0:100 sharing pattern), creation of Head of Accounts, and obtaining Master Sanction for utilisation of matching State share of Kind and IM Grants were in process.
- The state has deposited interest earned under SNA into consolidated funds; however, no unspent balance was refunded under NHM. Under PM-ABHIM, unspent balance of ₹35.78 crore has been refunded to the Consolidated Fund of India.
- Payment processes under SNA-SPARSH were being operationalised, with necessary actions underway at State, district, and block levels through Nodal Officers and Implementing Agencies for initiating daily payment files. DBT systems were functional; however, integration of Nikshay Poshan Yojana (NPY) with IFMS–SNA SPARSH was under process.
- Under DBT-NPY, 64,308 beneficiaries have been identified, of whom 61,861 (96%) bank details have been collected and 57,716 (90%) accounts validated. Beneficiary data was pending at the checker level due to ongoing Nikshay integration, and the State has adopted centralised payment processing at State level. Further, API 2.0 and master data have been shared for Nikshay–IFMS integration, with testing in final stages and completion expected shortly.
- Human Resources were in place through Andhra Pradesh Medical Services Recruitment Board (APMSRB) for recruitment under the HM&FW Department. Central release under Infrastructure Maintenance being pursued, with audit and UC submission process underway.
- Audit and financial management systems were in place, with statutory and concurrent auditors appointed for FY 2024–25; however, audit reports were pending submission.
- NHM incentives for ASHAs & CHOs (MLHPs) were fully utilised via centralised, performance-based payments aligned with facility needs and targets.
- The state follows a bottom-up approach for planning and budgeting, with expenditure booking through SNA and centralised, performance-based incentive payments. Measures to minimise OOPes include provision of free diagnostics, drugs and other services through PPP mode, namely, X-Ray, CT scan, MRI, Equipment Maintenance, Dialysis Sessions, RFID Tags, etc.

Assam

- State-level NHM Fund Utilisation was moderate; as of 30.10.2025, Assam utilized 51% of available funds. This corresponds to 34% utilisation against the resource

envelope and 24% against RoP approvals for FY 2025-26. A substantial proportion remains available for infrastructure, human resources, drugs, diagnostics, and programme management.

- The utilisation pattern suggests that facility and block levels were using funds more actively than the district society, however overall district utilisation remains low in both CRM districts.
- Discussions with district officials and facility teams indicated that low utilisation was due to factors such as delayed receipt of sanctions, lengthy tendering and civil works processes, limited technical capacity for proposal preparation, and cautious spending driven by audit considerations.

Bihar

- SNA SPARSH has been implemented under NHM at State and District levels from 20.11.2025, with block-level rollout in progress. The state has received the first Mother Sanction of ₹224.84 crore (10.11.2025), and the master sanction of ₹374.73 crore (19.11.2025), along with state share; utilization of matching state share SNA-SPARSH has been implemented under NHM at State and district levels from 20.11.2025, with rollout at block level under process.
- Utilization of Matching State Share under NHM was under process, with opening of a separate 0:100 SLS, creation of head of accounts, and operationalisation for utilisation of State share being taken up at State level.
- The State had deposited interest earned under SNA into Consolidated Funds; however, unspent Central share under NHM had not been refunded. Other key conditionalities, including submission of UC, FMR, and Fund Position Statements, have been complied with.
- Payment processes under SNA-SPARSH have been initiated at State level; district-level limit allocation and virtual allotment were under process. DBT systems were functional; however, integration of Nikshay Poshan Yojana (NPY) with IFMS/CFMS was under process.
- Audit and financial management systems were largely functional, with statutory audit report submitted and concurrent auditors selected, with appointment (LOI issuance) under process; central release under Infrastructure Maintenance was linked to completion of audit and submission of UCs, which was being pursued at State level.
- Planning and budgeting follow a bottom-up approach, with expenditure booking through SNA and financial progress aligned with physical progress (52% utilisation under PM-ABHIM as of October 2025).
- Public facilities have taken numerous measures to minimize OOPE faced by households. Some of the important interventions include free drugs and diagnostic services, Dialysis services, etc.

- Incentives under NHM were fully utilized by the ASHAs & CHOs through centralized payment system. All incentives were performance-based, and financial planning was aligned with facility needs and targets.

Chhattisgarh

- SNA-SPARSH implementation was in progress under NHM and operational under PM-ABHIM, with PFMS mapping and RBI e-Kuber linkage completed. However, implementation under NHM was not yet extended to block level as per DoE guidelines. Daily payment file initiation was under process, and DBT through SNA-SPARSH had not yet commenced.
- Utilization of State Share for Kind and Infrastructure Maintenance (IM) Grants was constrained as the 0:100 SLS RBI account was yet to be opened. No unspent Central balance was available at SHS level. The State has received the first Mother Sanction, and processing of subsequent sanctions was in progress.
- Fund utilization under NHM stand at 72% against available funds, while PM-ABHIM utilization was 47%. Utilization under 15th Finance Commission (0.03%) and ECRP-II (0.72%) remained low. At district level, utilization against available funds was high (e.g., 95% in Kanker and >100% in Mahasamund), though lower against approved PIPs.
- Financial management systems were largely functional, with PFMS operational up to block level, timely fund transfer from treasury to SNA, and DBT payments being made under JSY, JSSK, FP, and NTEP. However, integration of all payment systems with IFMIS was pending, and NPCI linkage was required for seamless beneficiary payments.
- Audit and internal control mechanisms were partially functional, with timely filing of Income Tax and GST TDS returns, joint signatory operation of bank accounts, and closure of inoperative accounts. However, statutory audit report for FY 2024–25 was pending, concurrent audit not implemented, and reconciliation, ASE submission (IM), and internal control systems required strengthening.
- Human resource gaps persisted in finance cadres at State, district, and block levels, with several positions vacant and no recent training conducted on new financial systems (SNA-SPARSH, PMS, PM-ABHIM, 15th FC). Delays in DBT payments (particularly JSY), large pending advances (₹63.80 crore and ₹193.78 crore), and procurement-related challenges (including unutilized equipment and reliance on quotation-based systems) were observed.
- The State demonstrates several good practices, including free service provision with no out-of-pocket expenditure for JSY beneficiaries, timely FMR/SFP reporting, proper maintenance of accounts books, functioning RKS systems, and bottom-up planning and budgeting.

Kerala

- SNA-SPARSH has been implemented under PM-ABHIM (October 2024) and NHM (October 2025) up to district level. The payment workflow was integrated with the Treasury through the Bill Information and Management System (BIMS), wherein bills were approved by the District Programme Manager (DDO), processed by the District Treasury, and forwarded to the State Finance Department for submission through PFMS. SOP for disbursement of matching State share has been implemented, with ₹150.47 crore allotted under Infrastructure Maintenance (IM) SLS and being utilized.
- The State has complied with key financial conditionalities, including refund of unspent Central share (PM-ABHIM: ₹9.70 crore approx.) and accrued interest (PM-ABHIM and NHM) to the Consolidated Fund of India. Required financial documents (UC, FMR, Fund Position) have been submitted, enabling receipt of the first Mother Sanction of ₹28.74 crore under NHM; refund of unspent balance under NHM was under process.
- DBT payments were being implemented for JSY, NPY, Family Planning, ASHA incentives, and salaries through account-based mode under SNA-SPARSH. Aadhaar-based DBT was in place prior to SNA transition; however, Aadhaar-based payments were yet to be operationalized under SPARSH. Integration of NIKSHAY was under process, ASHA portal was under development, and no dedicated portal was being used for JSY data capture.
- Human resources for finance were in position at State and district levels; however, no dedicated accounts personnel were available at block level (except in UPHCs, where accountant cum DEO was available), and no financial management training had been conducted in the past two years.
- Audit and financial management systems were largely functional, with statutory audit processes in place, audit reports laid before Governing Body, and facility-level verification of records and SOEs. However, concurrent audit reports were at various stages, executive summaries were pending submission, and TDS deduction was not consistently implemented at facility level.
- Financial monitoring systems require strengthening, as RoP figures were not reflected in the PMS portal under NHM and progress updates were available only up to March 2025. Under PM-ABHIM, geo-tagged evidence of completed works has not been uploaded despite completion of infrastructure activities. Instances of expenditure exceeding approvals and fund prioritization due to resource constraints were also observed.
- The State demonstrates strong financial discipline, including timely submission of FMRs/UCs across facility levels, closure of inoperative bank accounts, joint signatory controls, performance-based utilization of incentives, and alignment of financial planning with facility needs.

Madhya Pradesh

- SNA SPARSH has been implemented up to the district level under NHM and PM-ABHIM. The payment processing system follows a multi-level workflow Maker (DAM), Checker (DM&HO), Creator (Health Department Accountant), and DDO (DM&HO), resulting in a processing time of approximately 5-7 days before reaching the Treasury.
- Utilization of matching State share for Commodity and Infrastructure Maintenance (IM) grants was constrained, as the earlier SNA account had become inoperative and a separate State Linked Scheme (SLS) for 0:100 (State share) was yet to be operationalized.
- ASHA incentive payments were processed through multiple activity-based bills (up to 32 components), leading to a high volume of transactions. System limitations (maximum 900 beneficiaries per file) result in multiple payment files and fragmented credit entries, complicating reconciliation, especially in cases of transaction failures at RBI e-Kuber level.
- JSY payments were pending at district level following transition to SNA SPARSH, as earlier data integration from the ANMOL portal was no longer being utilized, leading to challenges in processing beneficiary payments.
- Financial record management practices require strengthening, as cash books were being maintained on an expenditure basis rather than reflecting actual balances, and updates were observed only up to September 2025.
- Governance processes at facility level show deviations, with Rogi Kalyan Samiti (RKS) expenditures being approved individually rather than through Executive Committee meetings as per norms.

Maharashtra

- Instances of non-compliance with statutory provisions were observed, including incorrect or non-deduction of Tax Deducted at Source (TDS) under relevant sections of the Income Tax Act, 1961, and delays in deposit of TDS and Employees' Provident Fund (EPF), resulting in avoidable interest and penalty payments (₹73 lakh reported in Satara district).
- Delays in salary disbursement of up to two months were reported across facilities, despite substantial monthly expenditure on human resources (approximately ₹180 crore), indicating gaps in financial planning and fund flow management.
- Financial monitoring systems require strengthening, as expenditure progress and SPIP entries under NHM were not regularly updated in the PMS portal, with data in some districts (e.g., Satara) updated only up to March 2025.
- Planning and expenditure patterns show imbalances, with misalignment between approved budgets and actual spending, resulting in over-expenditure in certain

heads and pending payments in others (including TBI, PBI, JAS/RKS, and untied funds).

- Financial record management gaps were observed, including discrepancies in cash book reconciliation and administrative constraints such as lack of financial authorization at facility level (e.g., ANM not granted signing authority, leading to non-utilization of untied funds).
- Payment processes for ASHA incentives were fragmented, with disbursements made under multiple components (Central share, State share, performance-based incentives), adding administrative complexity and potential delays.
- Operational constraints such as inadequate cost norms for vehicle hiring and POL (Petrol, Oil, Lubricants) in tribal areas were reported, impacting programme implementation.

Meghalaya

- The State has successfully migrated NHM and PM-ABHIM to the SNA-SPARSH model, with operational jurisdiction extended up to the block level. A State Linked Scheme (SLS) with 0:100 sharing pattern has been configured, and DoE SOP for disbursement of matching State share was being implemented.
- The State has complied with key financial requirements, including refund of unspent Central share along with accrued interest to the Consolidated Fund of India. Provisional Utilization Certificates for Infrastructure Maintenance have been submitted for FY 2023-24 and 2024-25; however, the final UC for FY 2023-24 was pending.
- DBT payments were being implemented through account-based mode, with physical Aadhaar verification. However, integration of DBT and Aadhaar Payment Bridge (APB) systems was incomplete, and key portals such as NIKSHAY and JSY were yet to be integrated with IFMIS, while ASHA First portal was integrated.
- Delays in DBT payments were observed, including backlog under JSY in North Garo Hills and delays in disbursement of ASHA Central Incentives, with payments pending at block and other levels since July (and in some cases since March) due to transition to SNA-SPARSH.
- Audit and compliance systems show partial gaps, with Statutory Audit for FY 2024-25 pending beyond the due date and minor income tax penalty observed due to administrative delays. However, finance personnel were in positions across all levels.
- Financial availability under NHM indicates total funds of ₹285.43 crore with expenditure of ₹109.70 crore (as on October 2025). Untied funds were not available at facility level during FY 2025-26. Progress under PM-ABHIM and XV-FC infrastructure components remains limited against targets.

Nagaland

- Key financial management positions were in place at the State and district levels, ensuring continuity in financial operations and reporting.
- Fund utilization under NHM has shown a consistent increasing trend, rising from 81% in FY 2021-22 to 95% in FY 2024-25, and reaching 97% up to Q2 of FY 2025–26. District-level utilization was also high, with 99.32% in Zunheboto and 99.59% in Mon.
- Under PM-ABHIM, fund utilization has improved significantly, increasing from 11% in FY 2023–24 to 36% in FY 2024–25 and reaching 96% in FY 2025–26.
- DBT payments for ASHA incentives and beneficiaries under JSY, Family Planning, and NTEP were being implemented through Direct Benefit Transfer mechanisms.
- Under Infrastructure Maintenance (IM), the State has submitted audited Statement of Expenditure and Utilization Certificates up to FY 2024–25, and 100% allocation amounting to ₹42.23 crore has been released by the Ministry.
- SNA-SPARSH has been implemented under NHM and PM-ABHIM. The first Mother Sanction of ₹3.71 crore under PM-ABHIM was issued on 06.11.2025, and the first Mother Sanction under NHM amounting to ₹82.65 crore was under process.

Odisha

- SNA SPARSH has been implemented up to CHC level in accordance with DoE guidelines, supported by a robust financial management system, including decentralization of DDOs and use of IFMS for improved financial traceability.
- The State has received 100% allocation amounting to ₹1,085.58 crore as Mother Sanction for FY 2025-26, indicating timely fund release at State level.
- Fund utilization under NHM remained high, with 93% utilization in FY 2024-25; however, utilization for FY 2025-26 (up to September) stand at around 41%. Under PM-ABHIM, utilization was 87% in FY 2024-25 and 28% in FY 2025-26 (till September).
- Statutory Audit for FY 2024-25 was completed at State and district levels, with audited Utilization Certificate submitted to the Ministry; compilation of the audit report at State level was in progress. Finance personnel were trained and available up to CHC level.
- DBT-related payments, including JSY, ASHA incentives, and salaries, were pending for over two months in several facilities. Gaps existed in beneficiary validation due to absence of account validation/Aadhaar linkage in IFMS, and failed transactions were not adequately tracked with clear reason codes.
- SNA SPARSH implementation below CHC level remained incomplete, with facilities such as PHCs, Sub Centres, and VHSNCs continuing to operate physical bank accounts and receiving funds as advances through BPMUs.

Punjab

- SNA-SPARSH implementation has been initiated at the State level under NHM and PM-ABHIM (since July 2025); however, operationalization at district and block levels remains incomplete, with PFMS configuration and SLS-wise mapping with RBI accounts under progress. Instances of continued use of current accounts at district level were observed.
- The State has complied with key financial requirements, including refund of unspent central share and accrued interest as per DoE guidelines through the Bharatkosh portal; however, supporting documentation for interest refund for FY 2024–25 was pending at the time of review.
- Separate SLS accounts for Kind and IM Grants were under process but not yet operationalized, and implementation of DoE SOP remains partial.
- DBT payments were being implemented through digital platforms, with JSY and ASHA incentives processed through SNA-SPARSH and TB incentives through the Nikshay-PFMS portal; integration with NPCI/APBS for Aadhar Based transactions was ongoing.
- Financial processes at facility level show partial digital adoption, with instances of manual payments through cheques. Procurement practices at district and peripheral levels include use of quotation-based systems instead of prescribed tender procedures as per GFR and NHM guidelines.
- Human resource gaps persisted across finance cadres at State, district, and block levels, affecting financial reporting and compliance. Audit systems were partially functional, with statutory audit completed; however, concurrent audit for FY 2025-26 and constitution of audit committees (DAC/SAC) were pending.
- Progress Monitoring System (PMS/IPMS) was functional for financial data entry under NHM; however, gaps remain in timely uploading of supporting evidence (including geo-tagged documentation) under PM-ABHIM.

Rajasthan

- SNA SPARSH has been implemented under PM-ABHIM up to district and block levels, with onboarding under NHM initiated following receipt of the first Mother Sanction of ₹804.92 crore on 27.10.2025. Provision of matching State share and operationalization of transactions under NHM were in process, and steps were being taken to initiate daily payment files.
- The State has complied with key financial conditionalities, including refund of unspent central share (Rs. 62 Cr) and interest to the Consolidated Funds, along with submission of UCs, FMRs, and fund position statements as required.
- Opening of a separate State Linked Scheme (SLS) for utilization of matching State share under Kind and Infrastructure Maintenance (IM) Grants was under process, with delays linked to administrative procedures.

- DBT systems were operational, with JSY and ASHA incentives being processed through OJAS software and NTEP payments through the Nikshay-PFMS portal.
- Under Infrastructure Maintenance, the State has submitted audited and provisional financial statements up to FY 2024-25 and has received ₹610.70 crore as Central share in FY 2025–26, supporting a workforce of over 13,300 staff.
- Human resources for financial management were largely in place; however, vacancies persist across key positions. Audit systems were functional, with statutory audit for FY 2024-25 under process and concurrent auditors appointed across most districts.
- At district level, while expenditure reporting was high (around 70%), a significant proportion was concentrated on salaries and HR incentives (about 51%), with relatively lower expenditure on programme activities.

Sikkim

- The State was in the process of rolling out SNA SPARSH; however, implementation has not yet commenced at the district level. District-level training has been completed (July 2025), preparing staff for operationalisation.
- Key finance positions such as District Accounts Manager and Finance & Logistics Consultant were in place; however, several other sanctioned financial management posts remain vacant, with no recruitment initiated.
- DBT payments had not been processed since July 2025 due to the ongoing transition to SNA SPARSH. Additionally, the State Treasury was currently processing only salary bills, with other categories of payments pending; however, salary payments have been made up to September 2025.
- Statutory Audit has been completed and submitted, while Concurrent Audit for FY 2025-26 was yet to be undertaken.
- Cash books were properly maintained and available at district level, and banking operations were conducted through joint signatories (CMO and DDO), ensuring adherence to financial protocols.
- Out-of-pocket expenditure (OOPE) on drugs and diagnostics remains high, primarily due to shortages of essential medicines and gaps in supply chain systems.

Tamil Nadu

- SNA SPARSH has been fully implemented up to CHC and PHC level under NHM and PM-ABHIM, with closure of erstwhile SNA accounts and transfer of unspent balances to the Consolidated Fund of India. However, separate State Linked Scheme (SLS) for matching State share was yet to be created.
- Fund utilization under NHM has shown a consistent increasing trend, reaching up to 94% in FY 2024-25 and above 80% in FY 2025-26 (till second quarter), indicating strong financial absorption capacity across districts.

- DBT payments under JSY, Family Planning, and NTEP were completed up to September 2025 through PFMS using RCH and Nikshay portals, with quarterly gap analysis undertaken for monitoring. However, daily payment files under SNA SPARSH had not been initiated for these schemes, and payments have been pending since October 2025 due to lack of Aadhaar/account upload functionality in IFHRMS. Currently, only ASHA incentives and vendor payments were being processed through SNA SPARSH. JSSK beneficiaries receive services in-kind rather than direct cash transfers.
- Human resources for finance were adequately positioned across State, district and block levels, with financial management systems such as Tally, PFMS, and GeM (for procurement) being actively utilized.
- Audit and internal control mechanisms were robust, with timely completion of statutory, concurrent, and PWS audits, functional audit committees, and no pending tax compliance. Financial governance practices were strengthened through joint signatory-operated bank accounts, use of Tally software up to block level for FMR generation, and regular maintenance and updating of books of accounts at facility level.
- The State has ensured comprehensive cost-free healthcare, with schemes such as PMJAY and CMCHIS enabling access across public facilities and empanelled private hospitals. High-end diagnostics and services including MRI, CT scan, dialysis, and drugs were provided free of cost, supported by enhanced budget allocation and waiver of user charges in public facilities, contributing to reduced out-of-pocket expenditure.
- Activity-wise financial progress under NHM was being captured through PFMS under the Progress Monitoring System (PMS Portal). Under PM-ABHIM and XV-FC, the State has demonstrated strong fund utilization and timely receipt of approved grants; however, system-level issues such as DBT delays, absence of real-time expenditure monitoring at facility level, and pending institutional processes (SLS creation, PWS renewal)

Telangana

- The State has onboarded SNA SPARSH under NHM and PM-ABHIM; however, daily payment and sanction files under NHM were yet to be initiated, while implementation under PM-ABHIM was ongoing with approximately 28% expenditure against the Mother Sanction.
- Infrastructure Maintenance (IM) allocation of ₹231.41 crore was available; however, release of funds was contingent upon submission of statutory audit report and Statement of Expenditure (SoE).
- Capacity building initiatives for finance personnel had not been conducted in the past two years.
- Institutional structures such as BPMU at district level and PMU at State level under PM-ABHIM were yet to be established, despite provision of dedicated funding.

- The State has not yet claimed eligible grants under the 15th Finance Commission for award periods 2024-25 and 2025-26, with pending submission of required documentation.

Uttar Pradesh

- SNA-SPARSH implementation has impacted DBT processes, with payments under schemes such as Ni-KSHAY Poshan Yojana currently on hold due to system-related issues. The state can start making DBT payments directly in IFMIS and subsequently reconciling in Ni-kshay.
- Programme implementation under NHM was affected by resource envelope constraints, with indications that certain approved activities, including ASHA incentives, were being impacted.
- Delays in financial flows were observed at facility level, including pending payments under Rogi Kalyan Samiti (RKS) since August 2025 due to delays in SNA SPARSH integration.
- Out-of-pocket expenditure (OOPE) persisted in areas such as diagnostics and medicines due to non availability at facilities, indicating gaps in service provisioning and financial protection.

Uttarakhand

- SNA SPARSH has been implemented up to the block level; however, delays in receipt of SNA limits and challenges in tracking, reversals, and reconciliation of transactions were observed.
- State Linked Scheme (SLS) and the State Government RBI account for disbursement of matching State share under Kind and Infrastructure Maintenance (IM) Grants were yet to be operationalized. Delay in these steps risks losing eligibility for the top-up state share before 31 March 2026.
- Unspent PM-ABHIM funds amounting to ₹43 lakh from erstwhile SNA accounts remained to be refunded, and reconciliation with State Treasury and MoHFW under NHM was pending.
- Treasury workflow involved direct routing of bills to State Cyber Treasury, with instances of delayed processing, rejection, and reversal of bills under SNA SPARSH.
- Integration gaps persisted, with IFMIS not integrated with PFMS and NPCI; DBT payments continue through account-based mode, and absence of bulk upload functionality has led to fragmented payment processes.
- Audit and compliance mechanisms require strengthening, with pending statutory audit reports, non-conduct of concurrent and AG audits, and shared administrative controls under SNA SPARSH.
- At district level, issues such as double debit of payments, pending Treasury approvals for upgraded facilities, non-availability of cash books, delayed processing of ECRP-II funds, and slow expenditure against planned budgets were observed.



TOR 2: PRIMARY HEALTH CARE

17th

TOR 2: OPERATIONALIZATION OF AAM, SERVICE DELIVERY OF 12 PACKAGES OF CPHC SERVICES

NATIONAL OVERVIEW

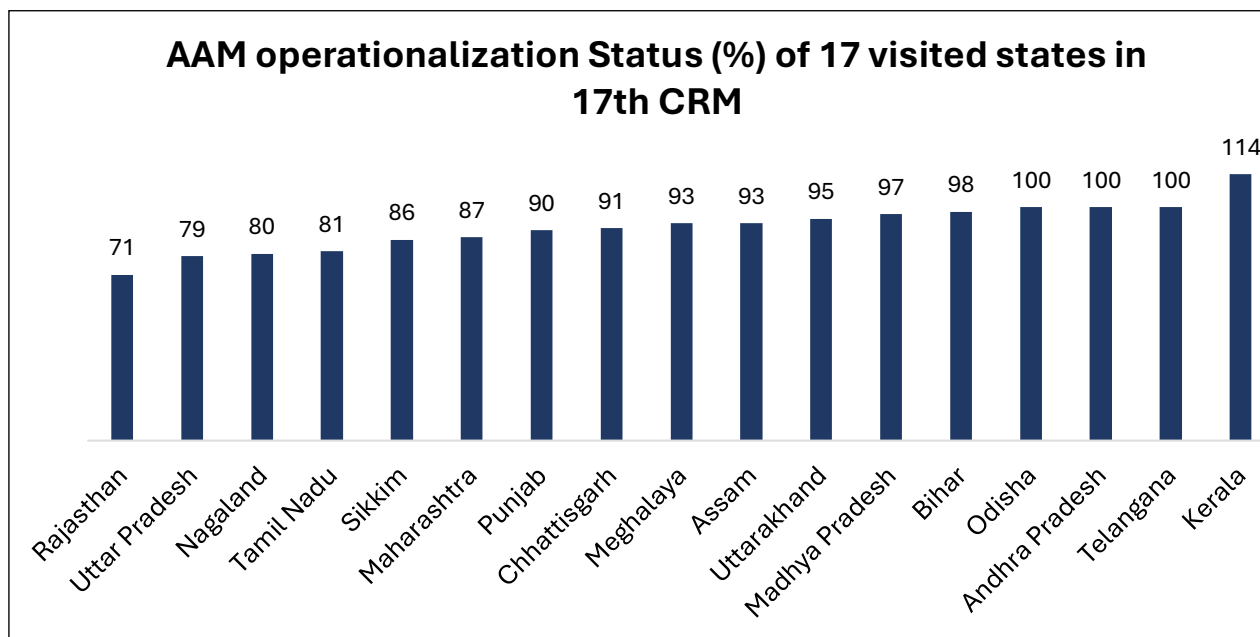
The Ayushman Arogya Mandir (AAM) has emerged as the cornerstone of comprehensive primary health care delivery within the public health system, providing care closer to the community. Through delivery of expanded service packages closer to communities, AAM is promoting access to quality healthcare services aligned with the broader goal of Universal Health Coverage.



The 17th Common Review Mission assessed the status of operationalisation of AAM across selected States and Union Territories, highlighting role of AAM as the fulcrum of comprehensive primary health care delivery within the public health system. The transition towards comprehensive primary healthcare was evident through gradual rollout of expanded service packages, integration of wellness and preventive services, and use of teleconsultation to extend specialist services. While AAM has significantly strengthened primary healthcare delivery, focused efforts are required to ensure uniform, equitable, and comprehensive implementation across all facilities.

The progress of AAM operationalization against their approval, and the facility-wise AAM operationalization status are depicted in the graph below.





AAM Operationalisation Status across CRM States

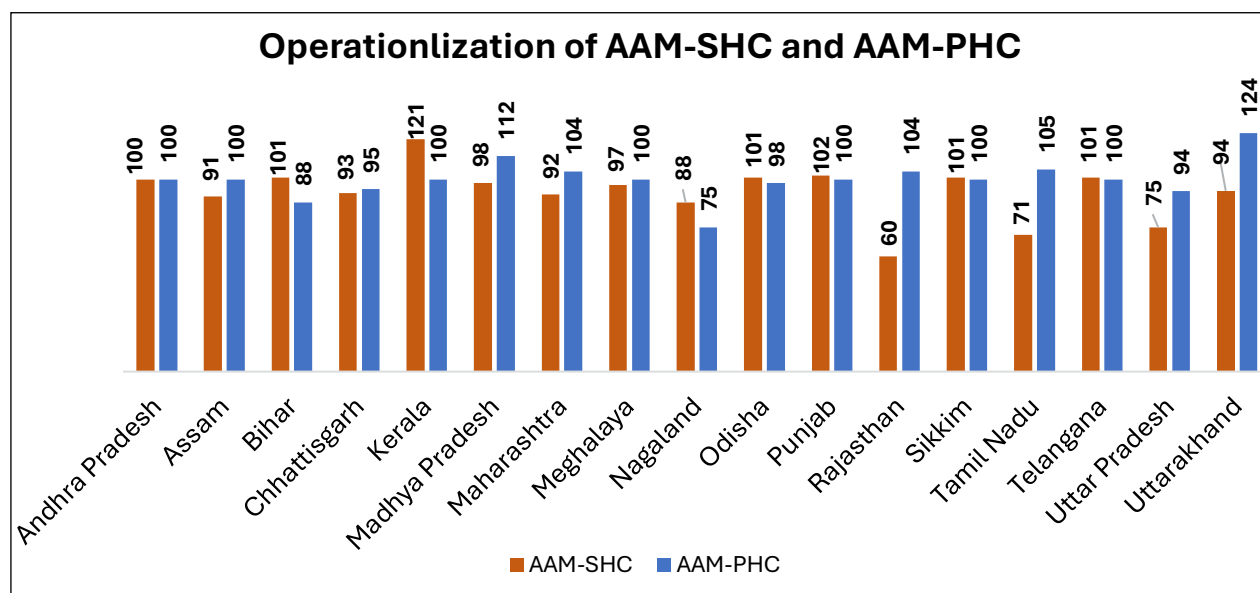
Among the 17 states that were visited, operationalisation was found to be high (above 90%) in the states of Kerala, Telangana, Andhra Pradesh, Odisha, Bihar, Madhya Pradesh, Uttarakhand, Assam, Meghalaya and Chhattisgarh. The operationalisation status in the states of Maharashtra, Punjab, Nagaland, Tamil Nadu and Sikkim was moderate (80-90%).

While AAM in rural areas had been progressively operationalized, operationalization of AAM Urban Sub Health Centre still remained a challenge, even in a few high-performing states.

Key factors influencing the status of AAM operationalisation included variations in state-level planning, financial allocation, and governance capacity. States with strong political commitment and financial prioritisation (e.g., Andhra Pradesh, Kerala, Telangana and Odisha) showed considerable progress by ensuring timely infrastructure upgrades, workforce recruitment, and strengthened supply chains.

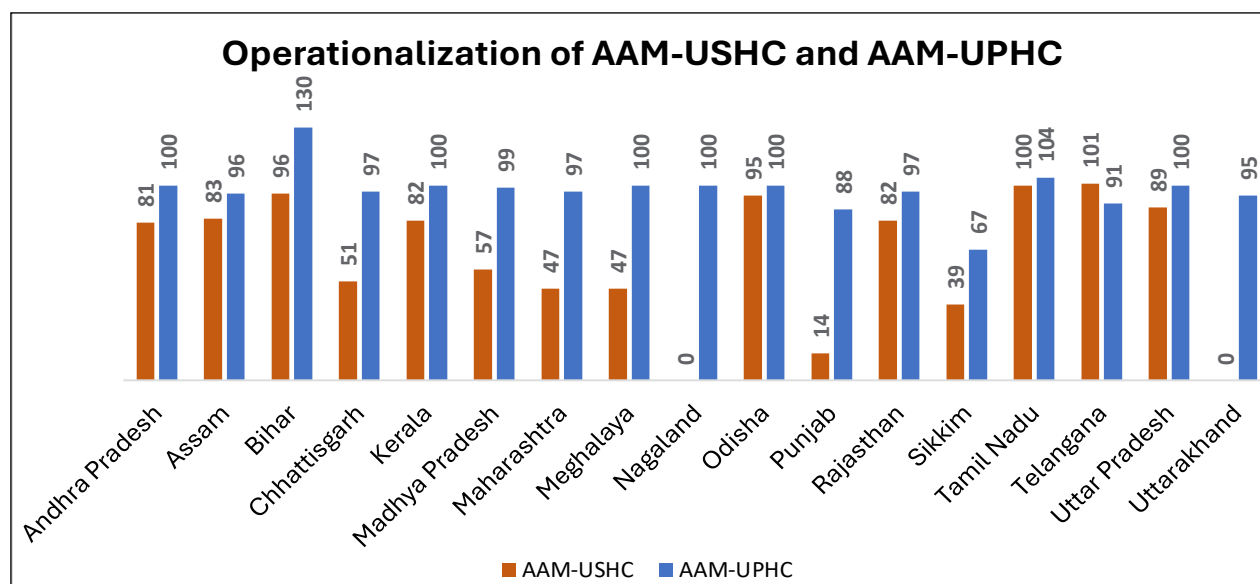
Facility-wise AAM Operationalization

- **AAM-SHC:** Most visited States had achieved more than 90% operationalization of approved AAM-SHC. However, less than 90% of the facilities had been operationalised in states including Rajasthan (60%), Tamil Nadu (71%), Uttar Pradesh (75%) and Nagaland (88%).
- **AAM-PHC:** Operationalization of AAM-PHCs was largely satisfactory with more than 90% operationalised across the visited states, except for in Nagaland (75%), and Bihar (88%).



Source: Ayushman Arogya Mandir Portal, September 2025

- **AAM-UPHC:** Other than Sikkim (67%) and Punjab (88%), all the visited states had operationalized more than 90% of approved AAM- UPHCs.
- **AAM-USHC:** Bihar, Odisha, Tamil Nadu and Telangana had operationalized more than 95% of approved AAM-USHC. Operationalization was comparatively low in Punjab (14%), Sikkim (39%), Maharashtra (47%), Meghalaya (47%), Chhattisgarh (51%) and Madhya Pradesh (57%). Further, Nagaland and Uttarakhand had not initiated AAM-USHC operationalisation till the time of the CRM visits.



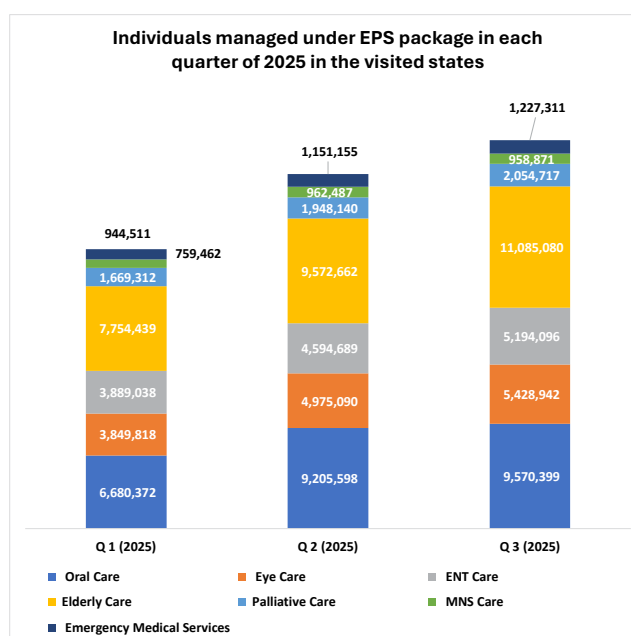
Source: Ayushman Arogya Mandir Portal, September 2025

- **AAM-AYUSH:** Most visited States had achieved over 95% operationalization of AAM-AYUSH with Meghalaya (115%) and Tamil Nadu (102%) exceeding approvals, while Bihar (73%) indicating shortfall. Sikkim had not yet initiated operationalization of AAM-Ayush.

Overall, the operationalisation of AAM had significantly strengthened primary healthcare delivery across states, increased access to essential services, NCD screening,

maternal and child health programs, and improved access to specialist care through teleconsultations at the grassroot level.

Progress in the rollout of the Expanded Package of Services (EPS) was observed to be variable across the visited states. However, services under different components of the expanded package were being delivered to beneficiaries, as illustrated in the graph below:



Source: Ayushman Arogya Mandir Portal, January 2025-September, 2025

As indicated in the graph, the total number of beneficiaries managed has been increasing gradually from Q1 to Q3 across all major service categories, reflecting strengthening of service delivery under EPS. Elderly Care accounted for the highest number of beneficiaries managed during the three quarters, rising from 77.54 lakh in Q1 to 110.85 lakh in Q3, suggesting a high demand for geriatric services. Oral Care showed substantial growth from 66.80 lakh in Q1 to 95.70 lakh in Q3, while Eye Care increased from 38.50 lakh to 54.29 lakh and ENT Care from 38.89 lakh to 51.94 lakh over the same period, indicating expansion in screening and management of common outpatient conditions under these packages.

KEY OBSERVATIONS

- **Infrastructure:** Most states had made significant progress in strengthening infrastructure at AAM, including improvements in branding, availability of power and water supply, and provision of patient waiting areas. AAM-PHCs had government owned buildings with dedicated space for various activities but disparities were observed between AAM-



SHC as some facilities were functioning with inadequate infrastructure. UPHC were mostly operating from rented buildings in most states with space constraints. Ongoing infrastructure augmentation and facility upgradation efforts were gradually addressing these gaps, though continued focus is required.

- **Branding:** Implementation of branding as per GOI guidelines was observed in most of the visited states, with renaming of the Health and Wellness Centre to 'Ayushman Arogya Mandir' with the prescribed tagline 'Arogyam Paramam Dhanam.' In Meghalaya, facilities were painted in blue and green shades that blended with the surroundings, reducing visibility from a distance. In Uttarakhand logo façade was not followed as per guidelines. Madhya Pradesh, Chhattisgarh, and Rajasthan had partial compliance, with missing taglines or illustrations in some facilities. In Nagaland, renaming and branding had not been initiated in any of the visited facilities.
- **Waiting areas:** Waiting areas were generally adequate in PHC/ UPHC and some SHC of most states, with Bihar Chhattisgarh and Kerala providing well demarcated spaces and seating arrangements. Nagaland, however, struggled with proper seating and ventilation.
- **Demarcated spaces (OPD, drug storage, laboratory):** Clear demarcation of OPD, drug storage, and laboratory spaces was inconsistent. In Punjab, SHC-AAK were observed to be functioning in one room with no dedicated space for screening, laboratory tests, or drug storage. Similar space constraints were noted in Parvathipuram Manyam district of Andhra Pradesh. In comparison, AAM-PHC generally had better-defined functional spaces than AAM-SHC.
- **Separate toilets:** Separate functional toilets were largely available at PHC level; however, differently abled friendly toilets remained a concern in most states. Bihar, Chhattisgarh, and Maharashtra reported functional male and female toilets, while Rajasthan had functional toilets at AAM-PHC but not consistently at AAM-SHC.
- **Water Supply:** Piped Water supply was available in most health facilities, and few states like Nagaland and Tamil Nadu had implemented rainwater harvesting systems too.
- **Power supply:** States like Chhattisgarh, Kerala, Nagaland, Tamil Nadu and Rajasthan were leveraging solar power in varying degrees. Conventional power supply in some states was inconsistent, especially in remote SHC-AAM. Facilities in Assam, Andhra Pradesh and Madhya Pradesh required strengthening power backup.
- **Roll out of Expanded Package of Services (EPS):** Uneven progress in the rollout of EPS was observed across States. Most States were delivering only 7–10 packages (e.g. seven packages in Andhra Pradesh, Rajasthan, Sikkim, and Uttarakhand, and ten in Uttar Pradesh), with a predominant focus on RMNCAH+N and NCD services. States such as Assam, Madhya Pradesh, Maharashtra, Odisha, Telangana, Rajasthan, and Sikkim reported partial rollout, with significant gaps in mental health, geriatric, palliative, ENT, oral health, and emergency services, largely attributed to limited training, workforce constraints, and inadequate equipment. MLHPs in Tamil Nadu demonstrated good understanding of all 12 CPHC packages, whereas CHOs in Punjab

demonstrated comparatively low confidence in delivering the expanded package of services. The online mode of training received by these CHOs may be a contributory factor to this output. Overall, focused strengthening is required to enable expansion beyond maternal, child health, and NCD services across most States.

- Polyclinic:** Polyclinics were operational in all three visited UPHCs in Kerala, with support from Local Self Government Departments, providing multiple specialist services including Obstetrics & Gynaecology, Orthopaedics, Paediatrics, Dental care, Optometry, Physiotherapy, and Dietetics, among others. Tamil Nadu reported 153 operational polyclinics across the State. In contrast, specialist services in Bihar were either unavailable or limited to paediatric services at Masumganj UPHC. Polyclinics were not operational in the visited districts of Sikkim, Rajasthan, Punjab, and Uttar Pradesh.
 
- Wellness Space:** Availability of dedicated space for wellness and yoga activities varied widely. Odisha had demarcated wellness spaces in some AAM-PHC. Madhya Pradesh conducted 10 wellness sessions monthly despite lacking dedicated wellness spaces and Maharashtra provided adequate areas and open gym equipment in Nandurbar. However rented facilities in most of the states had limited space for wellness activities.
 
- Primary Healthcare Team at AAM:** Primary Healthcare team across AAM consists of Medical Officers, Staff nurses, Community Health Officers, ANM/MPW and ASHAs divided as per level of care. In states such as Sikkim, Nagaland and Meghalaya, significant efforts were underway to roll out all CPHC service packages, though human resource availability as per IPHS 2022 norms remained inadequate. In Meghalaya, high staff attrition was reported in rural and remote areas, and delays persist in releasing incentives for ASHAs and ANMs.
 
- Training and Capacity Building :** Training and refresher sessions for CHOs, ANMs, and ASHAs were reported across all states, with an emphasis on expanded CPHC package, NCD screening, family planning, and digital platforms. Virtual and physical trainings were being rolled out simultaneously towards capacity building interventions for primary healthcare teams. While these trainings were effective in strengthening service delivery, some states reported that CHOs lacked confidence in implementing the expanded packages, while others highlighted the need for refresher training in cancer screening, family planning counselling, and digital reporting.
 

RECOMMENDATIONS

- States to standardize infrastructure across AAM facilities by ensuring reliable power and water supply, establishment of dedicated wellness spaces, differently abled friendly access (including ramps, handrails, wheelchairs, and toilets), adequate privacy at examination points, and compliant biomedical waste disposal pits. In addition, periodic infrastructure and safety audits should be institutionalised to ensure sustained quality and compliance.
- States should ensure uniform AAM branding and IEC display by completing facility renaming and standardising colour schemes, signage, taglines, and the prescribed logos/façade (in Uttarakhand) including the six mandated elements, across all operational facilities.
- States to strengthen AAM as the cornerstone of primary healthcare by ensuring comprehensive delivery of all 12 CPHC service packages, expanding access to basic diagnostics with functional referral linkages, and enabling AAM teams to systematically line-list and follow up high-risk groups, including high-risk pregnancies, high risk newborns/children, NCD patients, and the elderly. In addition, facility-wise service gap assessments should be routinely conducted, with clear targets set to address identified gaps.
- States should ensure regular mentoring and refresher training for CHOs, supported by district hospitals, medical colleges, or sub-district hospital (SDH) clusters. Additionally, training needs should be systematically planned, updated, and monitored through the SASHAKT portal.
- States should explore and implement offline or mobile-based data entry solutions for facilities located in low-connectivity areas and liaise with the Department of Telecommunications to identify innovative mechanisms and schemes to ensure reliable broadband and internet connectivity across all health facilities.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- Andhra Pradesh had operationalised around 10,000 AAM-SHCs, with 9531 CHOs delivering CPHC service packages.
- Out of the 2 districts visited, Chittoor had better infrastructure with most facilities operating from government buildings with standardised layout, signage and digital reporting systems. In contrast, in Parvathipuram Manyam, most AAM operated from rented premises, limiting infrastructure modification, affecting privacy provisions, storage, biomedical waste management and eligibility for national quality certification.
- Service delivery focussed on ANC registration, ANC/PNC risk tracking, immunization, and NCD screening for hypertension and diabetes. Most facilities were thus providing seven service packages rather than the twelve packages of services. Service delivery

gaps were observed in mental health, elderly care, palliative care, ENT services and family planning counselling.

- NCD service delivery and follow-up mechanisms were generally good at AAM-PHC, supported by digital registers. However, AAM-SHC in remote and hilly areas faced challenges in continuity of care due to workforce shortages, mobility constraints and difficult terrain. Mental health screening and tobacco cessation counselling were not consistently integrated into NCD services.
- Dispensing of chronic disease medications for extended durations was appreciated by beneficiaries; however, refill duration varied across facilities based on drug availability rather than clinical protocols
- Drug storage practices were generally satisfactory in Chittoor; however, facilities in Parvathipuram Manyam faced space constraints, inadequate shelving and limited temperature control affecting storage conditions. Issues related to expired drugs, improper vaccine storage and lack of pharmacists were observed.
- Several visited AAM in Chittoor lacked dedicated temporary storage areas limiting safe temporary containment despite segregation at source. Lack of designated enclosures or lidded colour-coded bins necessitated periodic transport of waste to linked PHC, often by ASHAs or support staff carrying segregated bags, increasing occupational risk, workload and highlighting the need for on-site containment facilities.
- Diagnostic services at AAM-SHC without laboratory technicians were limited to fixed-day sample collection, resulting in delays in clinical decision-making.

Assam

- Out of two districts visited, Charaideo district had a slower pace of operationalizing AAM as compared to the State (71% viz-a-viz 93%), with the district particularly lagging behind in AAM PHC operationalization (44%).
- The roll-out of the full 12 CPHC service packages was at different stages across facilities. Some AAM demonstrate strong implementation of NCD, maternal and child health and basic diagnostics; others were still at an early stage, particularly for adolescent health, mental health and elderly care. Tea gardens and remote tribal areas continue to depend on outreach camps or higher facilities for many services.
- AAM-PHC were generally government-owned with boundary walls, and were equipped with ramps, separate toilets, safe drinking water and herbal gardens, reflecting improved accessibility.
- AAM-SHC infrastructure showed wide variation, with several facilities operating from rented or temporary structures with limited space, storage and waiting areas, particularly in tea garden, tribal and border areas, affecting functionality and delivery of CPHC services.

- Branding was not uniform as gaps including missing taglines, incomplete colour coding and absence of prescribed illustrations, adversely impacting the desired visibility were observed.
- IPHS compliance ranged between 25–69%, with no facility reaching full compliance.
- Essential Medicine List (EML) and annual health calendar days were displayed and celebrated in the visited facility.
- Roll-out of CPHC service packages varied across AAM. Provision of NCD and RMNCAH+N related services, as well as the availability of basic diagnostics was relatively better, whereas mental health, elderly care and palliative services needed strengthening. Many facilities continued to function largely as traditional sub-centres with a partial transition to the CPHC model.
- Digital platforms were operational and staff was trained, but lack of power backup and unreliable connectivity constrained teleconsultation and real-time reporting.
- Herbal gardens and yoga/ AYUSH activities were observed in several AAM, providing opportunities for wellness and preventive care; however, integration with structured community health-promotion activities remained limited.
- Infection prevention and biomedical waste management practices were variable, particularly in some peripheral facilities, where colour-coded bins, proper segregation and safe storage were not consistently ensured.
- Within tea-garden communities, temporary and migrant workers faced disproportionate barriers, frequently remaining outside formal health coverage, while permanent workers benefitted from access to estate-based health services.
- Further, remote tribal and border areas were characterised by difficult terrain, poor connectivity and seasonal flooding which affected access, workforce availability and referral linkages. Limited health literacy and variable integration of PPP tea-estate hospitals with inconsistent government referral and reporting mechanisms influenced service utilisation and the continuity of care.
- A Best Practice noted for Transforming the quality of Health facilities was the 'Swasthya Sewa Utsav' launched by the state as a massive quality assessment drive inspired by the education sector's "Gunotsav." Unlike standard audits, this initiative sent high-level external evaluators, including Ministers, MPs, and IAS officers, to inspect health facilities personally. This external audit created a spirit of healthy competition among hospitals.

Bihar

- Bihar had 12,371 operational AAM, reflecting substantial expansion of primary health care services across rural and urban areas. Within the visited districts, Saran had a slower pace of operationalization in Urban-SHC (38%) and UPHC (29%).
- Facilities largely complied with the AAM branding norms, including facility name boards in local languages and renaming with the tagline "Arogyam Paramam

Dhanam.” However, directional signages to facilities were generally absent, limiting ease of navigation and access.

- Demarcated spaces for waiting areas, laboratory/ diagnostics, immunisation, and yoga/ wellness activities were available across facilities, with visual privacy measures in place.
- Citizen charter and IEC materials for all EPS were displayed prominently, and no dilapidated infrastructure was observed in visited AAM-SHC functioning from government-owned buildings and UPHC in rented buildings in the visited districts.
- Basic amenities, including power backup and clean water supply through RO systems, were available; however, routine water quality testing was not reported. Separate functional toilets for males and females were available.
- Accessibility provisions remained limited, with inconsistent availability of ramps with railings, wheelchairs/stretchers, and differently abled-friendly toilets across facilities.
- Mobile phones and laptops were provided to staff, facilitating digital reporting and service deliver. Staff reported the absence of a structured technical support system to address hardware or software-related issues.
- Biomedical waste management practices were compliant with segregation, collection, and disposal carried out as per the Biomedical Waste Management Rules, 2016 through an authorised private agency (SYNERGY). Foot-operated bins with clearly displayed biohazard signage and the use of non-chlorinated plastic bags and closed containers/bags for transportation were observed. Effluent treatment plant was there in every AAM-SHC for the treatment of contaminated water.
- Polyclinics- Apart from general OPD services, a pediatrician engaged through outsourced agency provides services at Masumganj UPHC polyclinic three times a week. However, specialist consultation services were unavailable in some polyclinics in the Munger district of Bihar.

Chhattisgarh

- Chhattisgarh had operationalised more than 90% of AAM, with expanded packages of services partially rolled out in most facilities. However, the CRM team noted that additional training and the provision of essential equipment and logistics are required to ensure effective and consistent service delivery.
- Repair, renovation, and rebranding of AAM had largely been completed except for visited UPHC. However, the physical condition of some facilities was suboptimal, with old infrastructure, unorganised layouts, and inadequate boundary protection.
- Beside CHOs and ANMs, Rural Medical Assistants (RMAs) were posted at the primary care level, contributing to service continuity. However, service provision at AAM remained focused on RMNCH+N and communicable diseases. The expanded package of CPHC services particularly mental health, geriatric care, palliative care,

emergency services, and adolescent health are partially available at few AAM only. CHOs and nurses needed refresher training on expanded package of services.

- A “Weekly Arogya Mela at AAM” was being conducted every Wednesday to supplement the routine delivery of comprehensive primary healthcare services. These “Melas” are organized locally within the AAM catchment area to raise community awareness about the importance of health, preventive care, and timely health screening. During these activities, AAM conduct screening for non-communicable diseases, including hypertension, diabetes, and common cancers such as oral, breast, and cervical cancer, along with maternal and child health services and immunization. In addition to clinical services, AAM emphasize health promotion and disease prevention through yoga sessions and other wellness activities, strengthening preventive and promotive healthcare and fostering greater community engagement at the primary care level.
- Citizen charter and IEC were displayed in prominent locations in most of the visited facilities.
- Adequate space for waiting area for patients, Yoga and Wellness activities, as well as separate toilets for males and females were available in all visited facilities for both patients and staff.
- Herbal gardens had been developed adjacent to AAM at designated locations fostering awareness of traditional Ayurvedic systems of prevention and treatment.
- Dedicated drug storage space was available at all visited facilities, indicating adequate basic infrastructure for storage.
- Visual privacy was ensured in LRs and examination areas and ANC check-up corners. Labour rooms at UPHC were functional though zoning into sterile and non-sterile areas was not maintained as per prescribed norms, indicating gaps in infection prevention and control practices.
- Uninterrupted water supply was available. However, several AAM had non-functional or poorly maintained water filtration units, raising concerns about the quality and safety of drinking water
- Electricity was ensured through grid power, supported by inverters/ UPS systems and solar power. However, the solar panels were found to be non-functional in some facilities, limiting their intended benefit.
- Biomedical waste at AAM was managed primarily through deep burial pits and sharp pits, ensuring safe and compliant disposal practices at the facility level. Appropriate segregation and disposal practices were in place.
- Essential accessibility features such as ramps, wheelchairs, handrails, and accessible toilets were not present.

Kerala

- The MO/CHO and facility staff of visited facilities had been trained however their knowledge on 12 packages of services varied.
- In both the visited districts, most of the AAM-SHC and AAM-PHC were operating from Government owned buildings, however significant number of AAM-USHC in district Kasaragod were operating in rented building.
- External branding was complete and renaming as Ayushman Arogya Mandir with the tagline had been done. However, the display of patient charter/ Essential Drugs & Diagnostics list/ IEC materials were variable across the visited facilities.
- Dedicated space for patient examination, laboratory services, drugs storage & dispensing was observed.
- Electricity with backup power (inverter) and water supply were available in all the facilities. Solar panels were installed and functional in Kasaragod district.
- The deep burial and sharp pits were available in the facilities as per Biomedical Waste Management Guidelines.
- In Kerala, polyclinics were operational in all the visited AAM-UPHC in both districts, with support from the Local Self Government Departments (LSGDs). The polyclinics provided specialist services including Obstetrics & Gynaecology, Orthopaedics, Paediatrics, Dental care, Optometry, Physiotherapy, and Dietetics, among others. All 63 designated laboratory investigations were available at the polyclinic level.

Madhya Pradesh

- Madhya Pradesh had operationalised 97% (12,645) of approved AAM with 98% (216) in Mandsaur and 97% (228) in Vidisha.
- Service delivery across facilities in both districts largely concentrated on RMNCAH+N interventions and communicable diseases such as malaria, TB and leprosy and NCDs. Limited progress in the rollout of the EPS was observed, attributed to lack of adequate EPS-related training for the primary healthcare team.
- All facilities in both districts were operational in government-owned buildings and maintained herbal gardens within their premises, except for one UPHC.
- External branding of AAM was in line with GOI guidelines. Citizen Charter and IEC were displayed at prominent location, supporting awareness.
- Dedicated space for laboratory sample collection was available across all the facilities, however dedicated wellness space was not uniformly available.
- Infrastructure across facilities was not elderly or differently abled friendly, with absence of ramps, disabled-friendly toilets, and boundary walls at several AAM, affecting safe and equitable access. Kuccha approach roads were present in front of several SHC in Mandsaur, impacting accessibility, particularly during adverse weather.

- Power backup/Solar panels were not available in SHC.
- 24×7 PHC in both districts had well-equipped labour room with essential amenities such as functional newborn care corner, and necessary instruments and equipment, ensuring safe and quality delivery services round the clock.
- Colour-coded bins for segregation were available, though liquid waste management was inadequate in Vidisha.

Maharashtra

- Maharashtra had operationalised 12,632 AAM (82.92%), with USHC-AAM operationalization being lowest at 46.6% (1041).
- A best practice noted in the Nandurbar district was the operationalization of 3 boat ambulances to overcome the geographical barriers to service delivery in the tribal and hilly regions along the Narmada River, covering ~20,000 population. They function as floating clinics, carrying medical teams to deliver a range of services, including primary care services, routine immunizations, and antenatal/postnatal check-ups, directly to the remote tribal communities.
- The AAM facilities visited had adequate space for yoga/ wellness activities. An SHC in Nandurbar also had open gym equipment within the facility premises for the utilisation by the community.
- Adequate space for laboratory was observed at SHC and PHC facilities.
- Several USHC were not located near the slum/ vulnerable population due to land unavailability, thereby hindering access.
- Separate functional toilets for males and females were available in most facilities, however differently abled friendly toilets and running water supply were concerns in some facilities. Additionally, ramps at certain facilities were steep, posing access challenges for elderly persons and persons with disabilities.
- Roll-out of 12 expanded services was inconsistent due to incomplete staff training and the unavailability of essential equipment.
- Biomedical Waste (BMW) management was inadequate across all levels, with inappropriate waste segregation despite the availability of color-coded bins.

Meghalaya

- Meghalaya had operationalised more than 90% of Ayushman Arogya Mandir, indicating substantial progress in primary health care expansion.
- Service delivery under the 12 Comprehensive Primary Health Care packages was progressing. However, packages related to mental health, geriatric care, and palliative care remained at a nascent stage, primarily due to workforce constraints and limited community awareness.

- MLHPs have been appointed in more than 90% of AAM in both districts, and they demonstrated adequate understanding of service delivery protocols.
- A blue and green colour schema for AAM branding had been adopted by the state. which camouflages the facilities with the surrounding environment and reduces visibility from a distance, potentially affecting ease of identification by the community.

Nagaland

- All facilities were operating from government-owned buildings or donated by the local GBs or CSOs.
- Delivery room was available in all visited PHC and few SHC in Zunheboto district. However, only minimum amenities such as clean bedding, sterilized instruments were available, and infection control practices needed improvement.
- Separate male and female toilets were available in PHC. However, most of the SHC did not have separate, functional toilets for male and female beneficiaries.
- Most facilities had uninterrupted electricity supply, primarily from the grid, with several having solar backup systems. Dedicated power backup (generators or inverter systems) was also available in some of the visited facilities except for UPHC Mon where there was no power back up. Energy-efficient lighting (LED bulbs) was commonly used.
- Rainwater harvesting systems were in place, promoting sustainable resource use in most of the visited facilities. Water tanks were available to store the water and sufficient to cater the requirements of the facilities at visited AAM-PHC, however piped water supply was not available in most of the visited AAM-SHC.
- All visited health facilities had bins and non-chlorinated plastic bag, covered and foot operated bins with Display of Biohazard sign. Needle/hub cutter & puncture proof boxes were available at all visited health facilities. All visited facilities had deep burial pits and sharp pits for biomedical waste disposal.
- Infrastructure constraints were observed at most of the visited facilities in both districts as other physical parameters of the facilities were inadequate. Wire or bamboo fencing was in place at few facilities to demarcate the premises, however boundary walls were missing in others. The branding of AAM and renaming of HWC into Ayushman Arogya Mandir had not been undertaken.
- Significant issues with internet availability and tablet access at PHC/UPHC and SHC were observed leading to delay in real time data entry.
- All 12 CPHC packages were not available at AAM with services for newer packages such as Eye and ENT care, Oral care, Mental health care, Emergency care, and Elderly and Palliative care not being provided. Major reasons for the same were limited availability of the human resources.

Odisha

- The State had operationalised 7365 AAM (99.9% of the target) comprising 5431 SHC, 1263 PHC, 116 UPHC, 133 USHC and 422 Ayush-AAM, indicating substantial coverage of primary health care facilities.
- Services provided include ANC, PNC, FP, Immunization, Child Health, Adolescent Health, NCD screening. Normal deliveries were being conducted at the PHC level.
- Physiotherapy units were in place at UPHC and peripheral facilities expanding access to rehabilitative services at the primary care level.
- Dental chairs were available in most UPHC, supporting provision of oral health services.
- Display of EML availability was well maintained across all the Healthcare facilities.

Punjab

- In Punjab Ayushman Aarogya Mandir are named as **Ayushman Aarogya Kendra** (AAK). Branding of AAK was completed with NHM Logo, façade and tagline.
- Most facilities in both districts were co-located i.e. either two or all three i.e. PHC, SHC and Aam Admi Clinics in the same premises, indicating the need for re-mapping and rationalisation of co-located facilities. In the co-located AAK-PHC and Aam Adami Clinics, service delivery of the PHC was largely restricted to Maternal and Child Health (MCH) services, while AAK-SHC were mainly focusing on outreach activities and other services gravitated towards AAC. This has led to non-implementation of the 12 expanded packages of services. In Faridkot SHC was functioning in single room without dedicated service spaces.
- Labor rooms at PHC in Faridkot were functional, well-maintained, and equipped; however, minor structural modifications are required to align with LaQshya and quality standards, particularly for streamlining patient flow.
- Ayushman Arogya Kendra in both Jalandhar and Faridkot were functioning in government buildings and were accessible to the community through adequate road connectivity. Facilities in Faridkot demonstrated better infrastructure and upkeep, while facilities in Jalandhar required minor repairs and renovation.
- Facilities were patient-friendly, with ramps and railings, wheelchairs, separate toilets, and separate queues for elderly patients.
- Waiting areas, registration counters, OPD services, laboratory space, and drug storage areas were available at PHC and UPHC AAK, supporting basic service delivery.
- Potable water and electricity supply with power back up and use of LED lighting were available.
- EML was displayed in both the districts and proper drug storage practices were followed.

- Virtual training on the expanded 12 CPHC packages was provided only to CHO; however, CHO reported lack of confidence to independently delivering the expanded services. Medical Officers and Staff Nurses were not trained on the expanded service packages, affecting comprehensive service delivery at AAK.
- Biomedical waste management infrastructure was in place across facilities, including covered and foot-operated bins with non-chlorinated plastic bags, needle and hub cutters, puncture-proof containers, and biohazard signage, and staff were trained in segregation, collection, and transportation of biomedical waste in line with prescribed guidelines. Biomedical waste management was outsourced to an authorised agency. Waste collection occurred every 2–3 days from PHC, while SHC transported waste to PHC.
- No Polyclinics had been established in the visited districts of Punjab.

Rajasthan

- Rajasthan had operationalised approximately 73% of Ayushman Arogya Mandir (12,171 facilities), with variations in service readiness across districts.
- In Nagaur district, 424 AAM-SHC were operational and only 146 (34%) had CHOs. AAM were providing seven Comprehensive Primary Health Care service packages. Services related to ENT, eye care, oral health, mental health, emergency care, elderly care, and palliative care were not available. In Jhunjhunu district, CHO demonstrated gaps in knowledge related to drug dosages and inventory management, indicating a need for focused capacity building.
- SHC in Nagaur were also functioning as delivery points, and service delivery followed a structured weekly schedule, including household surveys, Shakti Diwas, routine immunisation/ VHND, and sector meetings, indicating organised service planning.
- Branding of AAM was completed as per guidelines in most facilities, with exceptions noted at a few locations.
- Infrastructure and basic amenities were relatively better in Nagaur, with boundary walls, demarcated waiting area, laboratory space, and separate functional toilets for males and females available. However, facilities in Jhunjhunu district exhibited infrastructure gaps, including toilets requiring repair, electricity-related issues, and water seepage, indicating the need for renovation and maintenance.
- Power backup through inverter and/ or solar systems was available in most facilities in Nagaur, except at SHC Dhanni, where electricity supply was disconnected due to pending bill payments. However, in Jhunjhunu, power backup systems were largely absent, and facilities required electrical repairs and renovation.
- Active internet connectivity, was noted, however, data reporting in Jhunjhunu was neither timely, complete, nor accurate.
- UPHC in Nagaur district had not yet been upgraded to polyclinics.

Sikkim

- In Sikkim, 86% (184) AAM were operational with most of the facilities government-owned and generally well-maintained, with boundary walls ensuring secure premises.
- Branding at the PHC/ SHC level was largely compliant with national guidelines, with NHM logos and the prescribed six service icons prominently displayed. Renaming of facilities as “Ayushman Arogya Mandir” with the tagline *Arogyam Paramam Dhanam* was also completed in the visited facilities.
- PHC, UPHC, and SHC operated as per mandated timings, delivering OPD, ANC/ PNC, immunisation, NCD screening, FP counselling, ECCE, and outreach activities. CPHC service packages available, included maternal and newborn care, child and adolescent health, communicable disease management, reproductive and family planning, NCD screening, OPD care, and basic eye/ ENT/ oral services. CHOs and ANMs demonstrated proper protocol adherence and documentation, with increased community engagement reflecting a rise in footfall. Gaps in trained manpower, equipment, drugs were reported as reason for the non-availability of newer packages.
- Most PHCs had ramps, though universal access features such as hand railings, anti-skid flooring, functional wheelchairs and differently abled friendly toilets were not uniformly present.
- Adequate space for waiting areas, laboratory and wellness were available. Gaps were observed in the visual privacy at point of care.
- Transparency measures such as Citizen Charters, service timings, and signages were displayed, and records were complete.
- All PHC/ SHC reported regular electricity supply, supplemented by solar panels or inverters as backup systems. Energy-efficient LED lighting was available in most of the facilities.
- Potable water was available in all PHC/SHC. However, routine documentation of chlorination and water quality testing was inconsistent, highlighting the need for regularised monitoring and record maintenance.
- Separate and functional toilets for males and females were available across PHC-AAM & SHC-AAM with running water supply.
- Bio-medical waste management systems were compliant across PHC/ SHC, with hub cutters and puncture-proof containers, colour-coded bins, foot-operated containers and non-chlorinated bags available at all facilities. Most PHC were linked to the Common Biomedical Waste Treatment Facility, while others maintained approved deep burial pits. No open burning of waste was observed within or outside PHC premises.

- No dedicated Polyclinic facilities were operational in the assessed districts of Sikkim (Soreng and Mangan), thus Specialist services in the districts are currently delivered through District Hospitals.

Tamil Nadu

- Around 81% of Ayushman Arogya Mandir (8,489 facilities) were operationalised, indicating moderate progress in coverage.
- MLHPs in Tamil Nadu demonstrated good understanding of the 12 CPHC service packages and strong linkage with the community, supporting implementation of the tri-colour card system for identification and follow-up of high-risk cases. However, MLHP were required to manage multiple digital platforms simultaneously, increasing administrative workload.
- **Rainwater harvesting** was implemented in most facilities, and some have adopted LED lighting, however, solarization was yet to be initiated in the visited districts. Peripheral facilities in Salem district lacked power backup, limiting reliable delivery of digitally enabled primary care services.
- Biomedical waste segregation at the point of generation was in place using colour-coded bags and containers, supporting safe handling and disposal practices. Bar-coding of chlorinated biomedical waste bags was implemented, enabling end-to-end tracking from generation to disposal at authorised treatment facilities and strengthening compliance with biomedical waste management rules.
- 153 polyclinics were operational in the state of Tamil Nadu.

Telangana

- The State had achieved 100% operationalisation of AAM (5,051 facilities)
- A best practice noted was that Telangana is one of the first states to establish dedicated Transgender Clinics delivering stigma-free, inclusive health services. Services include general health care, mental health counselling, endocrinology support for gender-affirming therapy, and referral linkages for specialized procedures. Staff was trained in sensitized service delivery, ensuring dignity, equity, and continuity of care.
- Another good practice in the delivery of CPHC services includes the State initiative of Arogya Mahila Clinics. A fixed-day weekly women's health service model has been institutionalised to ensure provision of comprehensive reproductive and general health services. The initiative provides screening for cervical and breast cancer, along with services addressing menstrual disorders, menopausal health issues, urinary tract infections, and other common conditions. The initiative supports unmet health needs of women from underserved and economically weaker groups.
- Most of the visited AAM had well-maintained buildings with ramps, railings and adequate waiting area, supporting patient accessibility and comfort. However,

boundary walls were not consistently available, particularly at AAM-SHC, posing challenges related to security, safety, and controlled facility operations.

- The AAM were providing a wide range of services including telemedicine, wellness activities, preventive care, and early disease detection. However, internet connectivity was poor or inconsistent at several facilities, affecting optimal utilisation of digital platforms such as teleconsultation services, electronic health records, and portal-based reporting, thereby impacting continuity of care and real-time data entry.
- While Comprehensive Primary Health Care services had been initiated, service delivery remained largely focused on maternal and child health, hypertension, and diabetes. Expansion into other CPHC domains such as mental health, ENT care, geriatric care, palliative care, oral health, and emergency services was limited, highlighting the need for broader integration of twelve CPHC package at AAM.
- Biomedical waste management practices showed gaps, with instances of open waste burning reported, indicating inadequate compliance with prescribed protocols and the need for improved infrastructure and staff training

Uttar Pradesh

- Infrastructure across facilities partially complied with IPHS norms. Essential Drug Lists (EDL) and Essential Diagnostics Lists were displayed in all facilities, with gaps noted in building conditions and availability of essential amenities.
- Most AAM-SHC had CHOs in place, and were delivering ten out of twelve essential service packages. CHOs lacked training in palliative care and cancer screening, with limited focus on wellness services. The state had its time-bound plans prepared for training and delivering all 12 package of services.
- Polyclinic: No progress has been achieved so far in the operationalization of the 70 Urban Polyclinics sanctioned under the Fifteenth Finance Commission.

Uttarakhand

- The State had operationalized more than 2300 AAM, 95% of the target.
- All visited facilities had Govt. owned buildings with well-maintained infrastructure to provide the services. Few visited AAM facilities lacked boundary wall.
- OPD room, space for drug dispensing and sample collection/testing for diagnostic services and waiting area as per patient load was available. Elderly & differently abled friendly infrastructure (ramp, railings) was lacking in many facilities.
- Basic amenities including electricity, water supply and functional toilets were available at most of the visited AAM. However, several facilities lacked power back-up and needed strengthening.
- Roll out of Expanded packages of services was limited to seven packages as CHOs and ANMs were not trained on the expanded packages of CPHC.



NATIONAL HEALTH PROGRAMMES AT PRIMARY CARE LEVEL

17th

NATIONAL HEALTH PROGRAMMES AT PRIMARY CARE LEVEL

NATIONAL OVERVIEW

There has been notable progress in delivery of a wide range of maternal health services, including provision of ANC, institutional delivery including referrals and PNC at AAM across the majority of SHC-AAM and PHC-AAM. Newborn and Child health services were being delivered across all the states at the primary care level through AAM-PHCs and SHCs, encompassing key components such as early initiation of breastfeeding, counselling on danger signs, Kangaroo Mother Care (KMC) for low-birth-weight infants, functional Newborn Care Corners, growth monitoring, malnutrition management and routine immunization. Routine immunization services were operational across most states, supported by session planning mechanisms, outreach platforms, and functional cold chain systems. While overall service delivery structures were in place, variations were observed in microplanning, beneficiary tracking, documentation practices, and adherence to vaccine management protocols. In certain settings, geographical barriers and population migration affected the continuity of coverage and birth-dose assurance.

Family planning services were available across primary care level in many states, with facility-level readiness reflected through the presence of contraceptive commodities and display of basket-of-choice. Variations were observed in uptake of long-acting reversible contraceptives, providers' capacity for intrauterine contraceptive device services, consistency of counselling, follow-up, and documentation at SHC and PHC-AAM levels. The stock availability for selected commodities and the strategic placement of IEC was variable across settings. Across the states, availability of comprehensive abortion care (CAC) services at the primary care level remains limited, with variations in resource capacity and service readiness. Some states reported availability of Medical Termination of Pregnancy (MTP) services through designated facilities with availability of trained health care providers and documented good reporting systems, however expansion of 'CAC' service at the primary care level requires strengthening in several states. Variations were observed among facilities with regard to availability of trained human resources, and adherence to standard procedural protocols.

The Rashtriya Bal Swasthya Karyakram (RBSK) was operational across the states, undertaking systematic screening of children for Defects at birth, Diseases, Deficiencies, and Developmental delays (4Ds) through schools and Anganwadi Centres (AWCs). The programme included early identification, referral, and treatment of health conditions, with follow-up to ensure continuity of care.

There has been progress in implementation of adolescent health services across several states; however further strengthening is required at the primary care level. Counselling services at PHC-AAM were limited in scope, and health staff required additional capacity building in adolescent-friendly service delivery. The availability of AFHC spaces was variable across facilities, along with inconsistencies in menstrual hygiene service delivery, including availability of sanitary napkins in certain settings. Social and gender norms continue to influence participation of adolescents, particularly boys, in AFHC services across states. The Weekly Iron and Folic Acid Supplementation (WIFS) programme was implemented uniformly across several states; however, the level of preparedness, training, record maintenance,

and supply management varied significantly. While some states demonstrated strong systems and adherence to guidelines, others reflected gaps in areas of training, logistics, and monitoring mechanisms.

Nutrition care at the primary healthcare level focused on growth monitoring, anaemia prevention, and management of malnutrition among children under five, adolescents, and pregnant and lactating women. Growth monitoring and anaemia services were operational across most states, but gaps were observed in equipment functionality, stock management, and regularity of counselling, affecting quality of service. Community mobilisation, awareness generation, and engagement of beneficiaries remained varied across states.

At the national level, primary care facilities across several states have expanded TB diagnostic capacity, including sputum collection, NAAT/CBNAAT testing, and functional sample transport mechanisms. Active case-finding through ASHAs, CHOs, and frontline workers were operational in several states, supported by community-based screening and follow-up. Nutritional support under Nikshay Poshan Yojana and TPT implementation was observed in multiple regions, though the coverage varied. However, gaps persisted in NAAT utilisation, DBT disbursement, timely Nikshay registration, and community engagement affecting the uniformity in service delivery.

Implementation of NVBDCP showed overall progress in disease surveillance, vector control, diagnostic access, and integration with digital reporting platforms such as IHIP. Several states had reported substantial reduction in malaria burden, improved case fatality outcomes for dengue and chikungunya, active JE control measures, and strengthened MDA activities for lymphatic filariasis. However, gaps persisted in certain states related to drug availability, laboratory diagnostic capacity, reporting compliance, quality assurance documentation, and private-sector surveillance integration with interstate variability in program performance.

National AIDS Control Programme was uniformly implemented across several states, particularly with respect to HIV testing, linkage to Anti-Retroviral Therapy (ART) centres, and Prevention of Parent-to-Child Transmission (PPTCT) services. In some states, service delivery was largely referral based rather than on-site provision at primary care facilities.

Implementation of the National Leprosy Eradication Programme demonstrated varied performance across visited states. Active case detection and availability of Multi Drug Therapy (MDT) were observed. However, persistent endemicity in certain states, continued reporting of child cases and Grade II disabilities, gaps in early detection, variable surveillance mechanisms, and limited decentralization of advanced disability management services were reported. The digital reporting systems and community-based surveillance were not uniformly operational across all states.

Implementation of the National Programme for Prevention and Control of Fluorosis at the primary care level reflected limited and uneven visibility across the states. Active fluorosis-related activities, including water testing, screening, and community-level identification of suspected cases were reported in a few endemic districts. However, in several states, no programme-specific observations were recorded at the primary care level. Implementation gaps were noted in structured action plans, diagnostic services, and coordinated preventive interventions in fluorosis-endemic districts.

Implementation of Integrated Disease Surveillance Programme (IDSP) was operational across most states, with routine reporting through the Integrated Health Information Platform (IHIP) and use of prescribed surveillance formats at peripheral facilities. While basic reporting structures were in place, variability was observed in completeness of syndromic, presumptive, and laboratory reporting, digital platform utilization, documentation practices, and outbreak confirmation processes. Constraints related to reporting consistency, staff capacity, and laboratory linkage were observed in several states.

Leptospirosis-related activities at the primary care level were largely limited across states, with most states reporting no specific observations at primary care level. Where activities were visible, they were linked to the surveillance integration, availability of prophylactic drugs, and case documentation in endemic areas. Diagnostic capacity at the primary care facilities was limited.

Non-Communicable Disease (NCD) services under NP-NCD were operational across states through AAM, hypertension and diabetes being the most consistently implemented components. Population-based screening for individuals aged 30 years and above was being undertaken in several states, supported by CBAC-based risk assessment, trained ASHAs/ANMs/CHOs, availability of essential NCD drugs, and use of digital platforms such as the NP-NCD portal. However, variability persisted in cancer screening coverage, follow-up, defaulter tracking, referral linkages, data quality, and integration of lifestyle counselling and mental health services.

The implementation of the NPPC reflected uneven operationalization at the primary care level. While home-based and outreach services had been initiated in states through AAM, service delivery remained limited or nascent. Variations were observed in terms of availability of trained workforce, continuity of pain management, documentation systems, availability of essential equipment and supportive aids, and integration with elderly care services. In some states, palliative care services were embedded within broader geriatric or chronic disease platforms, whereas in others, programme visibility at facility and community level remained low.

Implementation of the NMHP reflected uneven operationalization across states. While certain states demonstrated structured district-level models, outreach mechanisms, and integration with primary care platforms, service delivery at the SHC-AAM and PHC-AAM remained variable. Gaps were observed in trained human resources, availability of counsellors, documentation systems, psychotropic drug availability, and linkage with Tele-MANAS.

Implementation of NPCB &VI showed varied levels of decentralisation and outreach across states. School eye screening and refractive error identification was noted in several states, with spectacle distribution mechanisms functional in some settings. In certain states, outreach activities at the primary level were limited. Gaps were observed in equipment availability, maintenance of vision screening tools, record keeping including blind registers, availability of ophthalmic assistants, and strengthening of referral and follow-up mechanisms.

Implementation of NTCP showed progress across states, though variations were observed regarding the extend of service delivery. While COTPA-related signage compliance was widely observed, structured tobacco cessation services, BCC activities, and integration with primary care remained inconsistent.

Implementation of NRCP demonstrated availability of Anti-Rabies Vaccine (ARV) at AAM-PHC across most of the states; however, variability was observed in adherence to animal bite management protocols, availability of dedicated wound-washing infrastructure, documentation of Category III cases and Rabies Immunoglobulin (RIG) administration.

Elderly care services at primary care facilities showed substantial variation across states. Common trends included availability of separate OPD queues and limited outreach through home visits by CHOs/MOs in some states; however, coverage remained inconsistent. Across multiple states, Comprehensive Geriatric Assessment (CGA) forms, elderly support groups, and structured follow-up mechanisms and rehabilitation/physiotherapy services were absent or irregularly implemented.

Implementation of NPPCSE showed variation across states in terms of 'ASV' availability, trained personnel, maintenance of essential drug lists and equipment, community level IEC activities, and adherence to treatment protocols.

Implementation under NPPCD at the primary care level showed variability across states, with limited screening activities at AAM, non-availability of basic screening equipment at primary healthcare facilities, and referral to higher facilities in many settings.

Hepatitis B and C services were largely integrated with ANC platforms across states, including screening, referral of HBsAg-positive cases, birth-dose vaccination, and healthcare worker vaccination. However, variability persisted in peripheral-level implementation, logistics, documentation, and coordination.

Implementation of NIDDCP showed variability across states, with salt testing activities conducted in selected districts but inconsistently implemented at community and facility levels.

Oral health services at primary level were limited to screening and awareness activities conducted through school health and VHSND platforms, while availability of dental chairs, trained dentists, and consumables remained uneven across the facilities.

Implementation of NPCCHH showed emerging institutionalisation in some states, with establishment of governance structures, preparation of State and District Action Plans, training of facility teams, heat-related illness surveillance through Integrated Health Information Platform (IHIP), and adoption of climate-resilient measures such as cooling systems and green energy initiatives; however, visibility and documentation of activities at the primary care level remained variable.

KEY OBSERVATIONS

Maternal Health

- Early ANC registration and structured line listing of pregnant women was observed in states like Odisha, Rajasthan, Sikkim, Punjab, Telangana, and Uttar Pradesh. However, gaps in completion of four or more ANC visits were observed in states like Assam and Odisha.
- Identification and tracking of high-risk pregnancy (HRP) mechanisms were in place in Assam, Bihar, Odisha, Rajasthan, Sikkim, and Uttarakhand. However, gaps in follow up and documentation were found in Assam, Bihar, Odisha, and Uttarakhand.
- Though several states reported normal deliveries at AAM-PHCs and delivery points-SHCs, however, there has been an increasing preference for normal deliveries or caesarean section (CS) at higher level healthcare facilities, as reported in states like Odisha, Tamil Nadu, Punjab, Telangana, Kerala and Rajasthan.
- Use of partographs and safe birth protocols were observed in states like Sikkim and Punjab, while gaps in labour monitoring and adherence to clinical protocols were observed in Telangana.
- Chhattisgarh demonstrated infrastructure readiness with protocols displayed at AAM facilities, with scope for strengthening the utilisation of the Safe Birth Checklist and updating of the Maternal Death Review (MDR) portal.
- Meghalaya reported use of digital platforms in NQAS certified facilities; however, strengthening of awareness and standardization of maternal care practices, including use of Misoprostol, is required.
- Adherence to national protocols such as availability of SBA trained personnel, display of SUMAN charters and institutionalized MDR processes was observed in Sikkim.
- Data quality issues, suboptimal utilization of digital platforms were observed across states affecting the monitoring and review processes.

Newborn and Child health services

- States like Punjab, Odisha, Telangana, Sikkim, and Nagaland had implemented relatively strong newborn and child health program interventions, including early initiation of breastfeeding, KMC for low-birth-weight infants, functional Newborn Care Corners, and availability of skilled staff trained in essential newborn care and newborn resuscitation.
- In several states such as Assam, Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Maharashtra, Uttarakhand, and Uttar Pradesh, child health services were available, however, variations were observed in consistency of service delivery, documentation practices, follow-up mechanisms, and overall service quality. Counselling on complementary feeding, developmental milestones, and early stimulation requires further strengthening across facilities.

- The infrastructure and equipment availability for child health services showed varied performance across the states. While anthropometric equipment and growth monitoring were widely available in states like Bihar, Odisha, Punjab, Rajasthan and Uttarakhand, strengthening is required in availability and functionality of infantometers, radiant warmers, and other essential devices at some facilities, particularly at SHCs levels in Maharashtra and Bihar.
- In Chhattisgarh and Madhya Pradesh, service readiness existed, including functional Newborn Care Corners, however further capacity strengthening is required in essential newborn care and neonatal resuscitation, merged ANC–PNC spaces, and awareness of entitlement-based schemes.
- Rajasthan and Maharashtra highlighted contextual challenges such as community preference for higher-level care facilities, which has implications for utilization of primary level services, along with the need for strengthening intrapartum and immediate newborn care practices and addressing higher prevalence of low-birth-weight babies in one of the visited districts of Maharashtra.
- Across high-burden states such as Assam and Uttar Pradesh, neonatal, infant, and under-five mortality rates remained above the national average. Higher patient load on secondary and tertiary care facilities reflected by high bed occupancy at the SNCU, underscores the need for further strengthening of primary-level newborn and child health services and referral linkages.

Universal Immunization Programme

- Routine immunization sessions were conducted regularly in states like Andhra Pradesh, Bihar, Chhattisgarh, Nagaland, Odisha, Punjab, Rajasthan, Uttarakhand, Kerala and Sikkim, along with maintenance of due lists across facilities. The beneficiary tracking mechanisms were in place in several states.
- Cold chain systems were functional in Chhattisgarh, Odisha, Rajasthan, Sikkim, and Uttarakhand, with temperature monitoring and availability of power backup. However, strengthening of vaccine handling practices, including adherence to Open Vial Policy (OVP) and Vaccine Vial Monitor checks, is required in states like Andhra Pradesh, Odisha, and Nagaland.
- Digital platformssuchasU-WINwereimplemented in Chhattisgarh, Kerala, Odisha, Uttarakhand, and Sikkim, with preparation of due lists and parallel maintenance of records in both online portal and registers, however, utilization across all cadres requires strengthening in Punjab.
- Adverse Events Following Immunisation (AEFI) registers were available in Bihar and Uttarakhand,



while strengthening of documentation and reporting practices is required in Andhra Pradesh and Odisha.

- There was a distinctive practice that was observed in Sikkim on systematic tracing of left-out children and availability of structured digital-based session planning was observed in Rajasthan.
- Assam continued to rely on VHSND platforms for routine immunization delivery, though updating and utilization of beneficiary tracking lists requires strengthening.
- Maharashtra reported satisfactory facility-level service provision, but low attendance at AWC limited opportunities for convergence with nutrition services.
- Nagaland reported extended travel requirements for outreach services in remote areas, influencing session planning, while Meghalaya observed pockets of lower outreach coverage despite the availability of functional systems.
- Absence of cold chain points at PHC/APHC facilities reflected a centralized storage model in Bihar, while Rajasthan and Sikkim demonstrated structured digital supported tracking practices, and Uttarakhand reported migration linked dropouts affecting the continuity of services in selected areas.

Family Planning

- Availability of contraceptive commodities and visible “basket of choice” display was reported in most of the states including Bihar, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim, Uttarakhand, and Telangana. The digital logistics system, including FP-LMIS, was functional in Bihar, Odisha, Uttar Pradesh, Tamil Nadu, Uttarakhand, and Meghalaya, with additional digital integration observed in Tamil Nadu and structured training support in Uttar Pradesh.
- Low uptake of long-acting reversible contraceptives and injectable methods was reported in Odisha, Madhya Pradesh, Nagaland, Maharashtra, and Telangana, including limited acceptance of IUCD and Antara. Capacity strengthening needs for service providers for IUCD insertion at SHCs level were observed in Odisha. Misconceptions regarding Antara were reported in Assam, Madhya Pradesh, and Odisha. The PPIUCD retention issues were observed in Bihar.
- Chhattisgarh achieved replacement-level fertility, with a Total Fertility Rate (TFR) of 1.8. States like Punjab and Tamil Nadu had reached the replacement level for TFR of 1.6 and 1.3 respectively.
- Counselling and follow-up mechanisms required strengthening in Andhra Pradesh, Maharashtra and Nagaland, including improvements in documentation practices such as maintenance of eligible couple register.
- Supply-side constraints were reported in Madhya Pradesh and Uttarakhand, while Meghalaya reported high cultural acceptance of Antara, however, supply availability needs strengthening to ensure sustained utilization.

- In Kerala, limited participation of males in family planning reproductive health, was observed.



- Distinct practices included the Sugam Model and condom box strategy in Bihar, use of medical eligibility criteria-based counselling, positive deviance for No-Scalpel Vasectomy (NSV) in Maharashtra, and structured documentation including Family Planning Indemnity Scheme record was observed in Telangana.
- Uttar Pradesh reported integrated training support for facility-based counsellors to strengthen service provision at multiple contact points.
- Service delivery in some states was influenced by contextual factors such as seasonal migration in Maharashtra or due to cultural perceptions and spouse resistance in Meghalaya, and limited designated counselling spaces in rented facilities as observed in Andhra Pradesh.
- Intra-district variation in commodity availability was reported in Uttarakhand, while Punjab reported referral-based provision of sterilization services at higher level facilities.

Comprehensive Abortion Care

- Partial availability of CAC services at primary care level was reported in Chhattisgarh, where Urine Pregnancy Test, Emergency Contraceptive pills, and counselling were available; however, availability of Manual Vacuum Aspiration (MVA) and uniform on-site abortion service provision required strengthening.
- Service provision at higher-level facilities was reported in Punjab, where CAC services were available only at District Hospital (DH) level.

- Structured service availability was reported in Odisha, where facilities from Primary Health Centre (PHC) to District Hospital (DH) were providing MTP services followed by post-abortion family planning, supported by CAC-trained Medical Officers.
- In Sikkim, designated facilities in both districts were providing CAC services with availability of Medical Methods of Abortion (MMA) drugs, MVA/Electric Vacuum Aspiration (EVA) kits, certified Registered Medical Practitioners (RMPs), and maintained MTP registers.
- Limited availability of CAC services at primary care level was also observed in Bihar and Nagaland.

Rashtriya Bal Swasthya Karyakram (RBSK)

- While RBSK was operational across states and contributes to early detection of child health conditions, variations were observed in screening coverage, outreach intensity, and institutional capacity.
- In states such as Uttar Pradesh, Bihar, and Uttarakhand, implementation requires strengthening in terms of staffing, DEIC capacity, and counselling support for families and caregivers. Although referral linkages are in place, further strengthening is required, particularly for children with special needs or complex conditions.
- Screening coverage varied across states, and in high-performing states, such as Telangana, large-scale outreach was facilitated through MHTs and DEICs, resulting in robust detection and treatment of identified children.
- Similar systematic screening and management were conducted in Punjab, where children identified with health conditions were referred to empanelled hospitals and medical colleges, with continued follow-up until treatment completion.
- In state like Odisha, RBSK teams had integrated anaemia screening for children, adolescents, pregnant women, and lactating mothers.
- Across several states, while referral linkages were functional further strengthening is required to ensure continuity of care, particularly for children with special needs and complex conditions.



Adolescent Health /RBSK

- Adolescent Friendly Health Clinics were either not fully functional or lacked dedicated spaces at health facilities in states like Assam, Bihar, Nagaland and Madhya Pradesh.
- In Punjab, although AFHCs (Umang clinics) were established up to the CHC level in Jalandhar, utilisation and awareness among adolescent girls remained limited, and such clinics were not part of the programme in Faridkot.

- Sessions on deworming, anaemia prevention, and menstrual hygiene were conducted across facilities in Andhra Pradesh, however, participation of adolescent boys remained limited due to the prevailing social norms.
- In Chhattisgarh, AFHC services were available at many facilities; however structured adolescent clinics/AFHCs were not conducted routinely, and service utilisation remained low due to human resource constraints, and limited community awareness.
- In Maharashtra, periodic Maitri clinics covered key themes, however, irregular adolescent sessions, gaps in sanitary napkin supply, and challenges in peer educators' placement, affected continuity of engagement. In Bihar, the absence of AFHC spaces was compounded by gaps in menstrual hygiene service delivery, including non-availability of sanitary napkins at some facilities.
- AFHC services showed organised implementation with dedicated counselling spaces, availability of essential commodities, and trained counsellors conducting regular weekly and monthly sessions in states like Sikkim and Odisha (AFHC known as Shraddha clinic). The Peer education activities were implemented as per the prescribed norms. At these AFHC, there was a structured reporting mechanism with display of IEC materials, and regular distribution of sanitary napkins via schools and frontline workers.
- Uttarakhand reported consistent implementation of adolescent health services across districts, with focus on counselling, awareness generation, and preventive interventions, supported by trained peer educators and RKSK counsellors conducting regular counselling sessions in schools and community settings.
- Uttar Pradesh has demonstrated large-scale outreach through the Peer Education Programme (PEP), with over 1.2 lakh trained peer educators actively engaged across high-priority districts. In addition, the state has institutionalised a state-funded Kishori Suraksha Yojana for free distribution of sanitary pads to government school-going adolescent girls, strengthening support to the menstrual hygiene practices at scale.
- While implementation of WIFS was effective in certain settings with high level of awareness among adolescents and active consumption of supplements, gaps were evident in training of nodal teachers, maintenance of school-level distribution records, and monitoring systems.
- Stock management issues were observed, including unavailability of IFA-blue tablets for eligible age groups and presence of expired IFA-pink tablets in some facilities. Additionally, absence of IEC materials and limited awareness additionally, absence of IEC materials and lack of awareness activities further limited effective programme implementation.



- WIFS activities were operational in Sikkim and Punjab, however implementation gaps were observed in Nagaland. There were trained nodal teachers, and properly maintained records were found in Sikkim. Also, high awareness among adolescents and active consumption of supplements were observed in Punjab. Although, a nodal teacher was identified in Nagaland but had not received formal training on WIFS.

Nutrition and Anaemia Mukht Bharat (AMB)

- Across most states, routine growth monitoring was implemented primarily through AWCs, with the use of digital weighing machines, stadiometers, infantometers, and weight-for-height charts. However, the functionality of equipment varied with non-functional digital weighing scales reported in Chhattisgarh, and non-availability of infantometers in some facilities in Bihar.
- Screening for anaemia and follow-up of identified cases was conducted in many states, with IFA supplementation and counselling provided, however gaps were observed in consistency of service delivery, stock management, and structured behaviour change communication (BCC).
- Targeted interventions such as biannual vitamin A supplementation, weekly IFA distribution in schools and AWCs, and ORS/zinc provision for diarrhoeal management were being implemented in states like Uttarakhand. However, challenges were noted, including the presence of expired IFA tablets at AWC in Uttarakhand and stock-outs in schools in Bihar.
- Counselling on nutrition, dietary diversity, complementary feeding practices, and adherence to supplementation schedules was widely undertaken in many states like Andhra Pradesh, however variations were observed in consistency and coverage, with gaps observed in states like Bihar and Chhattisgarh.
- In several states, including Chhattisgarh and Madhya Pradesh, coordination between health functionaries (ANMs, CHOs) and frontline workers (AWWs, ASHAs) require strengthening to ensure continuity of care, proper referral, and follow-up of severely malnourished children and anaemic beneficiaries.
- Referral systems to Nutrition Rehabilitation Centres (NRCs) were functional in Odisha, while in Nagaland and Punjab, screening and referral mechanisms for SAM children were limited or non-functional.
- While initiatives such as central kitchens in Nandurbar (Maharashtra) and structured peer educator support in Andhra Pradesh enhanced programme reach, low attendance of malnourished children at AWCs, inconsistent complementary feeding practices, and limited IEC materials restricted the impact of nutrition interventions in several regions.

National Tuberculosis Elimination Programme (NTEP)

- While several states had strengthened diagnostic capacity, active case-finding, and nutritional support at primary care level, gaps persisted in NAAT coverage, DBT disbursement, drug availability, community engagement, and follow-up.

- Active case-finding was functioning well in states like Chhattisgarh, Telangana, Sikkim, Maharashtra, Punjab, Rajasthan, Tamil Nadu and Uttarakhand, with ASHAs, CHOs, and frontline staff conducting vulnerable population screening, CBAC completion, and follow-up at SHC- AAM, and PHC-AAM.
- Chhattisgarh conducted sputum collection at PHCs with TruNAAT machines at block level and CBNAAT upgradation were ongoing, while Telangana operated CBNAAT and microscopy labs at PHC/UPHC level.
- Sikkim had functional sample transport from AAM to district labs, monitored by CHOs and ASHAs, and used chest X-rays and NAAT testing at selected facilities. Maharashtra ensured sample collection at SHC-AAM through MPWs with transport linkages to PHCs; however, limited availability of handheld X-ray machine affected effectiveness.
- Gaps in diagnostic utilization was observed including suboptimal NAAT coverage in Andhra Pradesh, inappropriate selection of suspects of sputum collection at AAM-SHC in Bihar and delays in Nikshay ID generation along with limited laboratory capacity in Odisha. Nagaland lacked active screening mechanisms, and TB drugs were not available at SHCs.
- Active surveillance and follow-up showed variability with limited follow-up in Bihar, minimal screening and incomplete line listing, lack of records for newly identified cases in Nagaland and Meghalaya, and migrant population related challenges affecting follow-ups in Uttarakhand. In Uttar Pradesh, only 50% of the line-listed vulnerable population was enrolled in Nikshay, with limited X-ray coverage.
- Nikshay Poshan Yojana and nutritional support were active at primary care levels in Chhattisgarh, Sikkim, Maharashtra, Telangana, and parts of Punjab. Maharashtra distributed food baskets through Nikshay Mitras.
- Telangana demonstrated strong TPT and NIKSHAY POSHAN implementation; However, delay in DBT disbursement were reported in Andhra Pradesh and Bihar due to integration and processing issues. Uttarakhand reported delayed DBT disbursement at primary level, and TPT uptake remained low.
- Community engagement and patient support showed variability with inconsistent counselling and follow-up in Andhra Pradesh and Bihar, and limited community engagement affecting case notification and line listing in Nagaland and Odisha.
- In Uttarakhand, CHOs used the Nikshay portal for data entry and follow-up, however presence of large migrant population was a challenge for consistent monitoring. Integration with other programmes was in place in some states, though implementation remained variable.

National Vector Borne Disease Control Programme (NVBDCP)

- While many states reported strong progress in malaria elimination, vector-borne disease surveillance, Lymphatic Filariasis (LF)- MDA coverage, and JE control, implementation gaps persisted with regard to drug availability (e.g., ACT, Primaquine),

laboratory capacity, reporting adherence, private sector surveillance, and backlog management of morbidity cases. Certain districts also reported supply constraints, delayed diagnostics, and variability in implementation.

- Malaria:** Significant progress in malaria control was observed in Telangana and Chhattisgarh, where the Annual Parasite Incidence (API) has reduced to below 1, including historically endemic districts. Tamil Nadu has achieved near-elimination, while Meghalaya reported substantial reduction due to active surveillance and LLIN coverage. Sikkim maintained the availability of RDTs and ACT blister packs, documented IRS coverage, regular IHIP reporting, and payment of ASHA incentives. Punjab and Nagaland reported no malaria deaths, with RDT-based diagnosis at community level and microscopy at higher facilities, ongoing surveillance, and trained staff. In Bihar, RDK kits and anti-malarial drugs were available at AAM levels, though microscopy was not conducted at PHC level. Healthcare facilities in Uttarakhand largely provided RDT and microscopy services, in contrast, Maharashtra reported non-adherence to NCVBDC reporting formats, delayed blood slide results, and shortages of antimalarial drugs including ACT blister packs. Odisha highlighted gaps in radical treatment drug availability (Primaquine), weak malaria laboratory capacity, and absence of quality assurance (QA) documentation at UPHC level.
- Dengue and Chikungunya:** Active surveillance and diagnostic services were functional in Punjab, Telangana, Sikkim, Nagaland, Tamil Nadu, and Bihar. Telangana reported zero case fatality for dengue and chikungunya, with expansion of sentinel laboratories. Punjab documented hotspot identification, IHIP reporting, and ASHA involvement in awareness activities, though registers and incentive payment to ASHA require strengthening. Sikkim used rapid tests and referred samples to sentinel labs, with source reduction by DBCs. Bihar had NS1 and IgM RDT kits which were available at AAM levels. Tamil Nadu reported increased dengue reporting due to improved IHIP integration. Maharashtra indicated rational use of dengue and chikungunya kits due to limited availability. In Uttarakhand and Uttar Pradesh, IEC activities and seasonal campaigns supported vector control, however, strengthening of surveillance particularly private sector reporting in Uttar Pradesh is required.
- Lymphatic Filariasis (LF):** Telangana and Sikkim demonstrated strong LF control performance, with high MDA coverage, low microfilaria rates, updated line lists, and strengthened morbidity management services. Bihar maintained line lists of positive cases from Night Blood Surveys (NBS). Maharashtra conducted MDA in one block of aspirational district in 2024 with 96% reported coverage. However, Chhattisgarh reported TAS-2 failure, ongoing transmission, and backlog of hydrocoele cases requiring intensified MDA, surveillance, and focused surgical interventions.
- Kala-azar:** Bihar and Sikkim reported availability of RDT kits at AAM levels, with designated blocks maintaining micro-plans and storage systems. Active case search was conducted in Sikkim, and no new kala-azar cases were reported in Bihar in 2025. Nagaland reported no endemic villages for kala-azar in the visited districts.
- Japanese Encephalitis (JE) and AES:** JE vaccination was implemented in Bihar and Sikkim, with IEC and prompt referral of suspected cases in Sikkim particularly.

Telangana reported nil JE-related deaths since 2014. In Uttar Pradesh, AES/JE control remained a top priority, supported by annual communicable disease control campaigns and inter-departmental coordination, resulting in reduction of cases and deaths. However, strengthening active surveillance, particularly in the private sector, is required.

National AIDS Control Programme (NACP)

- HIV testing services were observed at facility level in states like Andhra Pradesh, Punjab, Rajasthan, Sikkim, Telangana, and Uttarakhand, with testing kits available and referral linkages to ART centres where required.
- Linkage to ART centre and follow-up mechanisms for PLHIV were functional in states such as Punjab and Telangana, while PPTCT services were integrated with an antenatal care platform across multiple states.
- Variability in service delivery was observed with greater reliance on higher level facilities in states such as Uttar Pradesh, and predominantly referral-based mechanism with limited onsite ICTC services in Bihar and Madhya Pradesh.

National Leprosy Eradication Programme (NLEP)

- Active case detection through ASHAs and routine surveillance mechanisms was observed in states like Assam, Maharashtra, Telangana, Uttarakhand, and Sikkim with MDT availability ensured in facilities where cases were detected e.g., Maharashtra, Odisha, and Sikkim.
- Post-Exposure Prophylaxis (PEP) and contact tracing were operational in Maharashtra and Sikkim alongside structured community awareness activities SLAC (Sparsh Leprosy Awareness Campaign) and IEC in Punjab and Uttarakhand.
- Surveillance and digital reporting system showed variability, with ABSULS (ASHA Based Surveillance Leprosy Suspects) and Nikusth 2.0 portal non-functional in Rajasthan and Uttarakhand respectively while functional and regularly updated in Sikkim.
- High endemicity with prevalence above 1 per 10,000 population was observed in Chhattisgarh and Maharashtra, along with continued reporting of Multibacillary (MB) cases, while Grade II disability and child case reported in Chhattisgarh, Uttar Pradesh, and Tamil Nadu indicated delayed detection in certain areas.
- Reconstructive and disability management services varied across states with centralized dependency on RLTRI Raipur in Chhattisgarh, while Telangana demonstrated decentralized support through MCR footwear distribution and reconstructive surgeries.
- State specific variations were observed, with Maharashtra demonstrating a structured model of ASHA led detection and high SDR coverage, Sikkim reflecting low endemicity with strong digital systems (ABSULS and Nikusth 2.0) and Chhattisgarh continuing to report higher MB burden with centralized services.

- Localized challenges included continued transmission in selected districts of Tamil Nadu, limited assistive devices at peripheral level in Uttarakhand, partial LCDC coverage in Uttar Pradesh due to human resource constraints, and gaps in treatment adherence follow up in Odisha.

National Programme for prevention and control of Fluorosis (NPPCF)

- Fluorosis disease was endemic in selected pockets of Chhattisgarh, and Punjab. In Chhattisgarh, regular water testing for fluoride content was reported at primary care level; however, diagnosis of dental mottling and fluoride toothpaste distribution were not observed.
- In Punjab, water testing through kits and identification of suspected dental fluorosis cases were reported during community visits.
- Fluorosis screening was integrated with outreach activities in some states such as Rajasthan, where dental teams conducted screening through oral camps. However, diagnostic and laboratory services require strengthening.
- In Sikkim, community-led identification through ASHAs supported by water and urine testing and provision of alternative safe drinking water sources reflected a more coordinated approach in affected areas.

Integrated Disease Surveillance Programme (IDSP)

- Routine IHIP reporting and submission of surveillance formats were observed across several states, including Andhra Pradesh, Bihar, Chhattisgarh, Maharashtra, Meghalaya, Nagaland, Punjab, Rajasthan, Telangana, Uttarakhand, and Sikkim.
- Strong reporting compliance and structured outbreak response mechanisms were observed in Telangana and Punjab, while Sikkim and Uttarakhand demonstrated regular reporting and prompt outbreak investigation processes. Variability in reporting completeness was observed across states including selective reporting in Odisha (limited conditions and absence of laboratory reporting), lack of syndromic reporting in Nagaland, inadequate peripheral level reporting in Rajasthan, and irregular syndromic form entry in parts of Chhattisgarh.
- Digital awareness and surveillance understanding among frontline staff were observed in Andhra Pradesh. However, connectivity constraints affected real-time reporting in hard-to-reach areas.
- In Uttar Pradesh, a state-level reporting portal (UDSP) was operational; however, mismatch between conditions covered under the state portal and IDSP reporting requirements was observed. The Metropolitan Surveillance Unit was not operational due to human resource constraints.
- Variations were also observed in surveillance ownership, outbreak response dynamics, digital integration and utilization of data with Andhra Pradesh, Bihar and Telangana demonstrating active use of surveillance data for monitoring and response, while Rajasthan and Maharashtra reflected the need for strengthening uniform utilization across cadres.

- Outbreak response mechanisms were operational in several states including Chhattisgarh (local outbreak response) and Odisha (linkage with Integrated Public Health Laboratory), while Nagaland and Uttarakhand reported no outbreak during the review period and Madhya Pradesh highlighted gaps in Vaccine Preventable diseases surveillance and diagnostic availability. Chhattisgarh reported engagement of frontline teams during local outbreak response. Kerala reported use of the IHIP-IDSP platform for surveillance data reporting.

National Programme for Prevention and Control of Leptospirosis (NPPCL)

- Availability of prophylactic drugs such as Doxycycline was reported in states including Punjab, Sikkim, Kerala, with testing kits and case record maintenance observed in endemic areas of Sikkim and facility-level testing available from PHC level and above in Kerala.
- Diagnostic capacity remained limited across most states, including Punjab and Uttar Pradesh, where testing was largely restricted to higher-level facilities or selected districts. Programme implementation was integrated with surveillance systems in some states, such as Uttar Pradesh, where leptospirosis was monitored under IDSP; however, seasonal preparedness and inter-sectoral (one-health) coordination showed variability.

National Programme for Palliative Care (NPPC)

- Home-based palliative care services were present in Andhra Pradesh, Odisha, Sikkim, Tamil Nadu, Telangana, Maharashtra, and Kerala, supported by CHO and Medical Officer-led outreach.
- In Kerala, regular home visits were undertaken by multidisciplinary teams including MLSPs, JPHNs, JHIs, and ASHAs, with structured follow-up mechanisms.
- Variations in workforce capacity and training were observed, with gaps in training and sensitization reported in Bihar, Uttar Pradesh, Uttarakhand, Rajasthan, Madhya Pradesh, and Tamil Nadu, including limited orientation on pain management and narcotic use (notably in Tamil Nadu).
- Documentation practices showed variability with gaps in Odisha, Uttarakhand, Andhra Pradesh, and Maharashtra, while Kerala maintained a unified digital registry (Palliative Care Grid), enabling coordinated tracking and monitoring.
- Availability of equipment and supportive aids (mobility aids and palliative care kits) remained inconsistent, with gaps reported in Chhattisgarh, Uttarakhand, Andhra Pradesh, and Rajasthan. Programme rollout remained nascent in Meghalaya and not visible in Nagaland, while Telangana and Kerala demonstrated comparatively stronger integration of services across facility and outreach platforms.
- State-specific implementation models reflected variability: Kerala demonstrated a comprehensive, policy-backed model with multidisciplinary home-based care and

digital coordination; Telangana reported functional units with integrated outreach; Tamil Nadu provided home-based services through Mobile Medical Teams including physiotherapy support; and Maharashtra, Andhra Pradesh, and Odisha reflected district-level variation in service intensity and follow-up mechanisms.

National Mental Health Programme (NMHP)

- District Mental Health Programme (DMHP) activities were operational in Bihar, Chhattisgarh, and Odisha, with fixed OPD days and outreach services. Chhattisgarh additionally implemented the TORRENT programme with NIMHANS support for strengthening capacity of primary-level staff.
- Innovative models were observed in Maharashtra, (Manashakti Clinics at PHCs) and Sikkim (State Mental Health Strategy 2025-2030 with structured suicide prevention and training support for CHOs and ANMs), while Telangana integrated mental health screening within maternal care and utilized digital counselling platforms.
- Tele-MANAS visibility varied across states, with prominent display in Assam, Odisha, Tamil Nadu, and Sikkim, and low awareness or non-display in Punjab, Rajasthan, and Uttarakhand; non-functionality was reported in parts of Chhattisgarh.
- Variations in programme implementation were observed across states, with structured DMHP clinics in Bihar and Odisha (though with limited specialist coverage), youth-focused engagement in Tamil-Nadu (MaNaM programme), and limited visibility of structured services in Punjab, Rajasthan, Uttarakhand, and Nagaland.
- Service delivery gaps were observed in some states including inconsistent screening and documentation in Andhra Pradesh, limited primary-level counselling in Punjab, and absence of services in many facilities in Nagaland. Shortage of counsellors and specialized manpower was reported in Bihar and Madhya Pradesh.
- Kerala reported regular provision (twice a month) of mental health services through District Mental Health teams with maintained records at facility level.

National Programme for Control of Blindness and Visual Impairment (NPCB& VI)

- School-based vision screening and spectacle distribution were actively undertaken in Bihar, Chhattisgarh, Odisha, Punjab, and Telangana, including convergence with RBSK. Telangana demonstrated strong cataract surgery performance, achieving 92% of annual targets in successive years, and improvement in cornea collection, while Bihar institutionalized spectacle procurement to reduce supply delays.
- Referral linkages to higher facilities were functional in Andhra Pradesh, Madhya Pradesh, Punjab, and Uttarakhand, however, follow-up and loop closure remained inconsistent in some settings. Uttarakhand also conducted outreach camps in convergence with RBSK and ensured availability of common ophthalmic medicines.

- State-specific models reflected variations in implementation: Maharashtra demonstrated a community-supported NGO-led model for cataract screening and surgical facilitation (notably in Nandurbar), supported by outreach and transport mechanisms, though delays in spectacle distribution persisted. Sikkim maintained village-level blind registers, functional Vision Centres, and integrated diabetic retinopathy referrals.
- Gaps in equipment availability and human resources were observed across states, including non-availability of basic screening tools (Snellen charts), and equipment maintenance issues in Chhattisgarh, Rajasthan, and Odisha, shortage of Ophthalmic assistants in Odisha, and limited decentralized services at PHC/AAM levels in Madhya Pradesh. Rajasthan also reflected gaps in documentation systems at peripheral facilities.

National Tobacco Control Programme

- COTPA-compliant signage (“No Tobacco”/“Tobacco-Free Area”) was observed across multiple states including Bihar, Chhattisgarh, Kerala, Meghalaya, Nagaland, Punjab, Uttarakhand, and Sikkim.
- IEC and community awareness activities were undertaken in states such as Meghalaya, Punjab, Odisha, and Sikkim, including school-based tobacco-free initiatives in Odisha and OPD-based counselling in Punjab along with engagement of frontline workers during special drives. Sikkim integrated cessation counselling into routine services, while Meghalaya demonstrated sustained IEC outreach in high-prevalence communities.
- Variability in cessation services was observed, with limited integration with NCD or mental health services at primary level in Maharashtra, Rajasthan, Assam, and Andhra Pradesh, and non-uniform availability of Tobacco Cessation Centres. Tamil Nadu reported tobacco-free villages and facilities, though documentation of counselling required strengthening.
- Enforcement challenges under COTPA, including irregular enforcement drives were reported in Odisha. Maharashtra also reflected limited IEC integration with emerging outreach approaches under consideration.

National Rabies Control Programme

- Availability of ARV up to AAM-PHC level was observed across states like Chhattisgarh, Maharashtra, Nagaland, Odisha, Rajasthan, Punjab, Uttarakhand, and Sikkim. RIG availability was observed at higher facilities in Odisha and Sikkim, with high compliance to Category III management in Sikkim.
- State level performance varied, with Telangana demonstrated structured surveillance (approximately 1.21 lakh reported dog-bite cases) and zero rabies deaths through structured training, master trainer models, and Model Anti-Rabies Clinics contributing to zero rabies mortality. Training initiatives for Medical Officers were undertaken in Bihar, Punjab, and Telangana.

- Infrastructure gaps, particularly lack of dedicated wound-washing stations, were observed in Chhattisgarh, Maharashtra, Odisha, and Punjab. Documentation gaps in Category III case management and RIG administration were observed in Rajasthan.
- High burden settings such as Meghalaya reported continued rabies mortality and use of intramuscular regimens at PHC level, while Uttar Pradesh reported intermittent ARV stock-outs and limited inter-sectoral coordination with veterinary and municipal authorities for stray dog management.
- Inter-sectoral coordination for animal birth control and stray dog management remained weak in some states, alongside gaps in community awareness regarding first aid and early reporting, and documentation practices including case records and RIG administration.

National Programme for Healthcare of Elderly (NPHCE)

- Elderly care services remained uneven at the primary care level, with gaps in CGA implementation, equipment availability, forming of support groups, staff training, documentation, line-listing of elderly, and public awareness of home-based services.
- Relatively structured models were observed in states such as Sikkim, Andhra Pradesh, and Chhattisgarh. Sikkim demonstrated regular CGA use, physiotherapy support, geriatric OPD days, and elderly support groups. Andhra Pradesh implemented home-based care under the Family Doctor Programme with regular visits for chronic disease management, through supportive aids and documentation remained inconsistent. Chhattisgarh operationalized geriatric OPDs and Siyan Jatan Clinics with home visits; however, equipment availability, CGA awareness, and support groups were limited.
- Moderate implementation was observed in states such as Odisha, Uttarakhand, Maharashtra, and Bihar. Odisha provided physiotherapy services through visiting specialists and outreach by CHO/ANMs, through CGA usage and follow-up remained limited. Uttarakhand ensured service access through OPD queues but lacked dedicated geriatric OPD days, CGA implementation, and equipment. Maharashtra reflected partial line-listing and selective outreach, while Bihar lacked structured enumeration and documentation of elderly populations.
- Partial implementation gaps were observed in Tamil Nadu and Madhya Pradesh, where screening tools (ADL/MMSE) were inconsistently used and staff training remained limited. Rajasthan and Nagaland reflected the overall need for strengthening elderly care services at the primary care level.

National Programme for Prevention and Control of Snakebite

- Gaps remained in decentralised case management at AAM level, availability of trained staff, consistent ASV availability (including expired or absent stock), and limited drug supplies in certain PHCs.
- States such as Chhattisgarh, Telangana, and Sikkim demonstrated relatively stronger implementation, with availability of ASV, trained personnel, and functional case

management systems at primary care level.

- Nagaland and Punjab demonstrated functional availability of ASV and trained staff at PHC/UPHC level; however, referral dependency remained high in Punjab, indicating partial decentralization.
- Variability in supply and readiness was observed in states such as Uttarakhand and Rajasthan, where ASV availability was inconsistent (including expired stock or absence at PHCs), however community awareness on snakebite prevention was relatively good in Rajasthan with people promptly seeking care at medical facilities.
- Training initiatives for healthcare providers and IEC activities were undertaken in several states; however, the need for strengthening standardized training, drug lists, equipment availability, and community awareness on first aid remained.

National Programme for Prevention and Control of Non-Communicable Diseases

Key Observations

- HTN/DM screening under NP-NCD was widely operational across the AAM, variability persisted in cancer screening coverage, follow-up and defaulter tracking, referral linkages, data quality, digital portal utilisation, and integration of lifestyle counselling and mental health services.
- Strong implementation was observed in states such as Telangana and Sikkim. Telangana had screened 1.90 crore adults for HTN/DM, with high treatment initiation, achieved 75/25 initiative target, revised HTN/DM treatment protocols in March 2025 to include Fixed Dose Combinations, and integrated oral, breast, and cervical cancer screening with Arogya Mahila and Maternal Morbidity Clinics. Sikkim demonstrated well-equipped NCD corners, systematic screening, protocol-based management, 30-day drug dispensing, defaulter tracking, and cross-programme linkages with Tb, mental health, and RBSK.
- Moderate implementation with mixed performance was observed in states like Andhra Pradesh, Assam, Odisha, Tamil Nadu, Uttarakhand and parts of Maharashtra. Andhra Pradesh ensured screening at AAM level with availability of drugs and diagnostics, digital registers and listing of high-risk patients but showed gaps in referral, counselling, and follow-up. Tamil Nadu demonstrated strong doorstep service delivery (Makkalai Thedi Maruthuvam scheme) for HTN/DM and common cancer screening, and innovation (diabetic foot screening- Paatham Paathukaapom Thittam), though referral and follow-up required strengthening. Odisha reported defined screening coverage and treatment initiation under 75/25 initiative, though portal delays, incomplete PBS coverage, weak downward referral, and absence of control-status tracking were observed. Assam demonstrated established CBAC based screening, NCD tracking bags (tickler bag) and strong outreach through Village Health Outreach Programme (VHOP) camps. Maharashtra showed inter-district variation, with stronger performance in Satara (online CBAC usage, mission Tejaswini to promote screening among women, STEMI-linked ECG services, and

mobile cancer screening vans) and weaker implementation in Nandurbar. In Uttarakhand NCD corners were established and services were mainly limited to HTM and DM while cervical cancer screening was not being conducted.

- Uttar Pradesh reported large-scale screening (3.9 crore for HTN and 3.8 crore for DM through NCD E-Kavach). However, the proportion of confirmed cases, treated, and controlled cases remained low relative to screening volume. statewide implementation of the PMNDP, NAFLD, and COPD, with STEMI in 35 districts and Stroke in 7 districts was also reported.

NCD Screening Status	Screening Target (30+ Population) In Crores	Cumulative Screening Done	Percentage of Achievement
Hypertension Screening	36.82	29.45	80%
Diabetes Screening	36.82	29.28	80%
Oral Cancer Screening	36.82	23.43	64%
Breast cancer screening	18.41	10.78	59%
Cervical cancer screening	18.41	5.41	29%

**Source: NP-NCD Portal from 1st January 2025 to 30th September 2025 of all CRM states*

NCD Treatment Status	Diagnosed cases	Under Treatment cases	Percentage of Achievement
Hypertension	24937394	23844568	96%
Diabetes	14428178	13459020	93%
Oral Cancer	163643	144794	88%
Breast cancer	31963	19043	60%
Cervical cancer	49629	34595	70%

**Source: NP-NCD Portal from 1st January 2025 to 30th September 2025 of all CRM states except Kerala and Tamil Nadu (due to non-availability of data on portal)*

National Programme for Prevention and Control of Deafness

- NPPCD implementation at the primary care level remained inconsistent, with limited screening activities and minimal programme visibility at AAM-PHC level, non-availability of basic diagnostic equipment, inadequate training, weak IEC efforts, and heavy reliance on referral to higher facilities.
- Relatively stronger implementation was observed in Sikkim, where screening services, availability of otoscopes and essential ear drops were ensured at AAM level.
- Partial implementation was observed in states such as Punjab, Uttarakhand, and Chhattisgarh. Punjab conducted basic screening through OPDs, while Uttarakhand ensured availability of medications and awareness among ASHAs for screening of newborns, though equipment gaps persisted. Chhattisgarh reflected limited IEC visibility.

- Significant gaps were observed in Bihar, Maharashtra, Rajasthan, and Nagaland where screening activities were minimal or absent, basic tools (tuning forks) were not available; the services were largely referral-based, indicating limited primary-level implementation, further training and orientation of CHOs is required.

National Viral Hepatitis Control Programme

- Structured ANC-based screening and referral systems were observed in Telangana, Rajasthan, Punjab, Uttarakhand, and Nagaland. Rajasthan ensured universal ANC screening with referral support, while Punjab demonstrated programme implementation with IEC support, though kit shortages and incomplete HCW vaccination were noted. Uttarakhand ensured ANC screening at PHC/UPHC level with established referral mechanism but not at SHC-AAM.
- Partial implementation was observed in Bihar, Sikkim, Maharashtra, and Tamil Nadu. Bihar demonstrated training and HCW vaccination efforts but inconsistent ANC screening at AAM level. Sikkim reported partial screening coverage and approx. 90% health care workers vaccination with gaps in full-dose completion due to supply and tracking issues. Maharashtra relied on referral from AAM-HSC to PHCs for testing.
- Tamil Nadu demonstrated integration of screening into primary healthcare, though coordination gaps between blood banks and ICTC labs led to delays in viral load reporting. In Uttar Pradesh, large-scale screening was undertaken (28 lakh for Hepatitis B; 8.7 lakh for Hepatitis C), with identified positives and treatment initiation; however, findings indicate need for strengthening screening among vulnerable populations, vaccination coverage, and surveillance coordination.

National Iodine Deficiency Control Programme

- Salt testing activities were observed in states such as Chhattisgarh, Maharashtra (Satara), Odisha, and Sikkim. Community-level implementation was reported in Sikkim with ASHA-led testing and record maintenance also observed in Maharashtra, although delayed operationalization was reported in Satara district as testing kits were recently made available (from August 2025).
- Implementation gaps were observed across states, including limited availability of salt testing kits, missing samples during verification (Odisha), and delayed or inconsistent testing.
- Minimal or absent implementation was observed in Nagaland and parts of Rajasthan, where household-level testing by ASHAs and programme visibility were limited.

National Oral Health Programme

- Strong primary level implementation was observed in Rajasthan, Odisha, Sikkim, and Andhra Pradesh, with availability of dental infrastructure, trained personnel, and routine screening activities. In Rajasthan, dental facilities were available at PHC level, with provision of services supported by trained dental professionals and necessary equipment.

- In Odisha, dental surgeons were posted across blocks, and most UPHCs had functional dental chairs providing routine dental services and oral cancer screening, though intermittent consumable shortages were reported.
- In Sikkim, basic oral health screening was conducted at all AAM with PHC/UPHC level facilities providing services such as scaling, fillings, and extractions, supported by visiting dentists.
- In Andhra Pradesh, dental kits were available at several AAM-PHCs, and dental caries screening was frequently conducted during school health days.
- Partial implementation was observed in Chhattisgarh and Nagaland, where oral health screening and awareness activities were conducted through school health programmes and VHSND sessions; however, treatment services remained largely referral-based to higher facilities.
- Limited primary level implementation was observed in Maharashtra, Punjab, Tamil Nadu and Uttarakhand. In Maharashtra, no structured oral health activities were observed at the primary level beyond symptomatic OPD consultations by CHOs, and dental services were not available at the PHCs.
- In Punjab, basic dental equipment such as mouth mirrors and probes was not available, ASHAs were not oriented, and services were largely restricted to dispensing oral ulcer gels and upward referrals.
- In Tamil Nadu, lack of dental drugs at AAM-SHC level was reported. In Uttarakhand, no dental facilities were available at PHC/UPHC, and services were limited to symptomatic relief for dental emergencies.

National Programme on Climate Change and Human Health (NPCCHH)

- Gaps were observed in documentation, defined indicators, reporting mechanisms, structured implementation at peripheral levels, and affecting systematic monitoring of climate-related health risks.
- Telangana demonstrated strong institutionalisation with governance structures (establishment of governing body, task force, and environmental health centre), state and district action plans (for 33 districts), and heat-related illness surveillance through IHIP.
- Sikkim reflected operational readiness with trained staff, temperature monitoring systems, documentation of heat-related illness, and adoption of green practices (LED, solar systems). Odisha reflected limited visibility of programme implementation at primary care level, with the need for strengthening documentation, indicators, and reporting systems.
- Chhattisgarh established governance structures and line-listing of suspected death due to climate change related; however, gaps were observed in training (e.g., air pollution-related diseases), IEC visibility, and availability of mortality data.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- NCD services were well institutionalized at AAM-SHC and AAM-PHC levels with population-based screening, availability of essential diagnostics and drugs, and maintenance of digital records; however, gaps persist in continuity of care, follow-up of chronic cases, referral linkages, and integration of counselling, mental health, and lifestyle modification services.
- Maternal and child health services show good ANC coverage, risk stratification, and HBNC/HBYC implementation; however, gaps were observed in follow-up of high-risk pregnancies in remote areas, early breastfeeding practices, structured monitoring of newborn care, and consistency in counselling services.
- Immunization and VHSND services were regularly conducted with strong community participation and due-list tracking; however, challenges remain in reaching remote populations, adherence to cold chain and vaccine management protocols, and completeness of AEFI documentation.
- Family planning services had availability of commodities and awareness among frontline workers; however, uptake of long-acting reversible contraceptives remains low, with gaps in counselling, trained providers for IUCD insertion, documentation, and adolescent-focused IEC activities.
- Communicable disease programmes, including TB and public health surveillance, were operational with screening and reporting systems in place; however, gaps persist in NAAT-based TB diagnosis, follow-up after referral, DBT delays due to Nikshay-IFMS integration issues, and reporting challenges in remote areas due to connectivity constraints.
- School health, adolescent health, and mental health services were being implemented; however, gaps were observed in regular sessions, psychosocial counselling, integration of mental health screening at primary level, and training of frontline workers.
- Elderly and palliative care services were being delivered through home-based care models under the Family Doctor Programme; however, gaps remain in availability of assistive devices, structured follow-up protocols, and consistency of services in remote areas.
- Laboratory, diagnostics, and drug logistics systems support primary care delivery through functional linkages and availability of essential medicines; however, inconsistencies in sample transport, equipment calibration, stock management, and digital record updating affect service quality and continuity.

Assam

- NCD programme implementation shows key foundational elements in place, including CBAC-based risk assessment by ASHAs, availability of NCD tracking bags,

and awareness among frontline workers, with outreach through VHOP improving access in tea gardens and remote areas.

- Cancer screening has been strengthened through partnerships (e.g., Assam Cancer Care Foundation), with improvements noted in cervical cancer detection in some districts; however, cervical cancer screening was not observed at primary facilities visited.
- NCD services at primary level remain limited in scope, largely restricted to screening for hypertension and diabetes, with expanded service packages not yet operationalized.
- Follow-up and control of diagnosed NCD cases remain weak, with patients frequently shifting between public and private sectors and incurring out-of-pocket expenditure despite availability of medicines at government facilities.
- Wellness and health promotion activities at AAM level were minimal, largely limited to display-based IEC and observance of health days, with limited structured counselling or outreach on risk factors such as tobacco, alcohol, and mental health.
- Mental health services at primary level remain limited, with Tele-MANAS numbers displayed but minimal orientation of staff, absence of counsellors at PHC level, and negligible community-level mental health promotion.
- Service delivery at AAM and PHCs remains uneven across districts, with RMNCH and basic NCD services available but limited visibility and implementation of the expanded CPHC package, particularly in remote and tea garden areas.

Bihar

- Maternal health services include maintenance of line lists and high-risk pregnancy identification; however, gaps persist in complete ANC coverage, tracking and follow-up of high-risk pregnancies, and high referrals from APHC/SHC to higher facilities.
- Family planning services provide a basket of choice with functional FPLMIS usage and good uptake of Antara in visited districts; however, gaps include non-availability of IUCD insertion and CAC services at primary level, low retention of PPIUCD, and need for improved counselling and follow-up.
- Immunization services were being conducted with planned RI sessions and AEFI reporting; however, micro plans were incomplete, and none of the visited facilities functioned as cold chain points.
- Child health and nutrition services were being implemented with availability of growth monitoring tools; however, gaps were observed in availability of infantometers and absence of anaemia screening records at facilities.
- Adolescent health services show gaps with absence of dedicated AFHC spaces, inadequate menstrual hygiene services, and weak school health programme convergence.

- Communicable disease programmes were operational; however, gaps persist in TB programme (poor follow-up, weak active case finding, Nikshay portal issues), stigma in leprosy detection, suboptimal screening under NVHCP, and gaps in vector-borne disease reporting and record maintenance.
- NCD and other programmes were being implemented with screening for common cancers and portal-based reporting; however, gaps include incomplete portal entries, non-use of NCD app by ASHAs, weak counselling services, limited elderly care tracking, manpower shortages under mental health programme, and inadequate supervision and programme monitoring beyond key RMNCH activities.

Chhattisgarh

- Maternal health services were functional with availability of infrastructure, PMSMA implementation, and DBT under JSY; however, high MMR (146), weak follow-up of high-risk pregnancies, instances of high-risk deliveries at SHC level, non-use of Safe Birth Checklist, and gaps in referral and monitoring systems were observed.
- Family planning services provided a basket of choice with adequate awareness among providers; however, gaps persist in commodity availability (Antara, ECP), low uptake of spacing methods, irregular sterilization services due to HR constraints, weak documentation, and supply chain issues.
- Immunization services were largely satisfactory with functional cold chain, microplanning, and U-WIN usage; however, gaps were observed in newborn dose coverage in hard-to-reach areas, stock discrepancies (e-VIN vs physical), incomplete AEFI preparedness, and operational issues in vaccine delivery mechanisms.
- Child health and nutrition services were being implemented with growth monitoring, HBNC visits, and supplementary nutrition through AWCs; however, gaps persist in equipment functionality (Hb meters), IFA availability, weak ANM–AWW convergence, and limited effectiveness of screening, referral, and follow-up mechanisms.
- Communicable disease programmes (TB, leprosy, hepatitis, vector-borne diseases) were operational with improved diagnostics and treatment outcomes; however, gaps remain in decentralized TB care (limited PHC role), delays in DBT, suboptimal active case finding, continued leprosy burden with delayed detection, low HRG screening for hepatitis, and ongoing challenges in filariasis control.
- NCD and other public health programmes were being implemented with screening for hypertension and diabetes; however, gaps include incomplete 30+ population screening, weak follow-up and adherence, limited cancer screening due to supply constraints, inadequate referral linkages, and low utilization of primary-level management.
- Adolescent health, elderly care, palliative care, and mental health services were partially implemented; however, gaps persist in AFHC functionality, IFA availability

under WIFS, limited geriatric and palliative care services, training gaps, and non-operational Tele-MANAS services.

Kerala

- Primary healthcare services under National Health Programmes, including RCH, NCDs, TB, geriatric, mental health, and palliative care, were being delivered through outreach-based implementation of service packages at AAM level.
- NCD services including screening for hypertension, diabetes and breast cancer were being conducted; however, screening remains largely opportunistic, with gaps in universal screening, follow-up, and patient tracking.
- Screening services for cervical cancer (VIA), oral health, and ENT care were not being provided at all primary-level facilities, with patients referred to higher facilities for these services.
- Immunization services were being implemented with the use of U-WIN, maintenance of due lists, and adherence to cold chain protocols.
- Palliative care services were being provided through home visits by primary healthcare teams, and mental health services were delivered through periodic visits by district mental health teams; however, gaps remain in primary-level screening and trained manpower.

Madhya Pradesh

- Service delivery at primary healthcare facilities was largely concentrated on RMNCHA+N interventions and communicable diseases such as malaria, TB and leprosy, with limited progress observed in the rollout of the Expanded Package of Services (EPS), particularly for eye and ENT care, geriatric and palliative care, mental health, and emergency services.
- Limited rollout of EPS was attributed to the absence of adequate training of primary healthcare teams on newer service packages.
- NCD screening was primarily focused on hypertension and diabetes, while screening for common cancers (oral, breast, and cervical) was being conducted in a limited manner.
- Family planning services were available with a basket of choice at AAM, along with dedicated family planning corners and ORS corners at facilities.

Maharashtra

- Reproductive and maternal health services were being implemented with availability of ANC/PNC services and tracking under PMSMA/E-PMSMA; however, gaps were observed in completeness of MCP records, inadequate high-risk pregnancy (HRP) identification and tracking (particularly in Nandurbar), high teenage pregnancies, continued instances of home deliveries due to transport constraints, early discharge post-delivery, and limited awareness of JSY benefits among beneficiaries.

- Family planning services were supported by trained ANMs/ASHAs and use of counselling tools; however, gaps persist in limited FP counselling (especially in Nandurbar), low uptake of injectable methods, non-display of IEC materials, and low community awareness of available methods, with ASHAs not routinely distributing condoms.
- Child health services include newborn care and immunization; however, gaps were observed in newborn care infrastructure (lack of equipment such as radiant warmers at some facilities), risk of birth asphyxia due to delayed arrivals and poor intrapartum care, high prevalence of low birth weight, and limited effectiveness of growth monitoring and RBSK activities due to low attendance at AWCs and schools.
- Adolescent health and nutrition services show gaps with limited engagement of peer educators, non-availability of sanitary napkins for extended periods, poor menstrual hygiene practices, high prevalence of anaemia and undernutrition (particularly in Nandurbar), suboptimal complementary feeding practices, and incomplete data/reporting (e.g., Poshan Tracker).
- Communicable disease programmes were being implemented; however, gaps were observed in TB screening due to lack of handheld X-ray machines, low uptake of TB preventive therapy, limited mobility support for outreach, non-adherence to NVBDCP reporting formats, delays in malaria diagnostics, shortages of antimalarial drugs and diagnostics, and gaps in IDSP training and reporting.
- Non-communicable disease and other programmes were partially implemented with ongoing screening activities; however, gaps persist in CBAC-based population screening and data quality, limited opportunistic screening, weak follow-up and tracking of NCD patients, lack of primary-level elderly and palliative care services, low awareness of Tele-MANAS, absence of dental services at PHC level, delays in spectacle distribution, and infrastructure/equipment gaps for NPCBVI and NPPCD services.

Meghalaya

- Immunisation services were functioning with high coverage supported by microplanning and functional cold chain systems; however, pockets of low routine immunisation coverage persist in East Khasi Hills (EKH).
- Vector-borne disease control programmes have led to a significant reduction in malaria incidence in both districts, supported by active surveillance and LLIN coverage.
- Tuberculosis services were being implemented with AAM linked to DMCs and sputum collection points; however, gaps remain in awareness and follow-up mechanisms, particularly in remote villages.
- Leprosy and NCD programmes have been integrated with routine OPD services across most Health and Wellness Centres.

Nagaland

- RMNCHA+ services including ANC, PNC, institutional and home deliveries, and newborn care were available across most facilities, with regular VHSNDs and HBNC visits; however, gaps were observed due to shortage of Medical Officers, weak labour monitoring (partograph, foetal doppler), compromised referral due to poor connectivity, and cultural practices affecting biomedical waste management.
- Family planning services had availability of contraceptives and IEC materials; however, limited availability of Antara, low uptake due to socio-cultural factors, inadequate counselling and documentation, lack of IUCD services at some facilities, and absence of comprehensive abortion care services were observed.
- Immunisation services were operational with well-maintained due lists, availability of vaccines, and outreach in remote areas despite difficult terrain; however, gaps were observed in e-VIN functionality, improper cold chain practices in some facilities, and increased workload due to access challenges.
- Child health and nutrition services included breastfeeding counselling and anaemia management with availability of IFA; however, gaps were observed in screening and documentation for under-five children and SAM cases, non-availability of digital haemoglobinometers, and limited training and awareness under WIFS and school-level programmes.
- Communicable disease programmes showed availability of drugs and basic services; however, gaps were observed in TB programme implementation (lack of active case finding, line listing, and drug availability at SHC level), non-visible activities under leprosy, and connectivity issues affecting reporting and surveillance systems.
- Non-communicable disease and other public health programmes were partially implemented, with ongoing screening for hypertension and diabetes; however, gaps persist in cancer screening, referral and follow-up systems, programme visibility (NPCBVI, NPPCD, NMHP, NIDDCP, NPPC), availability of drugs (psychotropics), infrastructure for elderly care, counselling services, and utilisation of digital platforms due to connectivity constraints.

Odisha

- Maternal health services show improvement in ANC registration (79% to 87%) with high early registration (95%) and widespread IFA coverage (98%), along with functional VHSND/UHND platforms and PHC-level delivery services; however, decline in ANC check-ups (87% to 80%), high maternal mortality (MMR 153), reported maternal deaths, and gaps in follow-up and referral of high-risk pregnancies indicate challenges in continuity and emergency care.
- Family planning services were supported by adequate commodity availability and functional FPLMIS with proper record maintenance; however, low acceptance of IUCD and injectable Antara, inadequate provider competency for IUCD insertion at SHC level, and limited counselling and follow-up were observed.

- Immunisation services were being implemented with adequate vaccine supply, functional cold chain, and use of U-WIN; however, decline in full immunisation coverage (92% to 86%), gaps in AEFI reporting and data entry on U-WIN, non-adherence to open vial policy, and issues in vaccine storage practices were noted.
- Child health, adolescent health, and nutrition services including NBCC, breastfeeding practices, RBSK screening, WIFS, and Anaemia Mukht Bharat were being implemented with availability of equipment and trained staff; however, high neonatal contribution to child mortality, need for strengthening postnatal follow-up, and gaps in supplementation coverage and consumption persist.
- Communicable disease programmes including TB, leprosy, hepatitis, and vector-borne diseases were operational with availability of drugs and screening services; however, delays in Nikshay ID generation and patient tracking, gaps in TB laboratory diagnostics, lack of timely leprosy diagnosis and follow-up, shortages of certain diagnostics/drugs, and connectivity issues affecting reporting were observed.
- Non-communicable disease and other public health programmes (NP-NCD, NPHCE, palliative care, mental health, oral health, NPCBVI, NTCP, IDSP, etc.) were being implemented with ongoing screening and service delivery; however, gaps remain in coverage and follow-up of NCD screening, delayed data entry, weak referral mechanisms, limited specialist HR, infrastructure and equipment gaps, inconsistent reporting, and need for strengthening programme convergence, documentation, and service standardization at primary care level.

Punjab

- Maternal health services were well established with high early ANC registration (>90%), functional SUMAN-notified delivery points, availability of essential infrastructure and protocols, and effective implementation of PMSMA and JSSK; however, gaps were observed in non-availability and non-distribution of folic acid in the first trimester, need for refresher training on partograph use, and concerns regarding high rates of LSCS at higher facilities.
- Family planning services indicate achievement of replacement-level fertility (TFR 1.6) with adequate awareness and availability of contraceptives; however, programme focus remains skewed towards female sterilization, with low uptake of spacing methods (e.g., Antara), compounded by misinformation among providers and community.
- Immunization services were available with microplanning, complete due lists, high coverage with no missed children, and strong AEFI reporting; however, gaps were observed in UWIN usage (particularly by NHM staff and ASHAs), incomplete MCP card entries in some areas, and supply issues related to appropriate strength of paracetamol syrup.
- Child health and nutrition services show strong performance with low mortality indicators, effective HBNC visits, anaemia screening using digital haemoglobinometers, and active RBSK implementation; however, gaps were noted

in need for refresher training on newborn care, strengthening of child death reviews, and limited availability of DEICs in some districts.

- Communicable disease programmes, including TB, leprosy, and hepatitis, were being implemented with active community engagement and functional screening and referral systems; however, gaps were observed in limited screening of asymptomatic high-risk populations for TB, delays in DBT under Nikshay Poshan Yojana, non-operational aspects of leprosy surveillance, gaps in hepatitis documentation and vaccination of healthcare workers, and need for refresher training.
- Non-communicable disease and other public health programmes were operational with screening and medicine availability; however, gaps persist in limited scope of screening (restricted to HTN/DM), non-availability of CBAC forms, weak follow-up and compliance, absence of cancer screening, limited functionality of programmes such as NPPCD, NOHP, NPHCE, mental health, fluorosis, and IDSP reporting gaps, along with deficiencies in infrastructure, training, IEC, and programme convergence at primary care level.

Rajasthan

- Maternal health services were available with line listing of pregnancies, availability of essential commodities, and regular PMSMA sessions; however, deliveries were largely not conducted at AAM/UPHC level due to preference for District Hospitals.
- Immunization services were available with use of PCTS for due lists, regular vaccination sessions, and functional e-VIN system; no missed cases or AEFI were reported during the assessment.
- Family planning services provide a basket of contraceptive choices with proper documentation and referral for sterilization services; however, no information on use of FPLMIS was available.
- Child health and nutrition services including availability of essential equipment and anaemia screening, though implementation of school-based programmes was limited due to absence of schools in the catchment area.
- Communicable and non-communicable disease programmes were being implemented; however, gaps were observed in TB active case finding and TPT follow-up, non-operational leprosy surveillance and Nikusth portal, suboptimal implementation of NPCBVI, NPPCD, NPHCE, palliative and mental health services, limited NCD outreach and convergence, inadequate IDSP reporting, and gaps in availability/documentation under NRCP and ASV availability at PHC level.

Sikkim

- Maternal health services were largely aligned with national guidelines, with effective line listing, timely ANC/PNC follow-up, availability of essential commodities, functional referral of high-risk pregnancies, and adherence to delivery protocols; however, minor gaps were observed in diet provision, transport reimbursement under JSSK, and availability of SUMAN volunteers at some facilities.

- Family planning and CAC services with availability of a full basket of contraceptives, use of FPLMIS, proper documentation, and regular counselling were observed; however, fixed-day sterilization services remain limited due to dependence on district teams, and occasional last-mile supply issues result in short-term stock-outs.
- Immunization and child health services were robust, with strong microplanning, functional cold chain and e-VIN systems, active use of U-WIN, and effective tracking of beneficiaries; nutrition and anaemia services under AMB show good convergence, though periodic stock-outs of supplements and limited availability of functional haemoglobinometers in remote AAM were noted.
- Adolescent health, school health, and outreach programmes (RKSK, WIFS, AFHCs) were actively implemented with trained peer educators, availability of commodities, and regular sessions; however, implementation quality varied across facilities.
- Communicable and non-communicable disease programmes were well established, with effective TB screening and treatment adherence mechanisms, functional surveillance systems, and comprehensive NCD screening and management; however, delays in DBT under Nikshay Poshan Yojana, internet connectivity issues affecting real-time data entry, and gaps in universal ANC screening for Hepatitis B and referral mechanisms were observed.

Tamil Nadu

- Maternal health services were largely centralized at District Hospitals and designated CEmONC centres, with around 56% deliveries occurring in government facilities and 89% of these at CEmONC centres; however, this has led to underutilisation of peripheral PHCs for deliveries, increased travel time, and additional out-of-pocket expenditure for populations in remote areas.
- RBSK teams were actively screening children for the “4 Ds” (Defects at birth, Diseases, Deficiencies, and Developmental delays), with functional DEICs in place—Salem demonstrating a robust multidisciplinary team including paediatricians, physiotherapists, and special educators.
- NCD services have been strengthened through the ‘Makkalai Thedi Maruthuvam’ (MTM) scheme with doorstep delivery of medicines and large-scale screening for hypertension, diabetes, and cancers, supported by involvement of AYUSH practitioners; however, gaps were observed in follow-up of referred cases and non-functionality of certain diagnostic services (e.g., oral biopsy at Tenkasi DHQ).
- Mental health, palliative care, and elderly care services were being implemented through initiatives such as Tele-MANAS, ‘MaNaM’, and MTM-based home care; however, gaps remain in primary-level mental health screening, training of staff for palliative care (including use of narcotics), and utilisation of geriatric assessment tools (ADL/MMSE).

- Infrastructure and service delivery for ophthalmic and dental care were available at higher facilities; however, delays in spectacle distribution and limited availability of dental drugs at AAM-SHC level were observed.

Telangana

- Maternal health services demonstrated strong performance with high institutional deliveries (99.9%) supported by JSSK, robust screening for high-risk pregnancies (28.3%), and extensive training of health personnel; however, government institutional deliveries remain around 51%, indicating continued reliance on private sector.
- Family planning services show mixed performance, with high uptake of oral pills and condoms, while female sterilization remains moderate and male sterilization very low; uptake of IUCD/PPIUCD and Antara injectables remains limited, indicating gaps in spacing methods and injectable contraception.
- Child health services were with functional SNCUs, NBSUs, NRCs and digital mentoring support (e-SNCU) along with high coverage under National Deworming Day was observed. RBSK implementation shows large-scale screening and strong treatment linkage supported by mobile health teams and DEICs.
- Comprehensive Primary Health Care services include large-scale screening for hypertension and diabetes, with significant population coverage and integration of wellness activities; however, concerns exist regarding quality of screening, low proportion of confirmed and controlled cases, and need for strengthening follow-up.
- Communicable disease programmes show strong performance with high TB notification and treatment success, extensive screening of vulnerable populations, and effective vector-borne disease control; however, gaps remain in uptake of TB preventive therapy and nutritional support coverage.
- Disease control and surveillance systems, including NVHCP and IDSP, demonstrate high screening coverage, strong reporting compliance, and functional outbreak response mechanisms, supported by established treatment centres, laboratory networks, and surveillance systems across the State.

Uttar Pradesh

- Family planning services have shown improvement with use of FPLMIS up to SHC level and integration of counselling across service delivery points; oral pills, condoms, and Chhaya were commonly used methods.
- RBSK and RKSK programmes were being implemented with large-scale screening, peer educator engagement, and distribution of IFA and sanitary pads.
- NCD screening under CPHC was being conducted at scale for hypertension and diabetes using digital platforms; however, concerns were observed regarding

quality of screening and follow-up, with a very low proportion of confirmed and controlled cases.

- TB services at primary level include active case finding, screening of vulnerable populations, and use of Nikshay; however, DBT payments under Nikshay Poshan Yojana were on hold due to SNA-SPARSH issues, and gaps remain in TB preventive treatment and follow-up.
- Key system-level gaps at primary care include limited training of CHOs (e.g., palliative care and cancer screening), under-utilisation of infrastructure, gaps in digital integration (e-Kavach, UDSP), suboptimal use of DVDMS, weak community-level documentation and counselling, and challenges in service access in difficult areas, including preference for private facilities and limited availability of services during evening/night.

Uttarakhand

- Maternal health services including ANC and PNC were available across visited facilities, with line listing and due lists maintained; however, gaps were observed in completeness of MCP card entries, non-uniform maintenance of high-risk pregnancy registers, non-availability of digital haemoglobinometers in most facilities in US Nagar, and stock-outs of Calcium, Vitamin A and Antara injections in US Nagar district.
- Service delivery in remote areas was affected by geographical constraints, with home deliveries reported in inaccessible areas of Chamoli; palki services were being utilised for patient transport, while delays in care-seeking and lack of awareness among ASHAs regarding incentives for high-risk pregnancies and PNC care were observed.
- Family planning services were being implemented with availability of contraceptive choices and use of FP-LMIS; however, supply gaps of Antara injections and Mala-N, limited availability of IEC materials, improper placement of self-care kits, and gaps in maintenance of records on complications of PPIUCD/IUCD were observed in facilities, particularly in US Nagar district.
- Immunisation services were operational with functional cold chain, use of U-WIN, and maintenance of due lists; however, gaps were observed in maintenance of missed lists, instances of missed BCG doses, concerns related to e-VIN practices, and dropouts among migrant populations.
- Child health and nutrition services including HBNC, growth monitoring, anaemia screening, and RBSK were being implemented, with use of AMB portal; however, gaps in documentation of follow-up, inadequate staffing under RBSK, and gaps in training and record maintenance under school health programmes were observed.
- Communicable and non-communicable disease programmes were being implemented; however, delays in DBT under Nikshay Poshan Yojana, low uptake of TB preventive therapy, limited availability of diagnostics and medicines in certain

facilities, non-availability/expired stock of ASV in some facilities, gaps in NCD screening (cervical cancer), and weak referral and follow-up mechanisms were observed.

BEST PRACTICES

The Family Doctor Programme- Andhra Pradesh

The Family Doctor Programme represents an innovative strategy to bring primary care closer to households, especially for population in rural and tribal regions. Under this model, Medical Officers and frontline workers conduct outreach services twice every month, covering villages systematically and ensuring provision of healthcare at the doorstep of patients. The CRM team noted that the programme has significantly improved access for elderly individuals, bedridden patients, and those with chronic diseases. Home-based care, delivery of essential medicines, and on-site management of minor ailments have reduced the need for facility visits and thereby lowered the indirect costs borne by the families. Despite its strengths, the effectiveness of the Family Doctor Programme varies across districts. In Chittoor district, where the road connectivity was relatively better, the outreach teams were punctual and coverage was high, whereas, in Parvathipuram Manyam district, the difficult terrain and limited transport facilities had posed a challenge in increasing the frequency and duration of these home visits. The workload of Medical Officers in high-population clusters led to lesser time for facility-based service delivery. The documentation was often meticulous; however, the clinical follow-up plans were not always executed consistently due to time and manpower limitations.

The Care Companion Programme- Andhra Pradesh

The Care Companion Programme, which is being implemented equips families with practical skills to support the newborn and maternal care at home. It was observed that a structured counselling material, such as visual flipcharts, a demonstration doll, breastfeeding and hand-expression aids, and nutrition IEC in the local language were found to be used for caregivers' education. These tools enable hands-on learning for family members on essential home-based practices including newborn handling, breastfeeding support, hygiene and nutrition. By providing clear and practical guidance in an interactive format, the programme strengthens continuity of care after discharge and enhances caregivers' confidence in managing newborn and maternal health needs.

National Programme for Healthcare of the Elderly (NPHCE)- Chhattisgarh

The Siyan Jatan Clinic, initiated in Chhattisgarh in 2022 under the National Programme for Health Care of the Elderly (NPHCE), is a dedicated health service exclusively for senior citizens aged 60 years and above, and is aimed at ensuring comprehensive and age-appropriate healthcare. The "*Weekly Siyan Jatan Clinics*" were being organized at the Ayushman Arogya Mandir-Primary Health Centre (AAM-PHC) level, using a fixed-day approach on weekly basis i.e. every Thursday and were conducted across both rural and urban health facilities, providing services at the primary, secondary, and tertiary levels of care. Under the programme, yellow colour-coded health cards were being issued to

all elderly beneficiaries to record their medical history, ongoing treatment, and follow-up details, facilitating personalized and continuous care. The clinics offer a wide range of services, including screening and management of chronic conditions such as Hypertension and diabetes with regular medicine supply, vision and hearing assessments with the provision of spectacles and hearing aids, dental screening and treatment, and specialists' medical camps for specific geriatric health concerns. In addition, wellness activities such as yoga sessions were organized to promote physical and mental well-being, while walking sticks were being distributed to support mobility, collectively strengthening geriatric healthcare services and improving the quality of life of elderly populations in the state.

Individual Patient NCD Card and use of NPNCN Portal- Chhattisgarh

In Chhattisgarh, the NP-NCD portal is used for the digital management of chronic disease patients, linked with ABHA IDs, ensuring a seamless continuum of care for individuals aged 30 years and above. The key aspect of the portal system was that it could provide patients with an individual patient card that is equipped with the individual patient history for effective facilitation, tracking, and management of screening, diagnosis, treatment, and follow-up especially for hypertension, diabetes, and of the oral cavity, cervix, and breast cancers. The portal supports opportunistic screening, identification of high-risk individuals, referral to higher facilities, and long-term tracking of patients for treatment adherence.

Mother's Picnic of Chhattisgarh

The Mother's Picnic, organized in Chhattisgarh on the 9th day of every month, as part of the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA), is an innovative initiative aimed at improving quality of antenatal care (ANC) services during their second and third trimesters of pregnant women. The programme combines comprehensive ANC check-ups with focused counselling on maternal health services, including provisions under the SUMAN initiative, Respectful Maternity Care (RMC), and gender equality. A distinctive feature of the Mother's Picnic is the guided tour of healthcare facilities, allowing expectant mothers particularly those residing in remote and underserved areas for familiarizing themselves related to labour rooms, maternity wards, and available services. This exposure helps reduce anxiety, builds trust in the health system, and reassures women about safe and dignified care during childbirth. Alongside clinical services, structured counselling sessions address key issues such as nutrition, birth preparedness, women's rights, and informed decision-making, thereby empowering pregnant women with knowledge and confidence to seek timely and appropriate maternal healthcare.

Palliative Care Grid-Kerala

The Palliative Care Grid is a state-wide digital platform developed by the Health Department and Local Self-Government Department in collaboration with Kerala Digital University to coordinate home-based palliative care services across the state. It maintains a unified registry of palliative care patients, service providers, and volunteers, enabling structured care coordination and follow-up. The platform provides real-time dashboards at all administrative levels for the purpose of monitoring and ensuring transparency. The key features of the initiative include a Unified Registry that centrally registers palliative care

patients, especially the bedridden patients, and also registers palliative care units including government hospitals, NGOs and voluntary organizations. Through the Sannadha Sena portal, volunteers can sign up, and the system facilitates structured care coordination and follow up by clearly outlining when and how home visits are to be conducted. It includes dashboards at the state, district, panchayat, and ward levels for monitoring palliative care services, with an additional dashboard which is publicised for ensuring transparency. The volunteers receive appropriate training (for instance – visiting bedridden patients) to maintain quality of care services. The platform maintains a directory of all palliative care providers at public healthcare facilities including private/NGO run facilities, track infrastructure, human resources for health, drugs, service availability through the Grid, that enables sharing data between institutions and supports tele-consultations and mutual mentorship.

Nirnaya (Nava Kerala integrated referral network for advanced diagnostics and care at Hub & Spoke lab network), Kerala

Nirnaya (Nava Kerala Integrated Referral Network for Advanced Diagnostics and Care) is a hub-and-spoke laboratory network which is integrated with the state's e-Health system to ensure standardized and quality diagnostic services across public health facilities in Kerala. Under this model, diagnostic samples collected at spoke laboratories are transported to hub laboratories located in major hospitals and Block Public Health Units through a collaboration with the Indian Postal Service. In Kottayam district, the network currently comprises 23 hub laboratories, 82 spoke laboratories, and 17 Urban Health and Wellness Centres (UHCs)/AAM-USHCs functioning as sample collection and transport points. The initiative standardizes diagnostic services by defining 62 basic laboratory tests at spoke labs and up to 131 tests at tertiary hub laboratories, covering domains such as basic and complex laboratory tests, antimicrobial resistance surveillance, metabolic screening, TB and cancer screening, outbreak investigation, and diagnosis of infectious disease and monitoring. The test results are integrated with the state e-Health portal and can be accessed by patients through SMS or mobile applications. The system also includes provisions for home-based blood sample collection in selected institutions, improving accessibility of diagnostic services. However, the initiative is yet to be scaled up in certain districts such as Kasaragod and others.

Cough Against TB: AI-Powered Screening for Pulmonary Tuberculosis- Nagaland

Cough Against TB is an artificial intelligence–powered mobile application to support India's fight against tuberculosis through early, accessible, and accurate screening. The tool serves as a non-invasive, no-cost, point-of-care screening method that detects potential pulmonary TB cases by analysing the cough sounds in combination with symptom and co-morbidity data. It was designed for ease of use by the healthcare workers, as the app operates on Android smartphones and can function even in offline environments, providing results within three to five seconds. The app uses an ensemble AI model that combines acoustic analysis of cough sounds with clinical information such as symptoms and comorbidities to determine whether an individual is likely to have TB or not. With a reported sensitivity of 91% and specificity of 69%, the model demonstrates robust performance in real-

world settings. The tool's integration with the national NIKSHAY system ensures that all presumptive TB cases are linked to diagnostic and treatment pathways under the National TB Elimination Program (NTEP).

National Mental Health Programme (NMHP)- Sikkim

Sikkim has made exemplary progress in strengthening mental health services under the National Mental Health Programme. The State's leadership in developing the State Mental Health Strategy (2025–2030), operationalizing the Suicide Prevention Action Network (SPAN) in collaboration with NIMHANS, institutionalizing the youth mental health partnerships, and launching the SWASTH-MANN self-screening app demonstrates a holistic and forward-looking approach. The integration of Tele MANAS, availability of trained human resources, and consistent supply of psychotropic medicines reflect a robust mental health delivery system.

NCD Notebook for Families- Sikkim

In the state across the visited facilities, the patients were provided with a booklet on NCDs, which records the details of the beneficiary for ease of follow-up and for treatment adherence. The booklet contains the basic information of the patient such as dates of visits to NCD clinic, ABHA ID details, age, sex, etc. Furthermore, the booklet also captures the medical history of the patient for identifying risk factors. The information on NCD awareness has also been incorporated into the booklet, such as the dietary habits, avoiding tobacco, alcohol consumption and adoption of regular physical exercise etc. The booklet is primarily aimed to capture the data on treatment adherence of the NCD medication the patients were prescribed at the AAM-PHC, and follow-up by healthcare providers.

Integrated Diabetic Foot care program “Padham Padhukaappom Thittam (PPT)” – Tamil Nadu

The Government of Tamil Nadu, through its strong public health system and progressive Non-Communicable Disease (NCD) initiatives, TN–Integrated Diabetic Foot Care Programme – “Padham Padhukaappom Thittam (PPT)” to address diabetic foot complications across primary, secondary, and tertiary levels of care, with an emphasis on prevention, early intervention, and continuity of care. The programme is based on a successful pilot implemented in Thanjavur district under the NHM. The key outcomes included early identification of foot complications, streamlined referral pathways, strengthened surgical capacity, development of a state-level digital diabetic foot database, and improved patient follow-up. The programme represents a significant step towards comprehensive diabetic foot care and lays out the groundwork for the future institutionalisation of podiatry services in the state.

Birth Waiting Room (BWR)- Tribal pre-birth planning initiative -Tamil Nadu

The Birth Waiting Room (BWR) initiative is a targeted tribal health intervention designed to improve maternal and neonatal outcomes by facilitating pre-delivery accommodation for expectant mothers from remote and geographically challenging areas. The BWR provides

free stay for up to seven days for pregnant tribal women along with one attendant, ensuring access to nutritious food, essential screening, institutional monitoring for high-risk conditions, and post-delivery transport at no cost. This advance admission strategy has strengthened institutional deliveries and contributed to reductions in IMR and MMR. The initiative was piloted during 2008-09 in two PHCs in Dharmapuri and Krishnagiri districts. Following the positive outcomes, it was scaled up to 15 additional PHCs in tribal and foothill areas across the state. Under PIP 2024-26, four more BWRs were approved, increasing the total to 21 functional centres. The BWR at Valavanthi PHC, Yercaud Block, Salem district was observed, and between January 2025 to October 2025, a total of 233 women were admitted, of which 208 were kept under observation, 14 deliveries were conducted, and 10 cases were referred to higher centres. The initiative has been particularly beneficial in enabling early detection and timely management of Pregnancy-Induced Hypertension (PIH) among tribal mothers in Salem district.

Comprehensive Job Aids for Counselling on Sickle Cell Anaemia-Tamil Nadu

A high burden of hemoglobinopathies, particularly sickle cell anaemia, was observed among the tribal population in Yercaud block of Salem district in Tamil Nadu. Through discussions with the state and field level officials, it was observed that such genetic disorders represent a significant public health concern in the block. During community interactions, it was revealed that a majority of the marriages take place within the same tribal communities in the Yercaud block of Salem district and adjoining areas of Namakkal district. This endogamous practice has contributed to the continued transmission and higher prevalence of hereditary disorders, including hemoglobinopathies. A notable best practice was observed regarding the use of standardized job aids for genetic counselling, which was implemented specifically in Yercaud block, demonstrating a localized and focused intervention. Regular education and awareness sessions are being conducted among vulnerable tribal communities to enhance their understanding of hereditary conditions and thereby promoting early screening. Genetic counselling services were delivered by PHC teams, and in the community, particularly by ASHAs and designated counsellors. Additionally, Mobile Medical Units (MMUs) support outreach and counselling services in hard-to-reach habitations, thereby ensuring wider community coverage and access.

Color-coded ANC cards in Tamil Nadu

Salem district in Tamil Nadu has introduced a low-cost, color-coded ANC card system for strengthening antenatal care monitoring and follow-up. Each healthcare facility is assigned a unique colour, enabling easy identification of the registration point during follow-ups, outreach, and referrals. This simple system has improved beneficiary tracking, strengthened inter-facility coordination, and enhanced accountability, reducing the missed or delayed ANC visits.

The ANC card also ensures regular recording of maternal weight from early pregnancy, supporting continuous monitoring and early identification of high-risk conditions such as pre-eclampsia. Overall, the color-coded ANC card system represents a practical, cost-effective, and easily replicable innovation to enhance the quality and continuity of antenatal care.



HEALTH PROMOTION & WELLNESS

17th

HEALTH PROMOTION & WELLNESS

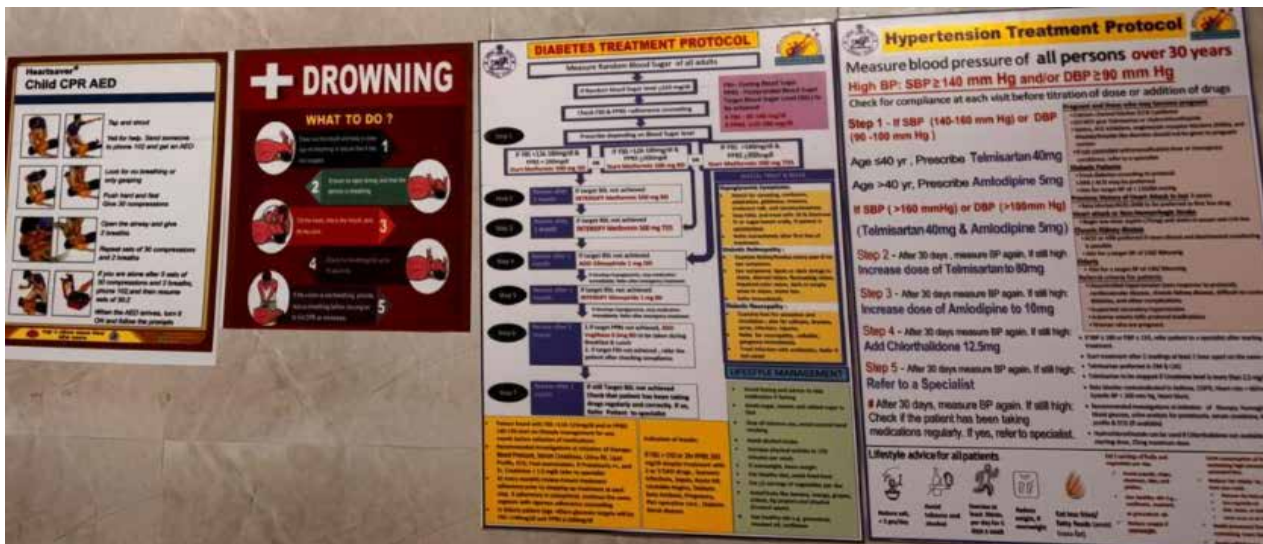
NATIONAL OVERVIEW

Health Promotion and Wellness initiatives under the Comprehensive Primary Health Care (CPHC) framework have been operationalised across states through AAM, reflecting an increasing emphasis on preventive and promotive healthcare services. CRM observations indicated that health promotion activities were largely embedded within existing service delivery platforms such as Village Health Sanitation and Nutrition Days (VHSNDs), outreach sessions, school health programmes, and routine OPD interactions. Preventive screenings for hypertension, diabetes and other priority conditions, along with counselling related to maternal health, nutrition and lifestyle modification, were commonly observed across states, indicating progress towards population-based preventive care under CPHC.

IEC materials and facility-based awareness activities were widely available across states, supporting dissemination of key health information related to maternal and child health, nutrition, communicable diseases and non-communicable diseases. States had also leveraged outreach mechanisms such as *health melas*, fixed-day camps, and home-based services to extend service coverage, particularly in underserved and geographically constrained and hard-to-reach areas. Wellness activities such as yoga sessions, outreach camps and health awareness sessions were observed in several states, reflecting gradual integration of wellness services within primary healthcare delivery. In some states, convergence of wellness activities with outreach and school health platforms have contributed to improved community engagement and service uptake. State specific innovations and good practices including care-giver counselling, youth mental health helplines, community awareness events, and intersectoral approaches for disease control have further enhanced outreach and strengthened service delivery, particularly in remote and underserved populations.

While notable progress has been observed, there remains scope to further strengthen the depth, consistency, and scope of health promotion activities across states. Counselling services were frequently programme-driven and limited to service encounters rather than structured and continuous behaviour change communication approaches. Expanded wellness components under CPHC, including mental health promotion, geriatric care, and palliative care services, remain variably operationalised across states. Limited availability of trained human resources, competing service delivery priorities, and variability in infrastructure and availability of dedicated spaces for wellness and counselling activities affected implementation in several states. Outreach-based health promotion activities were also reported to be irregular in certain settings, particularly in geographically difficult areas.

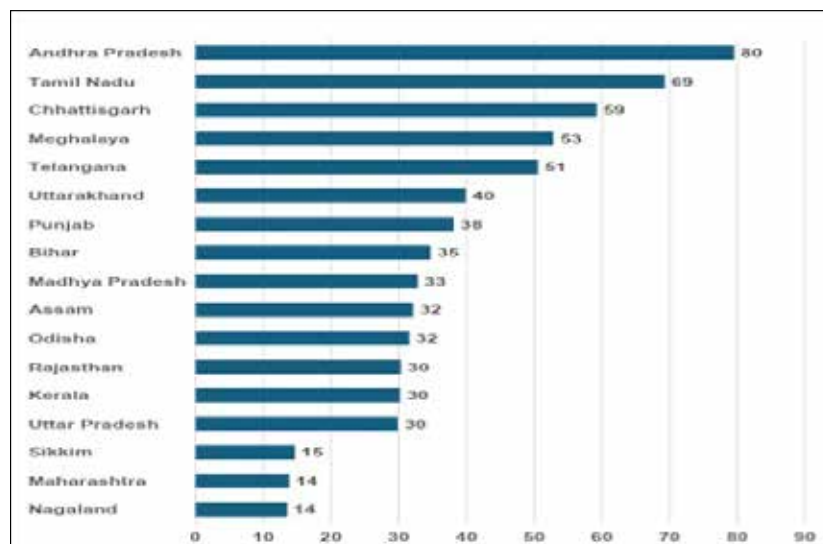
Overall, while foundational elements of health promotion and wellness have been established across states, continued efforts towards strengthening systematic counselling approaches, expanding the scope of preventive and wellness services beyond screening, and improving community ownership of wellness initiatives are necessary to fully realise the intent of CPHC.



• Strong IEC & Health Awareness Facility-based IEC, outreach awareness, VHSND sessions	• Strong Prevention & Risk Identification under CPHC Population-based screening for NCDs, cancers, RMNCAH+N risk identification, communicable diseases, elderly and mental health screening	Needs Strengthening Counselling & Behaviour Change Support Lifestyle counselling, nutrition, adherence support, preventive health education	Needs Strengthening Wellness & Community Engagement Activities Yoga, wellness sessions, community participation, health promotion events	CPHC Goal Comprehensive Preventive Care under CPHC Continuum of care, lifestyle modification, early management, mental health, geriatric and preventive services

Fig: CRM observations indicate that most states demonstrate strong implementation in awareness and screening components, while counselling-led behaviour change and wellness services for expanded packages remain areas for further strengthening.

State wise proportion of AAM (excluding AAM-AYUSH) conducting minimum 10 wellness sessions per month



(Source: AAM Portal, data analysed from January to September 2025)

Analysis of data from the AAM portal indicates considerable variation across states in the proportion of Ayushman Arogya Mandir (AAM) conducting the recommended minimum of ten wellness sessions per month. States such as Andhra Pradesh, Tamil Nadu and Chhattisgarh demonstrate relatively higher levels of implementation, reflecting stronger institutionalisation of wellness activities. In contrast, several states reported moderate to lower coverage, suggesting that wellness activities are still evolving from infrequent, event-based initiatives towards structured activities integrated into the weekly routine at AAM. CRM field visits indicate that these variations may be attributed to differences in availability of trained human resources like dedicated YOGA trainer/ wellness facilitators, scheduling mechanisms, space constraints, and community participation levels across states. In many states, wellness activities continue to be primarily centred around yoga sessions or observance of health days, while lifestyle counselling, behaviour change sessions, and preventive health engagement were yet to be consistently integrated into monthly activity plans.

KEY OBSERVATIONS

- Health promotion activities were largely delivered through routine service delivery platforms such as VHSNDs, outreach sessions and OPD-based counselling across most states.
- IEC materials were widely available across facilities, though their usefulness varied depending on placement and organisation. Some states demonstrated effective use of local language materials, systematic placement in waiting areas and counselling spaces, and alignment with ongoing service delivery and wellness activities, enhancing patient awareness and engagement. Conversely, in few states, IEC materials were displayed in a cluttered manner without thematic grouping, limiting visibility and impact.
- Wellness activities at AAM were primarily centred around yoga sessions, lifestyle modification counselling, and preventive health education linked to NCD screening and follow-up services. They were being conducted regularly in facilities where they were integrated with routine service delivery platforms. Despite constraints related to availability of trained personnel and dedicated space, several facilities continued to organise wellness activities, indicating sustained efforts towards integration of wellness within primary healthcare services.
- In some states, wellness and health promotion activities were also undertaken through community-based events and campaign-based initiatives aimed at promoting physical activity and healthy lifestyles. These activities were generally event-based and not uniformly institutionalised across facilities.
- School health and adolescent health platforms were utilised in several states for health awareness and preventive education.
- Frontline workers played a significant role in counselling and mobilising communities for preventive health activities, with ASHAs primarily supporting community

mobilisation and beneficiary follow-up, ANMs providing service-linked counselling during VHNDs and outreach sessions, and CHOs contributing to wellness and lifestyle counselling at AAM, particularly for NCD prevention and follow-up care.

- Screening and preventive health activities included population-based screening for NCDs (hypertension, Diabetes and three common cancers) under NCD programmes, alongside maternal and child health services, and communicable disease awareness.

KEY CHALLENGES

- Health promotion activities were often limited to awareness and screening, with limited emphasis on structured behaviour change communication, and sustained lifestyle modification interventions.
- Depth and quality of interpersonal counselling varied across facilities and states.
- Expanded CPHC wellness components such as mental health, geriatric care, palliative care, and cancer-screening were not uniformly operationalised.
- Community participation and availability of space at AAM for wellness activities remained inconsistent across some states.
- Wellness activities mainly remain limited to yoga and basic lifestyle counselling, with not enough emphasis on diversification of approaches tailored to community needs and local contexts.
- Monitoring and documentation of health promotion activities were not uniformly maintained.
- Workforce constraints including availability of trained personnel such as counsellors and AYUSH practitioners, large coverage areas, difficult terrain, and logistical challenges affected consistent outreach implementation in some states, leading to delays in community sessions, and reduced the effectiveness of preventive health outreach and community mobilisation activities.

RECOMMENDATIONS

- States to ensure rationalisation of IEC display within health facilities may be strengthened through improved localisation of materials, including adaptation to local language and cultural context, and strategic placement within facilities. Use of technology-enabled and culturally appropriate IEC approaches may further enhance effectiveness.
- States to ensure that structured behaviour change communication approaches may be strengthened through development of locally contextualised BCC strategies, improved interdepartmental convergence, and capacity building of frontline workers and CHOs.
- States to integrate health promotion and disease preventive activities more systematically into routine service delivery, moving beyond screening-based

approaches and expanding coverage beyond RMNCAH+N and NCDs to include components such as mental health, geriatric and palliative care under CPHC.

- States to ensure that supportive infrastructure, including provision of dedicated space for wellness and preventive health activities at AAM, may be strengthened.
- States to enhance community engagement through consistent and active involvement of community platforms and local governance structures, including PRIs, JAS, VHSNCs and MAS, to improve participation in wellness activities.
- States to Strengthen monitoring and documentation mechanisms for health promotion and wellness initiatives to ensure consistency and quality of implementation.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- IEC materials were available across facilities; and wellness activities were implemented in a programme-driven manner. Geriatric wellness, adolescent well-being and vector control activities were conducted in varying degrees across districts. Variations between districts indicate that wellness activities were more structured in more accessible/ better-connected districts compared to tribal regions.
- Preventive and wellness activities were being strengthened through organised outreach models such as Family Doctor visits and VHSND platforms. Awareness activities were largely delivered through routine programme platforms and outreach sessions, with counselling integrated into service delivery encounters.
- AYUSH MOs were not consistently involved in counselling, wellness sessions, community outreach or VHSNDs. There is a large potential to leverage AYUSH practitioners-especially in lifestyle counselling, stress management, yoga-based interventions and wellness promotion.
- School health platforms were being actively utilised for screening activities for anaemia, vision, and dental issues, as well as awareness generation, through the engagement of Wellness Ambassadors (teachers) & Wellness Messengers (students). Psycho-social counselling services, though available, were observed to be limited in terms of structured individual assessment and follow-up, indicating scope for strengthening.
- **Good practice:** The Care Companion Programme, implemented with support from an NGO equips families with practical skills to support newborn and maternal care at home. During the CRM visit, structured counselling materials, such as visual flipcharts, a demonstration doll, breastfeeding and hand-expression aids, and nutrition IEC in the local language were observed to be used for caregiver education. These tools enable hands-on learning for family members on essential home-based practices including newborn handling, breastfeeding support, hygiene and nutrition.

Assam

- The Village Health Outreach Programme (VHOP) has emerged as an important strategy for reaching underserved populations, particularly in tea-garden and remote areas, through screening camps and outreach-based delivery of NCD screening and basic health services.
- Wellness activities at the AAM level were observed to be present but largely limited to observance of annual health calendar days and maintenance of herbal gardens, with structured counselling and outreach-based wellness activities remaining limited.
- IEC materials were widely displayed across facilities; however, communication approaches were predominantly poster-based with limited interactive engagement. Tele MANAS numbers were displayed at facilities, though limited orientation of primary-care staff and absence of mental health counsellors at PHC level constrained community-level mental health promotion.
- At the same time, locally adapted practices, such as the use of illiterate-friendly Snellen charts, Self-Breast Examination (SBE) training for women at PHC level, and functional herbal gardens at AAM and tea-estate facilities were observed to improve accessibility and community participation in preventive health services.
- Preventive services at the primary care level were largely centred around screening for hypertension and diabetes, though follow-up and long-term management for maintain continuity of care remain variable.
- Gaps in preventive health interventions remain evident in areas such as tobacco and alcohol use.

Bihar

- IEC materials for the 12 packages of services, Eat Right Toolkit, Wellness calendars were displayed at facilities, indicating availability of health promotion resources. However, registers for wellness and health promotion activities were not maintained, indicating weak monitoring and documentation.
- Wellness activities were largely facility-driven, with variation in implementation across facilities. At the visited UPHC, a Yoga instructor would visit three days per week from 3 to 4 pm providing sessions to 8 to 10 beneficiaries on an average.
- Behaviour changes activities related to contraception and adolescent health were observed as good practices in selected UPHCs. Engaging games on risky and safe behaviour and information on various types of contraceptives were developed and used for adolescent education at schools as well as at UPHC.
- Quarterly Arogya Shivar was being organised at AAM, contributing to periodic outreach activities and service delivery.

Chhattisgarh

- “Weekly Arogya Mela” were conducted every Wednesday to supplement the routine delivery of comprehensive primary healthcare services, within the AAM catchment area to raise community awareness about the importance of health, preventive care, and timely health screening. Additionally, AAM teams were conducting weekly health shivir and Haat Bazaar Clinics to facilitate outreach activities and strengthen community engagement.
- The state has operationalised the 104 Health Helpline, a 24×7 toll-free service providing healthcare information, medical advice, and counselling support through trained paramedics and doctors, facilitating access to guidance for common health concerns.
- IEC material was available in local language. Use of MCH QR codes was observed as an initiative to improve access to maternal and child health information for beneficiaries and their families. Menstrual awareness camps and preeclampsia awareness activities were conducted periodically.
- While yoga sessions were planned as part of wellness activities at the visited AAM, only a limited number of sessions were conducted compared to planned frequency, and other structured wellness and health education activities, such as engagement with school-based Health and Wellness Ambassadors were limited.
- Community awareness campaigns were actively being undertaken under NLEP including active case-detection and referrals in cases of disabilities, as well as for conditions such as filariasis and snakebites.
- Health observance days were actively being celebrated in accordance with the approved Health Calendar.
- Eat Right Toolkit was not available at the facilities visited.

Kerala

- Health promotion activities were integrated with routine service delivery platforms such as VHSND/UHND sessions, including promotion of nutrition (“Eat Right”) and maternal health counselling. Annual health calendar days were observed with outreach activities conducted at community level.
- Wellness spaces were available in most AAM, and some facilities used community halls and open spaces for wellness activities. However, regular Yoga activities were not being conducted at all AAM.
- Public awareness initiatives such as the Kolayakkoottam community awareness programme demonstrated widespread community participation in health education activities on topics such as Anti-microbial resistance, Importance of Immunization, New-born care etc.
- IEC display and health promotion materials were variable and partial across facilities, limiting consistency in messaging.

- Integration of lifestyle counselling within disease-specific programmes such as SWAAS (Step Wise Approach to Airway Diseases) for COPD/ asthma management with lifestyle advice) was also noted.
- The presence of Cheruvathur AYUSH Health & Wellness Clinics reflects consistent service delivery and strong community acceptance of holistic wellness integration.

Madhya Pradesh

- Facility-level counselling and outreach-based awareness sessions formed the core approach for preventive health messaging.
- Wellness sessions were observed in selected facilities, though regularity and standardisation varied across districts. Wellness activities at AAM included yoga sessions and monthly Ayushman Arogya Shivar, though dedicated wellness spaces and uniform display of health calendars were lacking.
- IEC materials were appropriately displayed across all facilities, including prominent display of Tele-MANAS Helpline information.
- Institutional mechanisms for community participation were in place with the constitution of Jan Arogya Samitis across facilities, though the regularity and documentation of monthly meetings require strengthening.
- Monitoring of wellness activities may be strengthened, including ensuring display of activity calendars and improved coordination with School Health Ambassadors, to enhance accountability, community participation, and overall health promotion outcomes.

Maharashtra

- The availability of infrastructure and dedicated space at AAM enabled the conduct of counselling and awareness activities at the facility level; however, the utilisation of designated wellness spaces and regular engagement in wellness sessions remained inconsistent.
- At SHC-AAM, wellness activities were primarily limited to yoga sessions, with variation observed across districts, where these were conducted regularly in some facilities but not observed in others. Health promotion activities remained limited in scope, with yoga being the predominant activity under wellness.

Meghalaya

- An IEC Kit-ap has been developed for the Village Health Council members, and contains IEC regarding major public health issues in local languages for dissemination in the community. Use of local innovations for health promotion were noted, such as community-led health days in the North Garo Hills.
- IEC materials in regional languages were widely displayed across facilities, supporting community awareness on major public health issues. However, structured activities

beyond IEC dissemination are minimal, highlighting the need for more participatory approaches.

- Health promotion and wellness activities remain limited, though community-led platforms such as Village Health Sanitation and Nutrition Committees (VHSNCs) play a strong role in linking services to local populations.
- Mental health awareness efforts were visible, including the display and promotion of Tele-MANAS services, supported by community sensitisation activities. However, activities for mental health, geriatric, and palliative care remain at an early stage of integration.
- School health programmes require strengthening, with a clear need for training and capacity building of peer educators, as Behaviour Change Communication is shaped by cultural and social practices, making locally adapted IEC strategies essential.

Nagaland

- Facility-based counselling and IEC dissemination constituted the primary approach for preventive health communication.
- There was no separate space for conducting wellness activities at the AAM visited. Limited availability of structured wellness activities and language-related IEC constraints affected community-level engagement.
- Health promotion activities were largely taking place through community-based committees at platforms like the VHSND, rather than regular wellness sessions at the health facilities. Health promotion and disease prevention activities were discussed during JAS meetings, indicating integration of promotive health components within community platforms.
- Cultural and geographic factors adversely influenced the uptake of preventive and promotive services, particularly family planning.
- Outreach initiatives, including hypertension and diabetes screening camps, vector control measures were actively being supported by ASHAs through community mobilisation.

Odisha

- Integration of awareness activities with immunisation outreach and adolescent health platforms supported preventive messaging at community level. Health promotion activities through the adolescent health programmes were being conducted through trained Health & Wellness Ambassadors and mobile application-based reporting, on themes such as WIFS implementation, anaemia screening and counselling services.
- Outreach-based geriatric and palliative care services through CHOs and MPWs exemplified emerging practices under expanded CPHC services.

- IEC materials, including tobacco control measures around educational institutions were clearly displayed.
- Mental health services were being strengthened with fixed-day OPDs at Community Health Centres (CHCs) and outreach camps providing counselling, medication, and tele-psychiatry services.

Punjab

- Health promotion initiatives were supported through state-led programmes such as substance use prevention and caregiver orientation programmes, reflecting local public health priorities.
- IEC materials were prominently displayed at the health facilities, ensuring clear visibility of key health messages for patients and caregivers. This contributed to improved awareness about maternal health, newborn care, child nutrition, family planning, and other RMNCHA services.
- Miking from Gurudwara about availability of drugs and services in the Ayushman Arogya Kendra (AAK) was noted as a strategy to mobilize the community towards availing health services at the AAK.
- Preventive and wellness components remain less institutionalised within routine primary care service delivery, and a lack of awareness relating to celebration of annual health calendar days were noted.
- Adolescent health initiatives were being implemented through programmes such as WIFS. School and Anganwadi-based screenings under RBSK were being conducted as per schedule.

Rajasthan

- IEC materials for all 12 service packages were visibly displayed across AAM, with regular awareness sessions linked to all 42 Annual Health Calendar Days being conducted. While overall compliance was satisfactory, greater uniformity, standardized branding, and digital IEC dissemination are recommended.
- Wellness activities were being conducted regularly, through the engagement of a Yoga instructors on a rotation basis, with more than 10 wellness sessions being conducted per month in the visited facilities.
- Availability of dedicated space for wellness activities varied across districts. ASHAs were observed to mobilise communities through prior household visits; however, community participation in wellness sessions remained limited, with lower engagement noted among working populations, particularly farmers, who perceived these activities as less relevant.
- Eat Right counselling and food safety activities, including adulteration checks via Food Safety Vans, were conducted; however, community awareness remains limited, indicating the need for expanded outreach through schools and VHSNC platforms.

- Health promotion activities remain closely linked with platforms, like VHSNDs and reflecting strong RMNCAH+N integration. Limited awareness and training among staff regarding expanded packages affected the implementation of promotive services beyond RMNCAH+N. Mental health and geriatric wellness services were also in early stages of implementation.

Sikkim

- IEC materials covering all 12 CPHC service packages were widely and clearly displayed at facilities and in community spaces, ensuring beneficiaries were well informed about the full range of services available.
- The State also ensured regular promotive activities linked to the 42 Annual Health Calendar Days, VHSNDs, outreach camps, and Arogya Shivar, with active community engagement and ownership. The existing platforms of VHSNCs, MAS, and JAS were leveraged effectively for disseminating key health messages, planning local awareness drives, and identifying vulnerable households.
- Most AAM regularly conducted wellness activities, including twice-weekly Yoga sessions, breathing exercises, meditation, and basic physical activity, with proper documentation and participation across age groups, with community members taking the lead, highlighting a focus on holistic and preventive care.
- All facilities prominently displayed the Eat Right Toolkit and provided routine dietary counselling—especially for hypertension along with food safety demonstrations and adulteration testing during OPD visits, NCD sessions, and community events.
- Community participation in outreach and wellness activities were strong, supported by mobilisation efforts of ASHAs, and active involvement of PRI members and community volunteers. Local innovations, such as clustering villages for joint outreach events, have contributed to improved service uptake, particularly in geographically challenging areas.

Tamil Nadu

- Tamil Nadu demonstrated advanced integration of preventive programmes with service delivery, particularly through community-based screening and outreach initiatives such as Makkalai Thedi Maruthuvam.
- Demonstrating AYUSH integration, the Government of Tamil Nadu has effectively incorporated a Siddha-based maternal wellness kit named Magaperu Sanjivi Kit, supplied to pregnant women as part of comprehensive antenatal care.
- Disease-specific preventive models like the Paatham Paathukaapom Thittam (diabetic foot programme), MaNam program (youth mental wellness), represent innovative outreach and preventive approaches with streamlined referral linkages.
- Outreach activities under National Mental Health Program (NMHP) and National Vector Borne Disease Control Program (NVBDCP) were being conducted regularly.

Telangana

- Telangana has implemented multiple health promotion initiatives including Arogya Mahila Clinics, Maternal Morbidity Clinics, and community outreach models focused on preventive and promotive care. As per state reports, over 2.5 crore beneficiaries have participated in wellness sessions, indicating progress towards strengthening community-based health promotion and preventive care.
- Community engagement initiatives linked with maternal and women's health platforms and outreach events included awareness drives and community participation activities.

Uttar Pradesh

- The State reported that over 6.91 crore beneficiaries had participated in more than 58.51 lakh wellness sessions since 2020. However, gaps were observed in capacity, as CHOs lacked training in palliative care and cancer screening, with limited focus on wellness services.
- State-level vector borne disease (VBDs) campaigns demonstrated strong inter-sectoral convergence models, engaging multiple departments, public awareness activities, door-to-door outreach, and resulted in lower numbers of cases and deaths due to VBDs in the State.
- Limited accessibility and comprehension of IEC content by beneficiaries was noted due to language barriers in some facilities.
- Counselling services were found to be inadequate resulting in poor nutrition counselling and minimal behaviour change communication at the community level. Large population size and disease burden require scaling preventive and wellness services beyond RMNCHA focus toward comprehensive CPHC delivery.

Uttarakhand

- Yoga and Wellness sessions were being conducted at AAM by Yoga Instructors. In the absence of Yoga instructors, CHOs were conducting the yoga sessions at few visited AAM.
- Program-specific IEC material in local language was available for selected programmes such as TB, leprosy, and vector-borne diseases, particularly during the monsoon season. However, IEC material on family planning was not available in facilities visited in one of the districts, with supplies reportedly limited to distribution during annual events such as Saas Bahu Pati Sammelan, vasectomy camps, and World Population Day.
- School and adolescent health platforms were being utilised with teachers nominated under the School Health and Wellness Programmes, and RKSK counsellors conducting weekly counselling sessions at school and community level.



CONTINUUM OF CARE – REFERRAL & TELECONSULTATION SERVICES

17th

CONTINUUM OF CARE – REFERRAL & TELECONSULTATION SERVICES

NATIONAL OVERVIEW

Enhancing referral pathways and expanding teleconsultation services have been a key strategy to improve access to specialist care, minimize unnecessary referrals, and strengthen continuum of care in resource-limited and geographically challenging settings. Most states have established structural mechanisms for referral services, including mapped linkages between primary and higher healthcare facilities, as well as programme-specific pathways for maternal health, newborn care, communicable diseases, and non-communicable diseases.

Teleconsultation services, through e-Sanjeevani, have been operationalised across many states and were increasingly being used to address specialist shortages, particularly in remote, tribal and hilly regions. CRM observations indicated that teleconsultation has enhanced clinical decision-making at the primary care level and enabled access to specialists' advice without requiring physical referral in selected cases. States with stronger digital integration and well-defined workflows demonstrated more consistent utilisation of telemedicine services.

However, the effectiveness of the continuum of care varies across states due to structural disparities and resource limitations. Referral feedback and counter-referral mechanisms were not uniformly operationalised, leading to gaps in follow-up and continuity of care at the primary care level. Connectivity limitations, variability in trainings of healthcare providers, and limited integration of teleconsultation into routine service delivery workflows continues to affect optimal utilisation of e-Sanjeevani.

KEY OBSERVATIONS

- Defined referral linkages between primary, secondary, and tertiary care facilities were observed in most states, particularly under programme-specific referral pathways such as maternal health, SNCU referrals, TB care, and non-communicable disease (NCD) management. ASHA and CHO were observed to play a pivotal role in facilitating referral compliance and patient navigation at higher care centres.
- Referral pathways remain stronger for maternal & child health, and communicable disease programs, due to their long-standing implementation, while referral mechanisms for follow-up on chronic disease, geriatric care, mental health, and palliative care, under the Expanded Packages of Services (EPS) were in process of being rolling out and thus remain less institutionalized in several states.
- Community-level linkage through ASHAs and frontline workers contributed significantly to continuity of care, particularly in tracking referred beneficiaries and supporting follow-up visits.
- Teleconsultation services have been operationalised in a majority of states, primarily through e-Sanjeevani, supporting access to specialists' consultation at the primary care level. In geographically difficult and underserved areas, teleconsultation was

observed to reduce the need for physical referral in selected clinical situations. However, poor internet connectivity and shortages of doctors and specialists led to sub-optimal utilization of teleconsultation services in some hubs.

- Enablers for higher utilization of teleconsultation services were telemedicine integrated into routine clinical workflows and optimally supported by trained healthcare providers and reliable internet connectivity.

KEY CHALLENGES

- Referral feedback and counter-referral mechanisms remain inconsistently institutionalised across states, resulting in gaps in continuity of care and follow-up at the primary care level. While referral transport and upward referral processes were functional, systematic feedback to referring facilities was often limited.
- Capacity gaps in referral documentation and tracking mechanisms at facility level affect systematic monitoring of referral outcomes and continuity of care.
- Variable utilisation of teleconsultation services was observed across facilities, with telemedicine platforms sometimes functioning as standalone services rather than being fully integrated into routine outpatient workflows.
- Other variables like poor internet connectivity and digital infrastructure continue to affect optimal use of teleconsultation services, particularly in remote, tribal, and hilly regions, impacting real-time consultation and data reporting.

RECOMMENDATIONS

- States to institutionalise structured referral and counter-referral mechanism across levels of care to ensure continuity of care and follow-up including referral documentation and referral audit mechanisms to improve tracking of patient outcomes at the primary care level.
- States to expand referral linkages and follow-up mechanisms beyond programme-driven services, particularly for NCD, geriatric care, mental health, and palliative care under expanded CPHC packages.
- States to strengthen integration of teleconsultation services into routine clinical workflows at AAM and higher facilities, with clear protocols for referral case selection, scheduling, and follow-up to enhance clinical utilisation.
- States to improve the internet connectivity and digital infrastructure at AAM particularly in remote and geographically difficult areas, must be achieved to enable reliable teleconsultation and real-time reporting.
- There is a need to strengthen capacity building of MOs, CHOs, and frontline providers on referral protocols, documentation, and teleconsultation workflow to improve continuity of care.

- States to generate community awareness about teleconsultation benefits, to generate a demand for teleconsultation services.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- Referral pathways from AAM to secondary healthcare facilities were functional, though they were often individual-centric, driven by specific patient needs and clinician choices rather than systemic governed by standardized institutional protocols.
- Follow-up documentation at the primary care level remained inconsistent.
- Teleconsultation services through district level hubs were available at selected facilities, however it was underutilized and not yet fully integrated as a routine clinical resource and OPD workflows.
- Strengthening structured referral and back-referral systems, integrating teleconsultation into clinical workflows, and leveraging outreach models more systematically could enhance continuity and quality of care.

Assam

- The referral linkages existed from AAM-PHCs to higher level healthcare facilities, but their functionality varied depending on the availability of infrastructure and specialist. While e-Sanjeevani was technically available across the facilities, it was often considered underutilized as a routine clinical OPD workflows.
- At several AAM-PHCs, the data entry was done in bulk after teleconsultation sessions due to poor internet connectivity, which hampered the usefulness of digital tools for real time decision-making. As of 16th October 2025, across 360 hubs and 3223 spokes, a total of 28,73,645 tele-consultations has taken place.

Bihar

- The state had developed its own IT platform, the Bihar Health Application Visionary Yojana for All (BHAVYA), which was used to track and monitor service delivery under the National Health Mission (NHM).
- Teleconsultation services through e-Sanjeevani remain underutilized at the facilities.
- The state continues to face persistent challenges related to healthcare accessibility including quality of care. Availability of infrastructure and human resources were particularly pronounced in the districts of Saran and Munger.

Chhattisgarh

- Teleconsultation services via e-Sanjeevani were available at AAM-SHCs and PHCs but underutilized due to limited availability of specialists at hub facilities, poor internet connectivity, and inadequate doctors' time.

- A total of 25 doctors from district hospitals (DHs) and CHCs were enrolled on the e-Sanjeevani portal, the allocation of specialists' time for teleconsultation services was inadequate and hence could not meet the service demand.
- Emergency ambulance services (102 and 108) were available across the visited areas.
- Capacity-building efforts were evident, and Community Health Officers (CHOs) demonstrated good awareness of various digital health portals, and data entries were generally found to be up to date.

Kerala

- Strong digital health integration through e-Health systems had been established, enabling electronic health records, continuity of care, and telemedicine access across levels of care. However, at AAM level, utilization remained low with limited teleconsultation conducted daily along with limited availability of specialist.
- The Nirnaya hub-and-spoke laboratory network strengthened referral-linked diagnostics and improved access to advanced testing through structured sample transport mechanisms.
- The Palliative Care Grid demonstrated a strong example of coordinated referral and follow-up through digital platforms and home-based services.

Madhya Pradesh

- An upward referral mechanism was in place, with patients from AAM-SHC levels being referred directly to the district hospitals. However, downward referral systems were not functional, as no documented evidence of follow-up for referred patients was available at AAM-SHC and USHC.
- Teleconsultation services were provided through the e-Sanjeevani and were primarily used for routine health concerns to meet the reporting targets, with limited emphasis on follow-up consultations.
- The challenges of internet connectivity in rural areas resulted in call interruptions, adversely affecting both the quality and duration of teleconsultations.

Maharashtra

- Across the facilities, utilization of e-Sanjeevani services was observed. A hub-and-spoke model of teleconsultation under the ST-Elevation Myocardial Infarction (STEMI) initiative had been implemented in Maharashtra to facilitate ECG screening at the PHC level through portable ECG machines.
- ECG recordings were transmitted online through the *CardioNet* application, to designated hubs for teleconsultation and timely clinical decision-making, including the referral services if required. Usage of innovative tools like "What3Words," geotagging, and Good Samaritan App improved the referral response efficiency in

the state.

Meghalaya

- Across the facilities, the facility-level referral linkages exist but were not systematically documented.
- Teleconsultation was available across facilities; however, internet connectivity issues hampered the teleconsultation services and digital reporting in remote facilities.

Nagaland

- Multiple digital platforms such as HMIS, NCD portal, Nikshay, RCH portal and AAM portal were operational across facilities for patient tracking and reporting.
- The utilization of teleconsultation services remained limited due to poor digital infrastructure, internet connectivity and Human Resource (HR) constraints.

Odisha

- Teleconsultation services were functional via hub-and-spoke model with 255 spokes (212 active spokes) and 17 sub-hubs (15 active sub-hubs) supporting specialists' consultation.
- An average of 15 teleconsultations per day were conducted across the facilities, mainly for Hypertension (HTN), Urinary Tract Infections (UTI) and fever.
- The referral mechanisms for high-risk pregnancies and sick newborns were in place, with identification at primary level and referral to higher facilities.

Punjab

- Referral pathways were displayed at facilities and CHOs had coordinated referrals effectively, particularly for the high-risk pregnancy, maternal and child health cases.
- Backward referral mechanism was weak, with limited feedback to referring facilities, affecting both the continuity of care and follow-up.
- Teleconsultation services through e-Sanjeevani were operational, with CHOs conducting approximately 20–25 teleconsultations per month for general disease conditions such as fever, abdominal pain, skin diseases etc. However, medical officers and staff nurse at AMM-PHC/UPHC were not using teleconsultation services.
- Common issues like internet connectivity and unavailability of specialists and doctors at the hub were observed across the facilities.

Rajasthan

- Referral pathways were operational across the facilities.
- While the referral process was functioning, the formal display of referral pathways both upward and downward was not explicitly described.

- Telemedicine services through e-Sanjeevani were operational at the AAM, with an average of 15 teleconsultation sessions conducted each month.
- Wi-fi connectivity was available, although the absence of electricity backup occasionally posed challenges.

Sikkim

- AAM followed structured upward and downward referral pathways, with CHOs and ANMs managing referrals for emergencies, diagnostics, and follow-up care.
- The CHOs demonstrated strong orientation in teleconsultation workflows, delivery of CPHC services and teleconsultation services through e-Sanjeevani at PHCs, contributing to improved service delivery. However, specialists' availability at the hub remained a critical challenge in optimal uptake of teleconsultation services.
- Most AAM displayed the referral protocol outlining emergency and routine referral pathways, and flowcharts for upward and downward referrals were visible at PHCs and UPHCs.

Tamil Nadu

- The state exhibited structured referral pathways supported by program-based integration and digital monitoring systems, enabling stronger linkage between screening, treatment, and follow-up across levels of care.
- The telemedicine through e-Sanjeevani has been a mainstay in the AAM operational framework.

Telangana

- The state demonstrated strong programme-based continuum of care models, particularly in maternal health and NCD services, supported by structured referral pathways.
- Through e-Sanjeevani, 5.64 lakh specialist tele-consultations have been enabled from PHCs significantly enhancing specialist access in rural and remote areas.
- The Telangana Diagnostics operates on a robust hub-and-spoke model, offering centralized quality diagnostics and tele-radiology services, effectively linking peripheral health centres with secondary and tertiary care facilities.

Uttar Pradesh

- Dedicated MOs had been deployed for telemedicine services via e-Sanjeevani, and around 100 teleconsultation calls were received on daily basis, however, similar issues regarding availability of internet connectivity and specialists were observed across the facilities.

Uttarakhand

- Referral pathways were operational across facilities; however, the upward referrals were being made based on the proximity of next higher-level care facility. The backward referral mechanism and follow-up was largely missing.
- Teleconsultation services via e-Sanjeevani were operational at SHC-AAM level in the visited districts; however, inadequate internet connectivity remained a key challenge, leading CHOs to use personal mobile internet with reimbursement for mobile phone bills.
- Targeted approach of teleconsultation was still being followed for CHO incentives and revised directives of need-based teleconsultation was yet to be implemented at the field level.
- The waiting time for teleconsultation ranged between 5-15 minutes, although service unpredictability remains a major barrier.
- Under e-Sanjeevani initiative, the NHM hub was staffed with 9 doctors, of which 6 doctors were currently available.



COMMUNITY PROCESSES – ASHA AND COMMUNITY- BASED PLATFORM

17th

COMMUNITY PROCESSES – ASHA AND COMMUNITY-BASED PLATFORM

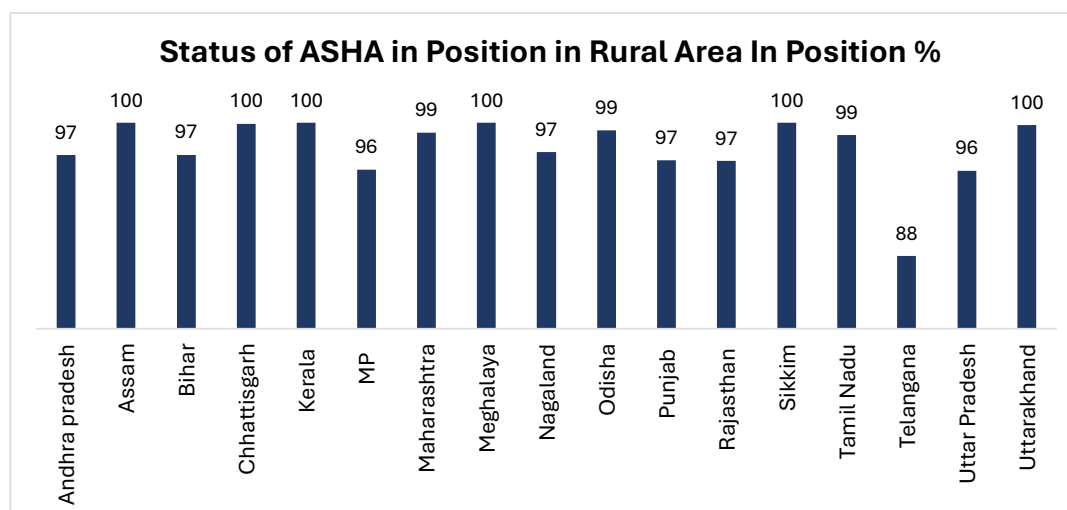


NATIONAL OVERVIEW

Community processes form the central pillar of the CPHC framework, enabling community engagement, and continuity of care through frontline workers and community-based platforms. Under Ayushman Arogya Mandir, the role of ASHAs has expanded beyond community mobilisation towards supporting preventive health, early identification of risks, and follow-up care. The 17th CRM observations indicate that community processes remain well institutionalised across states, particularly through platforms such as Village Health, Sanitation and Nutrition Committees (VHSNCs), Mahila Arogya Samitis (MAS), Jan Arogya Samitis (JAS), and celebration of Village Health Sanitation and Nutrition Days (VHSNDs). These platforms enable decentralized health planning, monitor health activities, and foster community engagement.

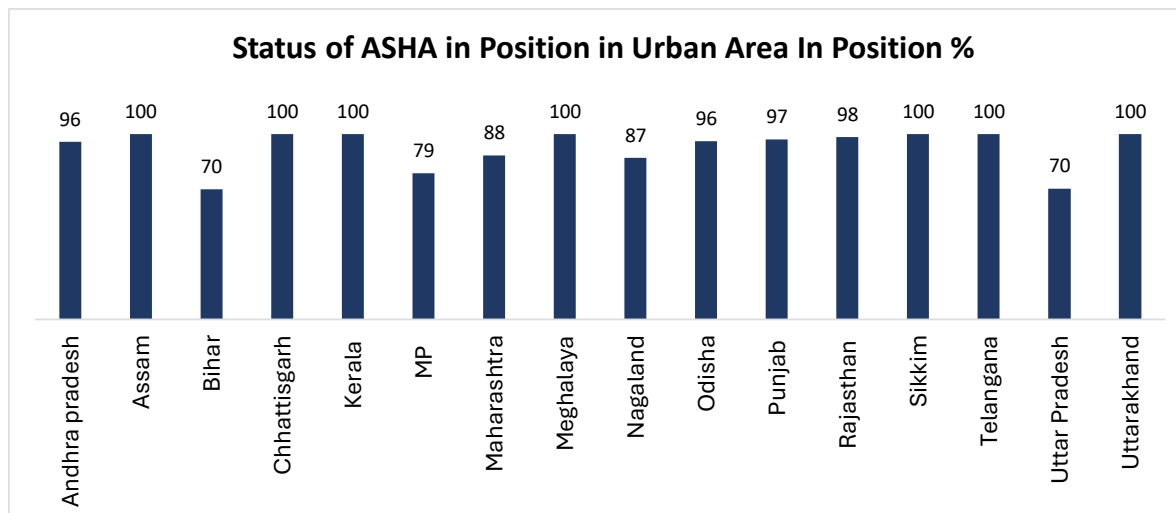
ASHAs

Across most states visited during the CRM, ASHAs were found to be largely in position against sanctioned targets, indicating sustained efforts by states to maintain a functional frontline workforce. Graphical data on rural ASHA availability indicates that most states reported coverage close to or above sanctioned targets (>96%), with only Telangana having 88% ASHAs in position against the sanctioned numbers (Fig 1.a).



Source: State reported for ASHA Update 2025.

For urban areas, the proportion of ASHAs in place was comparatively more variable across states. While several states such as Assam, Chhattisgarh, Kerala, Meghalaya, Sikkim, Telangana, and Uttarakhand reported complete coverage, states like Nagaland, Uttar Pradesh, MP, Maharashtra and Bihar reported less than 90% urban ASHA availability against sanctioned targets (Fig 1.b). Tamil Nadu does not have ASHAs in the urban areas, but Women Health Volunteers (WHVs) that play a similar role for their community.



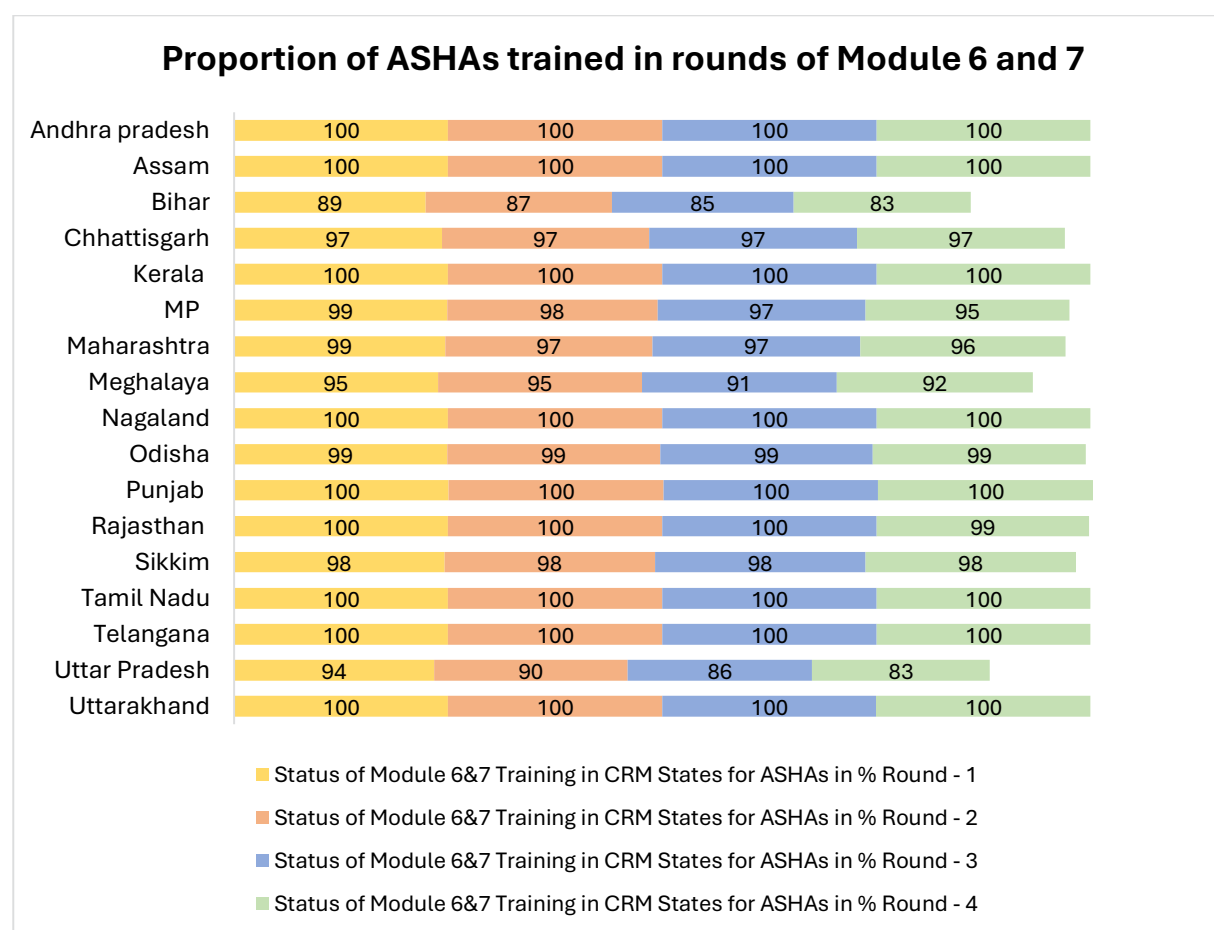
Source: State reported for ASHA Update 2025

Across states, ASHAs continue to play a pivotal role in community mobilisation, beneficiary tracking, and facilitating access to health services. Field observations highlighted their active involvement in maternal and child health services, immunisation services, mobilisation for VHSNDs, home-based newborn and young child care, non-communicable disease screening, tuberculosis follow-up, and referral support.



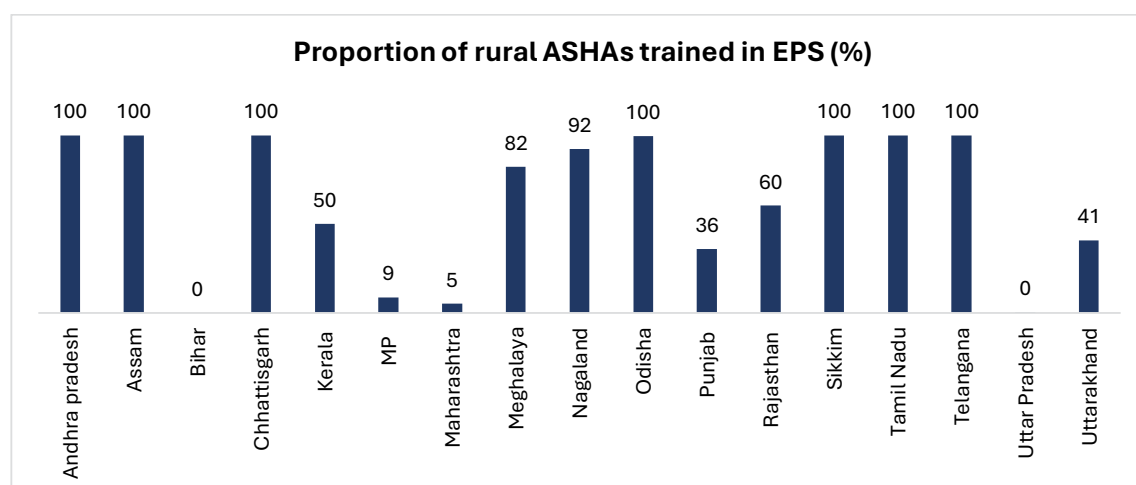
In several states, strong coordination on the ground between ASHAs, Auxiliary Nurse Midwives (ANMs), and Community Health Officers (CHOs) was observed, contributing to improved linkages between community-level outreach and facility-based services. ASHAs were also engaged in maintaining beneficiary line lists, conducting household visits, mobilising communities for outreach sessions, and supporting health education and awareness activities. Communities across multiple states expressed trust in ASHAs and reported relying on them for information on health services and government programmes.

Capacity Building and Training: The national data on training coverage for Module 6 and 7 and Expanded Package of Services (EPS) indicates that training coverage varies across states (Fig 2.a). For rural ASHAs, Andhra Pradesh, Assam, Kerala, Nagaland, Punjab, Tamil Nadu, Telangana, and Uttarakhand reported full coverage of Module 6 and 7 training; with others reporting more than 83% coverage.



Source: State reported (for ASHA Update 2025)

Expanded Package of Services (EPS) training - high coverage was reported in Andhra Pradesh, Assam, Chhattisgarh, Odisha, Sikkim, Tamil Nadu and Telangana, while Meghalaya, Nagaland, Rajasthan, and Uttarakhand showed moderate coverage. Lower coverage ($\leq 50\%$) was reported in Kerala, MP, Maharashtra, Punjab, and Uttar Pradesh, while Bihar and Uttar Pradesh reported no training of ASHAs in EPS.



Source: State reported (for ASHA Update 2025)

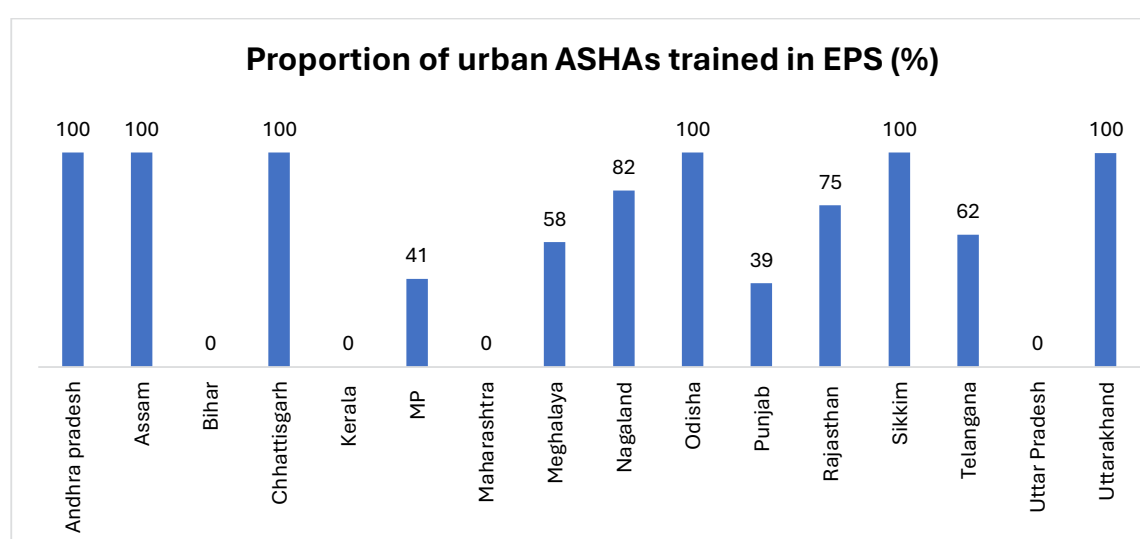
For urban ASHAs, 100% Module 6 and 7 training coverage was reported in Andhra Pradesh, Madhya Pradesh, Maharashtra, Nagaland, Odisha, Rajasthan, Sikkim, and Uttarakhand,

while Kerala, Tamil Nadu, Telangana, and Punjab reported zero coverage for the same (Table 1).

Status of Module 6&7 Training in CRM States of Urban ASHAs in %				
State Name	Round - 1	Round - 2	Round - 3	Round - 4
Andhra Pradesh	100	100	100	100
Assam	100	100	100	100
Bihar	82	73	64	27
Chhattisgarh	100	100	100	100
Kerala	100	100	100	100
MP	100	95	94	89
Maharashtra	73	73	53	47
Meghalaya	100	100	100	100
Nagaland	100	100	100	100
Odisha	100	100	100	100
Punjab	98	98	98	98
Rajasthan	99	95	94	88
Sikkim	97	97	97	97
Telangana	100	100	100	100
Uttar Pradesh	76	61	44	25
Uttarakhand	100	100	100	100

Source: State reported (for ASHA Update 2025)

EPS training coverage for urban ASHAs also varied across states, with Andhra Pradesh, Assam, Chhattisgarh, Odisha, Sikkim and Uttarakhand showing full coverage. However, none of the ASHAs were trained in EPS in Bihar, Kerala, Maharashtra or Uttar Pradesh.



Source: State reported (for ASHA Update 2025)

Observations from the CRM teams also noted that ASHAs have been trained in core programme areas such as maternal and child health, HBNC/HBYC, and NCD screening.

However, refresher training aligned with the expanding scope of Comprehensive Primary Health Care services - including mental health, elderly care, and palliative care - remains limited in some states.

Incentives, Support Structures, and Supervision: Many states have established structured mechanisms for incentive payments and monitoring of ASHA activities. Digital systems and portals for incentive payments and reporting have been introduced in several states to support transparency and timely payments. Yet in some areas, ASHAs reported delays in incentive payments or receiving payments in multiple instalments, which sometimes created confusion in understanding the components of payments.

ASHA support structures (DCM, BCM, and ASHA Facilitators):

As per *the Guidelines for Community Processes (2013)*, the ASHA support structure is designed as a three-tier system comprising ASHA Facilitators (AFs) at the sub-block level, Block Community Mobilizers (BCMs) at the block level, and District Community Mobilizers (DCMs) at the district level, each playing a critical role in supportive supervision, capacity building, programme coordination, and monitoring of ASHAs to ensure effective implementation of community processes.

However, field assessments indicate significant variation in the operationalization of this support structure across states. Overall, 9 out of 17 CRM states have fully established all three tiers with dedicated human resources. Among states where the structure was formally in place, in position number of these tiers also vary considerably: Chhattisgarh, Assam, and Meghalaya report 100% staffing across all three tiers, whereas gaps persist in states such as Telangana (DCMs in only 21% of districts) and Rajasthan (48% BCM and 73% ASHA Facilitator positions filled).

Andhra Pradesh, Odisha, Punjab, and Telangana do not have a dedicated Block Community Mobilizer (BCM) cadre, with functions being undertaken instead through alternative arrangements such as Block Extension Officers in Punjab, Health Educators (regular cadre at PHC/ UPHC level) in Andhra Pradesh and Block Programme Managers in Odisha, who oversee multiple programmes including Community Processes. Similarly, Sikkim, Kerala, Tamil Nadu, and Nagaland do not have a separate ASHA Facilitator cadre; instead, states have evolved context-specific mechanisms for ASHA support and handholding for instance, BCMs undertaking supervisory roles in Nagaland, and in Sikkim, selected high-performing ASHAs functioning in a dual role to support peers. While these adaptations ensure continuity of functions, the absence of a dedicated cadre may affect the consistency and intensity of supportive supervision.

Digital Mechanism for ASHAs

While the overall performance of ASHAs remains strong, several operational challenges were observed across states. Digital reporting requirements and use of multiple applications were particularly noted as operational challenges in some states, especially where government-issued devices were unavailable or non-functional. Connectivity constraints in remote areas further affected the timely submission of digital reports. Field observations also highlighted variations in documentation quality and reporting practices, as well as the

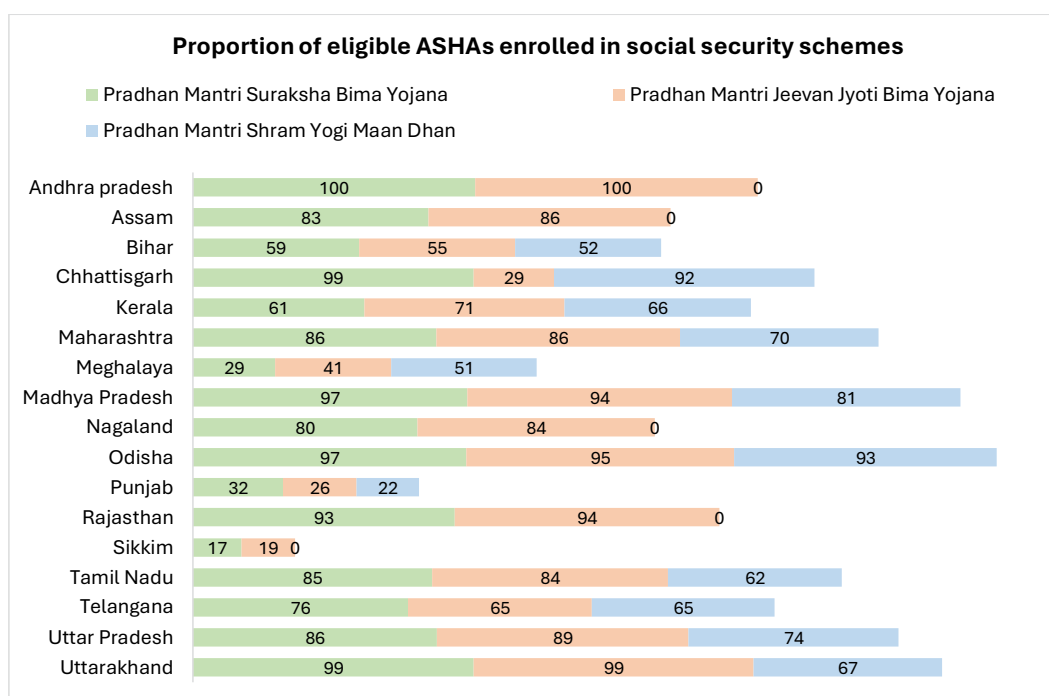
need for continued mentoring and supportive supervision to strengthen documentation and follow-up practices.

Social Security Schemes

Recognizing the critical role of ASHAs, the Government of India has progressively strengthened their social security framework by extending coverage under key national schemes. Since 2018, eligible ASHAs/ASHA Facilitators have been covered under Pradhan Mantri Jeevan Jyoti Bima Yojana (PM-JJBY) for life insurance, Pradhan Mantri Suraksha Bima Yojana (PM-SBY) for accident insurance, and Pradhan Mantri Shram Yogi Maan Dhan Yojana (PM-SYM) for pension benefits, ensuring financial protection and income security. The Enrolment in the insurance schemes (PMSBY and PMJJBY) was relatively high across most states, whereas enrolment in the pension scheme (PMSYM) shows significant inter-state variation.

States such as Andhra Pradesh, Madhya Pradesh, Odisha, and Uttarakhand demonstrate nearly 100% enrolment of all the eligible ASHAs in PMSBY and PMJJBY, indicating strong implementation of the scheme. Odisha, Chhattisgarh, and Madhya Pradesh demonstrate relatively high enrolment in PMSYM, indicating better adoption of long-term social security measures in these states. Maharashtra, Uttar Pradesh, and Tamil Nadu also report consistently moderate to high enrolment across schemes, including relatively better uptake of PMSYM.

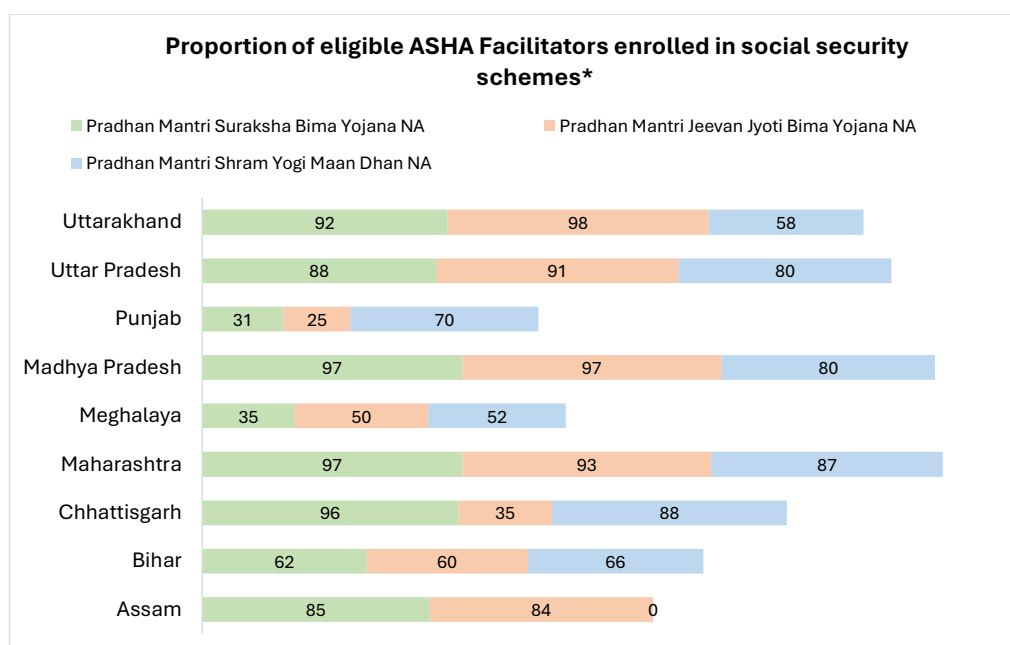
In contrast, Punjab and Sikkim show low enrolment across all three schemes, suggesting gaps in coverage and potential challenges in implementation or awareness. Bihar and Meghalaya reflect moderate enrolment levels across schemes, indicating partial coverage with scope for improvement.



(Source State Reported Data September 2025)

Proportion of eligible ASHA Facilitators enrolled in social security schemes

Overall, enrolment in insurance-based schemes (PMSBY, PMJJBY and PMSYM) was relatively high across Uttarakhand, Uttar Pradesh, MP and Maharashtra. Low uptake of one or more schemes was noted in Assam, Punjab and Meghalaya. Maharashtra and UP have good coverage, more than 80% of eligible AFs enrolled across all the schemes.



(Source: State Reported Data September 2025)- (Data not available for Kerala, Nagaland, Odisha, Rajasthan, Sikkim, Tamil Nadu, Telangana)*

Community Platforms

Village Health Sanitation and Nutrition Days (VHSNDs)

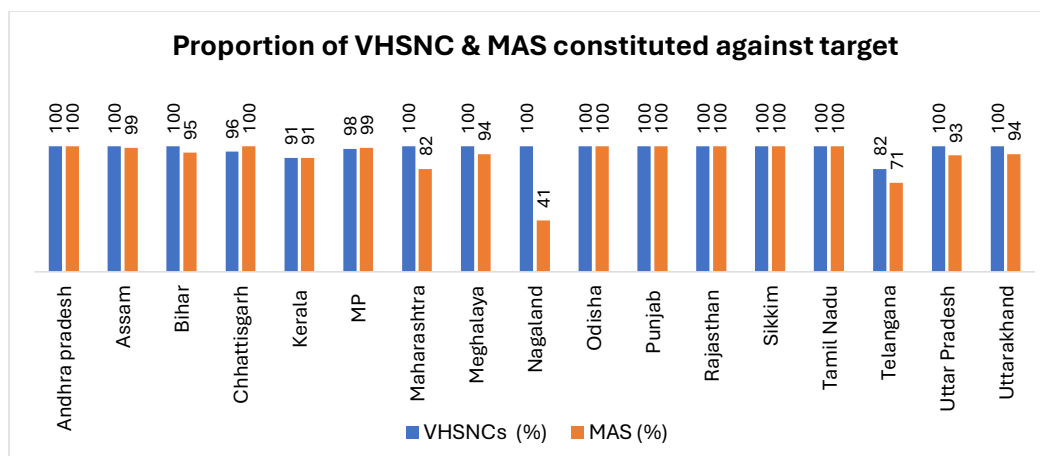
Across states, VHSNDs continue to serve as important platform for outreach service delivery and community engagement. VHSND sessions were reported to be conducted regularly in most locations and supported a range of preventive and promotive services including maternal and child health counselling, immunisation, nutrition counselling, NCD screening, and health education activities.

Coordination between ASHAs, ANMs, Anganwadi Workers, and facility teams during VHSND sessions was observed to support service delivery, beneficiary mobilisation, and awareness generation. In several locations, VHSNDs also served as platforms for community counselling and behaviour change communication activities.

Constitution and Coverage of Community Platforms

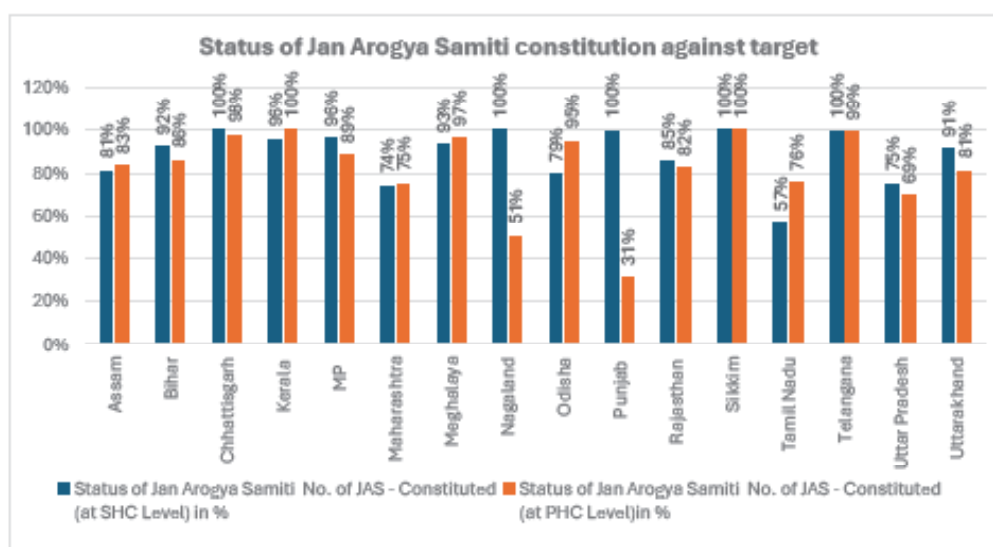
Data presented in the Figure indicates that VHSNCs have been constituted across most states against sanctioned targets, with several states reporting near-complete constitution of committees. Andhra Pradesh, Assam, Bihar, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Tamil Nadu, Uttar Pradesh and Uttarakhand reported near-complete constitution, while Chhattisgarh (96%), Kerala (91%), and Telangana

(82%) the coverage was slightly below the target.



Source: Number of VHSNC and MAS Constituted - MIS September 2025 & Target data - State reports

For Mahila Arogya Samitis (MAS), nearly 100% coverage of MAS formation was observed in Andhra Pradesh, Assam, Chhattisgarh, MP, Odisha, Punjab, Rajasthan, Sikkim, and Tamil Nadu, while Bihar, Kerala, Meghalaya, Uttarakhand, and Uttar Pradesh showed moderately high coverage. Nagaland (41%) and Telangana (71%) reported comparatively lower level of MAS formation.



Source: JAS Constituted - AAM Portal Sept. 2025 and Target Data - State Reports

The data on JAS constitution at Sub-Health Centre and Primary Health Centre levels indicates variation across states. Several states such as Chhattisgarh, Nagaland, Sikkim, Punjab, and Telangana reported 100% constitution of JAS at SHC-AAM while other states such as Assam, Bihar, Kerala, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, and Uttarakhand reported moderate levels of constitution. At the Primary Health Centre level, variation was more pronounced. While Kerala, Sikkim, Telangana, Chhattisgarh and Odisha reported relatively high levels of JAS at PHC-AAM, lower coverage was observed in states such as Uttar Pradesh (69%), Nagaland (51%), Punjab (31%).

Role of Community Platforms

Community platforms, VHSNCs, MAS, and JAS were observed to support community engagement, awareness generation, and local participation in health activities. These forums provide opportunities for community-level discussions, identification of local health issues, and mobilisation of communities for preventive health activities. In several locations, participation of PRI representatives, community leaders, and local institutions was observed to support outreach activities and strengthen community ownership of health programmes.

Despite their widespread coverage, the functionality of community platforms varied across states. In some areas, meetings were conducted regularly and records maintained, while in other locations variations were observed in meeting frequency, documentation of proceedings, and utilisation of untied funds.

Limited awareness among members regarding roles and responsibilities of community platforms was also noted in some states like Bihar, Chhattisgarh and Punjab. Orientation and capacity-building of committee members, structured monitoring mechanisms, and regular review processes may further strengthen the effectiveness of these platforms as mechanisms for community participation, local planning, and accountability in the health system.

Overall, CRM findings indicate that community processes under the CPHC framework have established strong foundations for community outreach and service linkages through ASHAs and community participation platforms. ASHAs continue to serve as trusted community health functionaries facilitating access to health services, while community platforms provide mechanisms for local participation and accountability. At the same time, strengthening of capacity building, digital reporting support, incentive management systems, and hand-holding support to ensure structured functioning of community platforms will be important to further enhance community engagement and the transition towards comprehensive preventive and wellness-oriented primary health care.

KEY OBSERVATIONS

ASHAs – Community Mobilization and Service Linkage

- Across states, ASHAs continue to serve as the primary interface between communities and the public health system, supporting service mobilisation, beneficiary tracking, and health promotion activities.
- Strong community engagement and coordination between ASHAs and frontline health teams were observed in several states. In Andhra Pradesh, coordination between ASHAs, CHOs and MPHA staff contributed to improved antenatal care coverage and NCD screening. Similarly, in most of the states, ASHAs were actively engaged in home visits, beneficiary tracking, mobilisation for immunisation, and community awareness activities, reflecting strong community trust and participation.
- Some state specific initiatives supported ASHAs in overcoming geographic barriers and connecting with the community. In Uttarakhand, particularly in Chamoli district, Palki services were utilised to facilitate patient transport in areas with limited road

connectivity, with incentives provided to both the individuals carrying the palki and the ASHA accompanying pregnant women. Another good practice noted at UPHC in Maharashtra, included public display of ASHA details and creation of WhatsApp coordination groups for early disease identification

- In several states, ASHAs demonstrated good knowledge of programme components such as anaemia screening, maternal health services, and CBAC-based NCD screening. For instance, Andhra Pradesh, Maharashtra, Rajasthan and Sikkim reported strong programme awareness among ASHAs across maternal health, NCD screening, and disease surveillance activities.
- Reports from states of Punjab, Madhya Pradesh and Rajasthan have noted presence of structured support systems including ASHA Facilitators and supervisory mechanisms, which support monitoring and mentoring of ASHAs at field level. Regular review meetings and coordination with facility teams were also reported in states of Uttarakhand and Sikkim.
- Structured incentive payment mechanisms were reported in several states, with digital or system-based platforms such as ASHWIN in Bihar, ASHA First in Meghalaya, APPMS in Kerala, and ASHA Soft in Rajasthan, which support improved transparency and monitoring of ASHA incentives. However, despite the presence of these systems, variations in incentive payment timelines were reported in some states like Chhattisgarh, Maharashtra and Punjab indicating the need for further strengthening of payment processes to ensure timely disbursement.
- Several states reported active participation of ASHAs in a wide range of community health activities beyond routine maternal and child health services. For example, Sikkim and Uttarakhand reported ASHA involvement in multiple public health interventions including vector control activities, TB awareness, menstrual hygiene promotion, and NCD screening.



Community Platforms – VHSNDs, VHSNCs, MAS, and JAS

- Village Health Sanitation and Nutrition Days (VHSNDs) continue to function as important outreach platforms for service delivery and community engagement across states. Effective convergence between health and nutrition interventions was observed in several states. Regular conduct of VHSND sessions with participation of ASHAs, ANMs and Anganwadi Workers was reported in Andhra Pradesh, Assam, Kerala, Meghalaya, Nagaland, Telangana, and Uttarakhand, supporting outreach

sessions, beneficiary mobilisation and service delivery such as immunisation, maternal and child health services, and awareness generation.

- VHSNCs, MAS and JAS have been established widely across states. Regular meetings with proper documentation were noted in states like Nagaland,
- Some innovative community engagement practices were also noted. In Uttarakhand, Participatory Learning and Action (PLA) interventions were reported to support community participation in identifying local health priorities. Similarly, in Assam, participation of PRI representatives and local community leadership like tea garden management representatives contributed to mobilisation for outreach activities.
- Active engagement of local level community leadership was reported in Kerala and Sikkim where participation of Local Self Governments or PRI representatives contributed to community mobilisation and local health planning.



KEY CHALLENGES

ASHAs – Community Mobilization and Service Linkage

- Need for refresher training aligned with Expanded CPHC services: Several states reported the need for strengthening refresher training for ASHAs, particularly on the expanded package of services such as mental health, elderly care, palliative care, and also in some RMNCAH+N related thematics like adolescent health.
- Operational challenges related to digital reporting systems: In a number of states, ASHAs reported difficulties in digital reporting due to use of multiple applications, lack of functional devices, or connectivity constraints. ASHAs in some states often relied on personal smartphones or faced connectivity issues affecting timely reporting. Increased workload associated with expanded programme responsibilities and digital reporting was noted, where frontline workers reported managing multiple digital systems and expanded service responsibilities as a challenge.
- Delays or complexity in incentive payment systems: While digital payment mechanisms exist in several states, delays or complexities in incentive payments were reported. In some states, incentives were received in multiple transactions, creating confusion regarding payment components.
- Mobility and geographic constraints affecting outreach: Difficult terrain and long travel distances were reported as barriers to outreach and follow-up activities in tribal districts, indicating the need for logistical and transport support.

- Variations in documentation practices and reporting quality: Variations were noted in record-keeping practices, including home visit documentation and beneficiary records, highlighting the need for continued mentoring and supportive supervision.

Community Platforms – VHSNDs, VHSNCs, MAS and JAS

- Variation in functionality of community platforms: Although VHSNCs, MAS and JAS have been constituted across most states, their functionality varied across states. Irregular meetings, limited documentation, and inconsistent follow-up of action points were noted.
- Limited awareness of roles and responsibilities among members: In some states, members of community platforms had limited awareness of their roles and responsibilities, orientation and capacity building of committee members was reported to be limited.
- Challenges in fund utilisation and financial processes: Issues related to utilisation of untied funds, delays in fund release, or limited awareness of fund utilisation processes were reported in a few states, affecting the functioning of the community platforms.
- Variation in MAS formation and functioning in urban areas: While MAS platforms have been formed in most of the states, relatively lower % of formation or engagement was noted in Nagaland and Telangana, indicating need for stepping up efforts for their formation and hand-holding.
- Need for hand-holding support to community platforms to enable them to undertake health planning: In some states, community platforms were not being fully utilised for monitoring facility performance or local health planning. Strengthening review and hand-holding support for these platforms was suggested.

RECOMMENDATIONS

ASHAs – Community Mobilization and Service Linkages

- Capacity building of ASHAs: States need to support the implementation of the revised training strategy, and support capacity building of ASHAs as per the new Integrated Training Modules. Till the time, the Integrated Training was rolled out at the grass-root level and Training of Trainers were conducted, states may consider selective refresher training for ASHAs on the Expanded Package of Services, including mental health, elderly care, palliative care, adolescent health, and lifestyle-related risk factors, to support effective community level service delivery.
- Strengthen Supportive supervision and Mentoring systems: States to Strengthen the role of ASHA Facilitators, Block Community Managers, and facility teams in providing structured mentoring, field supervision, and performance feedback to help improve service delivery, documentation practices, and quality of outreach activities.

- Strengthen documentation and reporting practices: There is a need to strengthen the periodic mentoring and supportive supervision may help improve documentation quality for home visits, beneficiary tracking, and programme reporting.
- Strengthen Incentive payment systems: States to ensuring timely and transparent payment of ASHA incentives, along with improved communication regarding payment components, to help sustain motivation and engagement of frontline workers.
- Provide logistical and Mobility support in difficult terrains: areas, states to support provision of mobility support mechanisms or locally appropriate transport solutions in geographically challenging areas to improve outreach coverage and follow-up visits.

Community Platforms – VHSNDs, VHSNCs, MAS and JAS

- Strengthen orientation and capacity building of community platform members: States to conduct regular orientation programmes for VHSNC, MAS and JAS members to improve understanding of their roles, responsibilities, and functions in local health planning; as well as support to, and monitoring of health programs.
- Strengthen functionality and regularity of meetings: States may sensitize program management units and primary healthcare teams to actively monitor and ensure regular meetings of community platforms, documentation of proceedings, and follow-up of action points. Improved oversight may strengthen the role of community platforms in supporting primary health care delivery.
- Improve utilisation and transparency of untied funds: States to strengthen financial management processes, timely release of funds, and capacity building of committee members on fund utilisation to enhance the effectiveness of these platforms.
- Strengthen convergence with local institutions and community groups: States to ensure greater engagement of local governance institutions, (PRIs and urban local bodies) self-help groups, and community leaders to strengthen intersectoral coordination and community ownership of health initiatives.

STATE SPECIFIC FINDINGS^[1]

Andhra Pradesh

ASHAs – Community Mobilisation and Service Linkage

- ASHAs, Community Health Officers (CHOs/MLHPs) and MPHA (Multi-Purpose Health Assistant) workers were found to be well integrated into service delivery across both visited districts. In Chittoor district, coordination between CHOs and ASHAs was particularly strong, ensuring high coverage for ANC, NCD screening and tracking of high-risk pregnancies.
- ASHAs in the tribal and remote areas of Parvathipuram Manyam frequently travel to distant hamlets without transportation support and often use personal funds for

travel, demonstrating a high degree of motivation yet revealing a need for system-level mobility and logistical support.

- In the tribal blocks of Parvathipuram Manyam district, large geographic coverage areas and difficult terrain significantly increased the workload of CHOs and affected regular follow-up visits.
- Refresher trainings for ASHAs and CHOs on RMNCAH+N (especially identification and referral of high-risk pregnancies), TB and mental health had not been conducted recently, highlighting the need for periodic capacity strengthening.
- ASHA incentives and CHO payments were reportedly processed through a centralised system and were largely on time. Interactions with ASHAs confirmed satisfaction with timely salary payments and good awareness of anaemia screening, MHS and NCD CBAC forms. Concerns regarding career progression were expressed.
- ASHAs also reported the burden of reporting similar information across multiple digital applications and highlighted that government-issued phones were not functioning well, resulting in reliance on personal phones for routine work.

VHSNDs – Village Health, Sanitation and Nutrition Days

- VHSNDs were held regularly in most villages and serve as a critical platform for vaccination, growth monitoring, HBYC counselling and maternal health services.
- Regular VHSND sessions were also observed being held at Anganwadi Centres on dedicated days of each month.
- In Chittoor, VHND sessions demonstrated effective coordination among ASHAs, Anganwadi Workers and CHOs, with due-list tracking sheets largely updated. However, in Parvathipuram Manyam, mobilisation of remote tribal settlements remained challenging due to long distances, resulting in delays in immunisation among children from hard-to-reach habitations.

Assam

ASHAs – Community Mobilisation and Service Linkage

- Assam had a fully staffed ASHA network, with 33,656 ASHAs in the state – 32,376 in rural areas and 1,280 in urban areas. All sanctioned rural and urban ASHA positions were in place.
- Routine trainings have been conducted; all ASHAs have completed Modules 6 & 7 and were trained in NCD, and MNS.
- However, refresher training on expanded CPHC packages including adolescent health, mental health, elderly care and palliative care was still pending. Variations were also observed in documentation quality, requiring mentoring and supportive supervision.

- ASHAs were found to be active in home visits, mobilisation for VHSNDs, ANC and PNC follow-up, immunisation, NCD screening through CBAC forms, and accompanying beneficiaries to facilities.
- ASHAs, ANMs, CHOs and Anganwadi workers across both districts demonstrated strong ownership of their roles and good rapport with communities, including in tea-garden areas and tribal habitations.
- ASHA incentives were reported to be released timely in both districts, which had a positive effect on motivation and helps maintain a regular presence in the community, including in tea-garden lines and remote habitations.
- Awareness and structured engagement on adolescent health, mental health (including Tele MANAS), tobacco/ alcohol counselling, and wellness activities were limited. Targeted outreach strategies were needed in tea-garden areas, as awareness of health facilities was low among temporary and migrant tea-garden workers.

VHSNDs – Village Health, Sanitation and Nutrition Days

- VHSNDs were being organised regularly, serving as a key platform for ANC check-ups, immunisation, growth monitoring and basic counselling, indicating their continued relevance in delivery of primary healthcare services.
- VHSND sessions reflected active community participation, with community members observed to be familiar with ASHAs, AWWs and services available at AAM and PHC levels. Participation of PRI representatives and local leaders, including tea-garden representatives in some areas, supported mobilisation for VHSNDs, immunisation and outreach activities.
- Coordination between ASHAs and AWWs was observed to be strong at the village level; highlighting the importance of continued strengthening of frontline coordination and community platforms.
- Limited integration of AAM with VHSND planning and community platforms was observed, indicating the need for strengthening convergence for improved microplanning and service delivery.

Community Platforms – VHSNCs, JAS and Rogi Kalyan Samitis

State had established community platforms, with all 27,913 VHSNCs formed and having bank accounts; 658 MAS constituted in urban areas; and JAS constituted in 81% of SHC-AAM and 89% of AAM PHC^[2], supporting community engagement and service delivery.

- VHSNC and JAS members had limited structured training on their roles in monitoring AAM performance and follow-up of local health issues, constraining their effectiveness as accountability and problem-solving platforms at the community level, and indicating the need for a structured orientation for VHSNC and JAS members on their roles and responsibilities.

- Functioning of community platforms was observed to be uneven across districts. JAS and VHSNC meetings were not held regularly in several areas, with limited documentation of meeting minutes and follow-up actions. These platforms were not being optimally utilised for monitoring AAM performance or grievance redressal, indicating the need for strengthening regularity, documentation and functional utilisation of these forums.

Bihar

ASHAs – Community Mobilisation and Service Linkage

- A community mobiliser cadre was in place at state, district and block levels, linked with ASHA Facilitators, supporting programme implementation and mentoring.
- ASHAs were available as per norms; however, their role in mentoring and operational handholding at the grassroots level requires further strengthening.
- Capacity building initiatives were ongoing, and most ASHAs have received training in HBNC and HBYC modules, with moderate coverage of NCD-related training. Yet, awareness and skills related to HBNC and HBYC were variable, particularly in counselling, identification of danger signs, and recognition of malnutrition/ SAM. CPHC related trainings and utilisation of learning from digital platforms such as Mobile Academy and Kilkari certification was limited.
- State had implemented a centralised online incentive payment mechanism through the ASHWIN portal (operational since December 2020), enabling monthly submission of activity reports with multi-level verification (ANMs, BCMs, DCMs and MOICs) and DBT-based payments. While the system had streamlined reporting and verification processes through defined timelines and auto-forwarding provisions, delays of 3–4 months in incentive payments were reported in some areas.
- IT infrastructure and smartphones were generally available at facilities and with ASHAs, supporting digital processes; however, ASHAs expressed the need for support in mobile application use and digital claim submission, indicating scope for further digital capacity strengthening.
- Record-keeping for Performance Linked Payments (PLP) and Team-Based Incentives (TBI) remained largely manual, indicating scope for further digitisation and integration with platforms such as m-ASHA and Bhavya.
- ASHA diaries were not being maintained. It was reported that ASHA Facilitators, ANMs, CHOs and BCMs had not oriented ASHAs on maintenance of work diaries.
- Regular home visits were not consistently undertaken by ASHAs, with their focus primarily on Routine Immunisation and ANC services. There is a need to expand their engagement across the continuum of care, including NCD screening, family planning counselling, adolescent health and elderly care.

- In some remote areas, ASHAs were not available, and paid mobilisers were engaged in their place, indicating gaps in last-mile service coverage.

VHSNDs – Village Health, Sanitation and Nutrition Days

- All contraceptives were available at VHND sites in Munger. However, counselling for family planning was less emphasised, and community members reported limited knowledge about various contraceptive options.

Community Platforms – VHSNCs, MAS and JAS

- VHSNCs and JAS had been formed in the visited facilities; JAS accounts have been operated as per norms and registers and records were being maintained; noted as a good practice.
- However, awareness among ASHAs and community members regarding the roles and functions of VHSNCs and JAS varied, with confusion noted between the two platforms.
- Knowledge of fund utilisation processes and committee responsibilities among JAS members was limited, and formal orientation/training had not been conducted uniformly.
- Strengthening orientation and regular review mechanisms may enhance the effectiveness of these platforms as community accountability and planning forums.

Chhattisgarh

ASHAs (Mitanins) – Community Mobilisation and Service Linkage

- Chhattisgarh had a well-established community processes framework through the Mitadin programme. Mitadin covered an average population of approximately 350 in rural areas and around 720 in urban areas, broadly aligned with programme norms.
- Mitadin serve as an important interface between the community and health system, undertaking regular household visits and supporting antenatal and postnatal care, newborn and young childcare, communicable and non-communicable disease awareness, and beneficiary mobilisation for outreach services.
- All Mitadin had received training on Modules 6 and 7, Non-Communicable Diseases (NCDs), and Home-Based Young Child Care (HBYC). However, none of the Mitadin in the visited areas had been trained on the Expanded Package of Services under CPHC, limiting their role in newer programme components.
- A majority of Mitadin were enrolled under social security schemes including PM-SBY and PM-SYM. However, enrolment under PM-JJB was found to be relatively low, indicating incomplete coverage under social security schemes.

- Delays in disbursement of Mitadin incentives were reported in certain blocks (e.g., Baghbara block in Mahasamund, and Kanker), affecting morale and routine field functioning.
- Smartphones had not been provided to Mitadins in the blocks visited, and no digital or IT platforms were being used by them for service delivery, reporting, or community tracking.
- Career progression mechanisms appeared stagnant, with no observed promotion of Mitadins to Master Trainers or Block/District-level coordinators over the past several years, potentially affecting motivation and retention.
- A strong involvement of Mitadins in community outreach was observed during the visit. However, gaps in population-based screening for hypertension and diabetes among the 30+ population were identified, primarily due to inadequate community mobilisation.
- Disrespectful behaviour of hospital staff towards Mitadins/ASHAs was reported by community members during FGDs, noted as highly demotivating for the cadre.

VHSNDs – Village Health, Sanitation and Nutrition Days

- UHSNDs/VHSNDs were being conducted regularly and served as important platforms for service delivery and awareness generation. Positive behaviour change was observed in PVTG areas, including improved adoption of preventive practices such as long-lasting insecticidal nets and LPG usage.
- Frontline health workers regularly disseminated information related to ANC/PNC services, JSY, JSSK, and other health schemes through door-to-door visits and during VHND sessions, as reported across community FGDs.
- Family planning outreach and leprosy screening were conducted inconsistently, indicating the need for strengthened fixed-day outreach planning and improved coordination between facility teams and community-level workers. Further, adult NCD screening coverage remained relatively low in some areas, indicating scope for strengthening preventive outreach and follow-up.

Community Platforms – VHSNCs, MAS and JAS

- Community governance platforms were in place across facilities, though their functionality varied. In several facilities, Jeevan Deep Samiti (JDS) committees were functioning in place of Jan Arogya Samitis (JAS), though alignment with national guidelines and roles was not uniform.
- Community participation in governance platforms was uneven. PRI engagement was stronger in facilities that had undergone quality certification processes, while in other areas meeting regularity, documentation, and follow-up actions were less consistent.

- Monthly meetings of VHSNCs and JAS/JDS were irregular or absent in many areas. Untimely release of untied funds for VHSNC/JAS was reported, affecting planning and execution of community-level activities.
- Untied funds were predominantly utilised for facility upgradation, with limited evidence of their use for community-driven actions addressing sociocultural and environmental determinants of health such as sanitation, nutrition, or behavioural change initiatives.
- Representation within committees was incomplete in some locations, with limited participation from civil society groups, self-help groups, education sector representatives, or adolescent health teams, indicating scope for strengthening intersectoral convergence and inclusiveness.

Kerala

ASHAs – Community Mobilisation and Service Linkage

- ASHA selection had been completed in the State against their sanctioned targets, with a well-defined support structure in place for their functioning.
- ASHAs play a central role in community-level service delivery and health promotion, including promoting health awareness and facilitating antenatal care, tracking high-risk pregnancies and mobilising beneficiaries for institutional deliveries, counselling for immunisation, family planning, care of LBW babies, and providing health education on hygiene, nutrition, and disease prevention. They undertake regular home visits and maintain ASHA diaries for documentation of day-to-day activities.
- ASHAs also contribute significantly to the implementation of National Health Programmes and support home-based care for newborns, children, elderly persons, and vulnerable groups.
- All ASHAs have been trained on Modules 6 and 7, with periodic training on programme components such as HBNC, HBYC, and NCDs screening and follow-up. Module 9 training had been completed for all working ASHAs in the visited district, and Module 2 training had been completed for Hamlet ASHAs as well. While training coverage was substantial, the need for periodic refresher training was noted to support the expanding scope of responsibilities under Comprehensive Primary Health Care (CPHC).
- State had a robust ASHA incentive payment mechanism; the ASHA Payment and Performance Monitoring System (APPMS). ASHAs receive a monthly fixed honorarium of Rs 8,000 per month from state funds, in addition to activity-wise performance-based incentives and social security benefits; noted as a significant good practice.
- Family folders have been maintained by ASHAs for their respective areas.
- ASHA kits were found to be unavailable, weakening HBNC and HBYC activities. No reports of HBNC/HBYC visits were shared at the national level.

VHSNDs / UHNDs – Village Health, Sanitation and Nutrition Days

- VHSND and Urban Health and Nutrition Day (UHND) sessions were being conducted regularly. Outreach activities were carried out on designated days.
- Outreach activities were being conducted through coordinated engagement of ASHAs, MAS, Junior Public Health Nurses (JPHN), Junior Health Inspectors (JHI), Anganwadi Workers, and Local Self Government (LSG) representatives.
- ‘Eat Right’ promotion and nutritional counselling were being integrated into VHSND/ UHND sessions to encourage healthy diets during pregnancy, though community acceptance and penetration remain low.

Community Platforms – VHSNCs, MAS and JAS

- Under NUHM, 90 ASHAs and 42 MAS Groups were in position to strengthen community engagement and conduct Urban Health and Nutrition Days (UHNDs). MAS groups have received training to strengthen their skills.
- JAS have been constituted at SHC-AAM, USHC-AAM, UPHC-AAM and PHC-AAM levels. Registers were maintained and monthly meetings were being held regularly.
- Active engagement of Local Self Government Department (LSGD) members and PRI representatives was observed as a key strength in the state. LSG participation supports infrastructure development, maintenance, local monitoring, and inter-sectoral coordination, enabling the health system to address social determinants of health through community-led approaches. This collaborative model strengthens community ownership and contributes to improved convergence across sectors at the local level.
- At the visited AYUSH facility (Cheruvathur AAM), the Ayush JAS had not yet been constituted, indicating a gap in extending community governance structures to AYUSH-run facilities.

Madhya Pradesh

ASHAs – Community Mobilisation and Service Linkage

- A total of 68,295 ASHAs were in position across the state, comprising 64,093 rural ASHAs and 4,202 urban ASHAs achieving 94.6% of sanctioned targets. Rural ASHA placement stands at 96%, while urban coverage was comparatively lower at 79%, highlighting the need for focused recruitment in urban settings. ASHA Facilitator placement stands at 89.5% (5,071 against a target of 5,666).
- ASHAs were observed to be actively engaged in community mobilisation and awareness activities across both districts, effectively facilitating access to maternal, child health, and other essential services.
- Districts such as Mandsaur and Vidisha demonstrated high placement of ASHAs and ASHA Facilitators, reflecting strong support and supervision mechanisms in both districts.

- Training coverage under HBNC and HBYC showed substantial progress for ASHAs and ASHA facilitators. For NCD screening, 72.7% of ASHAs had been trained. Training under MNS (Mental, Neurological and Substance Use) and Elderly & Palliative Care had covered 28.2% and 6.53% ASHAs respectively. OEEE (Orientation on Essential Emergency Exercises) training had yet to be initiated.
- Capacity-building activities for ASHAs in Vidisha district have not been conducted during the past two years, highlighting a significant gap in refresher training and continuous skill enhancement.
- On average, ASHAs reported receiving Rs 10,000–12,000 per month through routine incentives and task-based payments. The state provides an additional fixed monthly incentive of Rs 4,000 to ASHAs and Rs 6,000 per month to ASHA Facilitators, further strengthening financial support.
- Incentives were processed through SPARSH, contributing to transparency, but multiple activity heads result in multiple transactions per cycle, creating reconciliation challenges. System-related constraints such as limits on beneficiaries per payment file and technical issues with RBI e-Kuber occasionally affected reconciliation timelines.
- Delays in JSY payments were reported during the transition from ANMOL-based to SPARSH-based systems, due to procedural adjustments and clarification requirements.
- State had initiated enrolment of ASHAs in ANM/GNM courses for career progression. However, ASHAs in both districts were unaware of any such career progression process.
- Awareness of social security schemes among ASHAs and ASHA facilitators was found to be satisfactory. A number of eligible ASHAs and ASHA Facilitators have been enrolled under PMSBY, PMJJBY, and PM-SYM schemes.

Community Platforms – VHSNCs, MAS and JAS

- In Madhya Pradesh, VHSNCs were known as 'Gram Sabha Swasthya Tadarth Samiti. 93% of VHSNC and 80% of the MAS had been constituted in the State against their target.^[3]
- VHSNCs in the visited villages were found to be functional and meetings were being conducted at regular intervals. However, proper documentation of Minutes of Meetings was lacking, indicating the need for strengthened record-keeping practices. Monthly and annual health action plans had not been developed in either district, highlighting a gap in structured community-level planning and prioritisation.
- A total of 80% MAS had been constituted in state and functioning as per the national guidelines. Members demonstrated a high level of motivation and long-standing commitment, with many members having served in the MAS for up to nine years.

- Monthly MAS meetings were being conducted regularly at Anganwadi Centres. However, the record of meeting minutes was not available to members at the time of the visit, indicating a gap in documentation. MAS reported receiving an annual untied fund of Rs 5,000; the Chairperson displayed good awareness of fund utilisation, but documented expenditure records were not available.
- Jan Arogya Samitis (JAS) had been constituted in all facilities visited. However, role clarity among JAS members was limited. JAS monthly meetings were not being conducted regularly. Minutes of Meetings were maintained, but documentation quality and follow-up actions require strengthening.

Maharashtra

ASHAs – Community Mobilisation and Service Linkage

- ASHAs across both visited districts were found to be highly motivated, dedicated, and knowledgeable about their roles and responsibilities. They were observed effectively mobilising tribal women for ANC services and promoting institutional deliveries, reflecting strong trust and rapport with the community.
- ASHAs reported receiving Rs 10,000 as fixed incentive for her work in addition to the performance-based incentives. However, these incentives were not being disbursed as a consolidated lump sum amount, leading to administrative burden and causing delays and confusion. Salary disbursements were also delayed by up to two months across facilities.
- ASHAs reported low incentive for institutional deliveries (Rs 600/case) in the context of tribal and remote areas. They also raised concerns regarding the lack of stay arrangements in hospitals when accompanying pregnant women, often having to sleep on the floors during such visits.
- ASHAs in Nandurbar district requested mobility and transport support, to facilitate commute in hilly terrain.
- ASHAs and ANMs showed good knowledge of family planning services, though in Nandurbar counselling coverage was limited and many multiparous women were unaware of available FP methods, and condom distribution was not routinely being done by ASHAs.
- ASHAs were being involved in NCD screening through CBAC forms, TB surveillance, leprosy active case detection, and mobilisation for sickle cell screening camps. In Satara district, ASHAs were using the online NCD portal for CBAC screening. However, in Nandurbar, CBAC forms had not been filled for the past 2–3 months as ASHAs had not received the revised physical formats for population screening.
- ASHAs in Nandurbar were actively using the FP-LMIS portal to identify beneficiaries and track contraceptive logistics; however, poor internet connectivity poses significant challenges to timely data entry.

- ASHAs in hard-to-reach and tribal areas of Nandurbar district demonstrated initiative in arranging emergency referrals and ensuring continuity of care despite significant travel challenges and difficult geographic barriers. In remote blocks such as Dhadhgaon, ASHAs reported safety concerns during night-time emergency travel and relied on their partners to accompany them on such trips.
- ASHAs reported a need for refresher trainings on programmes and digital portals. Virtual trainings conducted during the COVID period have resulted in lower knowledge retention and significant skill gaps, particularly in clinical documentation and portal usage.

Community Platforms – VHSNCs, JAS and Rogi Kalyan Samitis

- Rogi Kalyan Samitis (RKS) were found functional across all levels of health facilities in both districts.
- Jan Arogya Samitis (JAS) had been constituted in newly operationalised Primary Health Centres and Sub-Centres. However, in older Sub-Centres and PHCs, the RKS structures have not yet been converted into JAS, leading to non-uniformity in community governance frameworks.
- Regular committee meetings were observed at the SHC level, indicating utilisation of community platforms for decision-making. However, meeting data was not consistently recorded, and meeting minutes were not recorded in JAS registers.
- It was observed that no JAS/RKS grants had been received during the current financial year in some facilities, resulting in delays or non-implementation of planned activities.
- Innovative community engagement practices were observed at UPHC Maliwada in Nandurbar district, where an IEC board displayed the names, photographs, and contact details of each ASHA along with their respective catchment areas- noted as a good practice for community reference and accountability. WhatsApp groups of Medical Officers, leprosy technicians, and ASHAs had also been formed for early identification of leprosy cases.

Meghalaya

ASHAs – Community Mobilisation and Service Linkage

- ASHAs demonstrated active involvement in ANC care, Vector-Borne Disease (VBD) control, VHND sessions, and other national health programme activities.
- Strong Coordination between ASHAs, ANMs, and CHOs was reported, and ASHAs participated actively in maternal and child death reviews and outreach activities, reflecting commitment to community-based service delivery.
- Tablets and ASHA diaries were being properly utilised by ASHAs for service delivery and documentation.

- State had implemented the ASHA First mobile application, enabling ASHA Facilitators to facilitate timely, weekly, online payment of incentives to ASHAs. However, ASHA Central Incentive disbursement had been on hold since July 2025 due to SNA-SPARSH system implementation delays, with some ASHAs not received payment since March 2025.
- Documentation gaps were observed in Mother and Child Protection (MCP) cards, specifically in recording PNC, HBNC, and HBYC visits.
- Cultural acceptance of Antara (injectable contraceptive) was high among women in Meghalaya; however, supply chain shortages leading to stockouts have resulted in poor follow-up and reduced compliance.
- Field challenges faced by ASHAs included illiteracy among beneficiaries, vaccine refusal, inaccessible areas, unavailability of local transportation, poverty, and cultural sensitivities. Most community members in some areas did not comply with health messaging and were reported to get offended when approached.
- Digital reporting was affected in areas with limited connectivity, requiring improved device access and connectivity support.

VHSNDs – Village Health, Sanitation and Nutrition Days

- VHSND sessions were conducted regularly, though documentation quality (MCP card entries, HBNC/HBYC visit records) requires strengthening.
- Convergence between AWWs, ASHAs, and ANMs was strong at VHSND sites, particularly for maternal and child health sessions. However, joint home visits were limited due to logistical constraints and workload. Documentation of convergence activities was weak.
- Community-level awareness about availability of referral transport remains limited. Adolescent health clinic and awareness activities in VHNDs need to be strengthened.

Community Platforms – Village Health Councils (VHCs) and RKS

- In Meghalaya, Village Health Councils (VHCs) serve as the equivalent of VHSNCs, constituted across rural and urban localities as nodal community institutions, supported by state-issued operational guidelines and locally adapted IEC materials.
- VHC members were actively involved in cleaning drives, plantation, and PHC-assigned activities such as anaemia, malnutrition, mental health, and high-risk pregnancy management. They conduct home visits alongside ANMs and hold monthly meetings regularly.
- VHC members in Khaldang AAM highlighted that untied funds for the current financial year have not been released, affecting planned community-level activities. Untied funds were not available in any of the facilities visited for FY 2025-26.

- Variability in VHC engagement and record maintenance exists across villages. Inconsistent functionality and poor record maintenance of VHC proceedings were noted in some SHCs.
- RKS meetings were held regularly in East Khasi Hills and partially in North Garo Hills. Fund utilisation was satisfactory but lacks detailed activity-based planning.
- Effective inter-sectoral coordination for vector control through convergence with ASHA, AWW, and PRI networks was noted as a good practice. Community-led health days in North Garo Hills were identified as a local innovation for health promotion.

Nagaland

ASHAs – Community Mobilisation and Service Linkage

- ASHAs were actively engaged in community-based activities, including postnatal home visits under HBNC and maintenance of beneficiary line lists.
- ASHAs, ANMs and CHOs had been trained for NCD screening and CBAC administration and verification and were well-informed about the range of services available at their respective facilities.
- ASHAs maintained updated line lists for weekly Iron and Folic Acid supplementation, contributing to nutrition outreach.
- Payments to ASHAs and beneficiaries under JSY, Family Planning, and NTEP were routed through Direct Benefit Transfer mechanisms, ensuring transparency. However, payment delays were reported in some areas, including pending ASHA incentives since August 2025 and delays in JSY and Nikshay Poshan Yojana payments, largely due to SNA–SPARSH transition issues.
- ASHAs reported significant challenges in online data entry due to the unavailability of electronic devices and poor internet connectivity across both districts.
- Inter-departmental convergence between facility staff and field staff (ANMs and ASHAs) was reported to be lacking, with workers functioning independently in the absence of proper supportive supervision.

VHSNDs – Village Health, Sanitation and Nutrition Days

- VHSNDs were being regularly conducted in the community across both districts with ASHAs playing a central role in mobilisation and counselling.
- Promotion of tobacco cessation was being undertaken during VHND sessions. However, overall community-level IEC activities required strengthening.

Community Platforms – VHSNCs, MAS and JAS

- VHSNCs and JAS were constituted and found to be functional in visited facilities. Meetings were conducted regularly, and records of proceedings were maintained.
- Discussions during JAS meetings included disease prevention and health promotion initiatives, indicating their use for community engagement and local health planning.

- However, formation of MAS platforms was not observed in the visited Urban Primary Health Centre in Mon district, highlighting scope for strengthening urban community platforms.

Odisha

ASHAs – Community Mobilisation and Service Linkage

- A total of 49,508 ASHAs were in position across the state - 47,233 rural ASHAs and 2,275 urban ASHAs. In the visited districts, 1,970 ASHAs were in position in Kalahandi and 1,545 in Bargarh, indicating near-adequate coverage at the primary level.
- ASHAs were actively involved in facilitating community awareness about teleconsultation (e-Sanjeevani) benefits through IEC activities.
- Incentive payments under JSY and ASHA schemes were processed through SNA-SPARSH, though delays were reported in some facilities due to operational challenges during system alignment. There was a need to strengthen financial workflow processes to ensure timely clearance of pending payments and sustain frontline workers' motivation. Integration of Aadhaar-Based Payment Systems (ABPS) with existing financial management systems such as IFMS can improve transparency and streamline payment processes.
- Digital reporting challenges were noted among ASHAs, especially due to non-functional tablets and limited access to operational devices, while ANMs and CHOs were generally able to use applications effectively. Simplification of digital tools and provision of hands-on training support can improve adoption and ease of reporting at community level.

VHSNDs – Village Health, Sanitation and Nutrition Days

- VHSND and Urban Health and Nutrition Day (UHND) meetings were conducted twice weekly across visited facilities, focusing on maternal and child health education. Sessions were being regularly held in the community.

Community Platforms – VHSNCs, MAS and JAS

- VHSNCs were functional and maintaining physical bank accounts at the sub-centre level, with funds being transferred directly by Block Programme Management Units (BPMUs). Extending the SNA-SPARSH fund flow system to the VHSNC level as per Department of Expenditure guidelines remains a challenge for the state.

Punjab

ASHAs – Community Mobilisation and Service Linkage

- The state had a high proportion of ASHAs in position (97%) against sanctioned posts, with adherence to prescribed selection criteria and representation from marginalised communities.

- ASHAs were found to be functional and aware of their roles and responsibilities, playing a key role in community mobilisation and service linkage across rural and urban areas.
- Performance-based incentive mechanisms were in place, with an average monthly earning of Rs. 5,000–6,000, including a fixed incentive of Rs. 2,500. However, delays of 2–3 months in disbursement were reported. In addition, non-payment of certain programme-specific incentives, particularly under NCD services, was observed.
- Additionally, maternity benefits of Rs. 2,500 were implemented for ASHAs and ASHA Facilitators during maternity leave.
- Supportive supervision structures were functional, with ASHA Facilitators and CHOs overseeing ASHA activities. Performance monitoring systems were in place across administrative levels.
- Most ASHAs have received training on key programme components, including HBNC, HBYC, and NCD services. However, gaps in training effectiveness were noted, particularly with increased reliance on virtual modalities, impacting knowledge retention and practical skills.
- Variations were observed in the adoption of digital platforms for reporting. In Jalandhar, ASHAs use multiple apps via personal phones, while in Faridkot many were not using portals due to grievance/union issues. ASHAs, ANMs, and Staff Nurses were required to update entries on UWIN application so that real-time data was reflected, but compliance was inconsistent.
- No formal ASHA grievance redressal system exists; grievances were addressed informally by the CMO and District ASHA Nodal. The state had developed an Online ASHA Portal to facilitate real-time access to ASHA-related information, but ASHAs in the visited districts were largely unaware of this application.
- Availability and replenishment of ASHA kits were found to be inadequate, indicating gaps in logistics and supply chain management.
- Variations in ASHA engagement across programme components were observed, linked to operational and incentive-related challenges.
- As an enabling practice, efforts to support continued education of ASHAs for career progression into ANM roles were reported in some areas.
- As an encouraging practice, in Faridkot district, ASHAs were being motivated to complete their 12th standard education, making them eligible to qualify for ANM positions.
- ASHA and ASHA Facilitators were covered under Ayushman Bharat – Mukhya Mantri Sehat Bima Yojana (AB PMJAY MMSBY).

VHSNDs – Village Health, Sanitation and Nutrition Days

- ASHA and ANMs were found to be involved in conducting VHSNC and UHND sessions in both the visited districts.
- Intersectoral convergence was observed, including collaboration with the Ministry of Forestry for sapling distribution, fogging activities by Urban Local Bodies (ULBs), and coordination with the Agriculture Department to reduce stubble burning.
- In urban areas, ULBs were involved in hygiene and sanitation-related activities but had limited coordination meetings with the health department.
- Communities expressed satisfaction with MCH outreach, but raised concerns about water quality, dengue/chikungunya burden, limited IEC, and weak wellness activities.
- Community participation extended to local contributions for facility strengthening, including provision of essential amenities and infrastructure support, indicating a good practice in community-led health system strengthening.

Community Platforms – VHSNCs, MAS and JAS

- VHSNCs and MAS were constituted in the visited districts. Meetings were held regularly. However, orientation of members regarding their roles and responsibilities remains inadequate. The state reported not receiving VHSNC untied funds for the last three years.
- MAS were formed in Faridkot district; however, MAS involvement was found to be limited in Jalandhar, with MAS non-functional at most centres. Monitoring mechanisms for ensuring timely, streamlined, and need-based activities of VHSNCs and JAS committees require strengthening, particularly in urban areas.
- JAS have been formed in the visited facilities; however, JAS members lack full understanding of JAS functioning and their roles.
- JAS meetings were conducted regularly, with registers maintained and action-taken activities recorded. However, discussions during JAS meetings were found to be primarily focused on AAM infrastructure development, rather than health-related service improvements.
- In Faridkot district, the visited facilities had active patient support groups in the community.
- As a notable good practice, in Faridkot district, JAS registers were well-documented with team composition highlighted in photographs to demonstrate accountability.

Rajasthan

ASHAs – Community Mobilisation and Service Linkage

- The state had a high proportion of ASHAs in position against sanctioned posts, with minimal vacancies and adherence to defined selection criteria.

- ASHAs were found to be well-motivated, and aware of their roles and responsibilities, with good community rapport and active involvement in beneficiary identification, mobilisation for ANC, immunisation, and follow-up of high-risk cases.
- ASHA Soft, the online payment and monitoring system was being used to capture beneficiary-wise service data, process online incentive payments directly to ASHA bank accounts, and generate monitoring reports for timely and transparent Performance-based incentives were being disbursed in a timely manner through digital platforms (e.g., OJAS/ASHA Soft), with verification at block and district levels. No major pending payments reported.
- Supportive supervision mechanisms were in place, with ASHA Facilitators and block-level officials (including BCMs) overseeing approximately 20–25 ASHAs. ASHAs maintain all mandated registers, including ANC/PNC, immunisation, NCD screening, home visits, and VHSND records.
- ASHAs have been trained on Modules 6 and 7, and key programme components including HBNC, HBYC, NCD screening, and reproductive and child health services. While 2–4 trainings per year were being conducted, gaps were noted in availability of refresher trainings and absence of a structured state training calendar.
- Most ASHAs used personal smartphones with a monthly compensation of Rs. 600, but device-related issues persist. ASHAs also reported a high burden of multiple digital applications (ASHA Soft, Khushi Baby, PMJAY, PCTS, NCD, ABHA, FP-LMIS, Marudhar, U-WIN), leading to duplicate data entry and repeated logins. NCD app password regeneration after short inactivity (4–5 days) was cited as a practical difficulty.
- Social security coverage of ASHAs under schemes such as PMJAY, PMJJBY, PMSBY (MAA), and state-specific health insurance schemes was observed; however, awareness regarding schemes such as PM-SYM remains limited.
- The state had provisions for career progression, including reservation in ANM training (e.g., 10% quota) and enrolment in certification courses such as NIOS. Recognition of best-performing ASHAs at district level (e.g., annual awards) was also reported.
- A functional grievance redressal mechanism at district level was observed, supported through online platforms and linkages with support systems such as Sakhi centres.
- ABSULS (ASHA-Based Surveillance of Leprosy Suspects) was not operational, and capacity building was needed for salt testing and reporting.
- Mechanisms for grading ASHAs (A–D) were established but not actively functional, requiring periodical implementation.
- Context-specific challenges affecting ASHA acceptability were noted in some areas, highlighting the need to account for local socio-cultural factors in programme implementation.

VHSNDs – Village Health, Sanitation and Nutrition Days

- VHND sessions were conducted by ANMs as per a structured weekly schedule; however, CHOs generally do not participate in outreach activities, indicating a gap in the CHO's role in field-level community engagement.
- Outreach activities including VHNDs, UHNDs, and special health camps were effectively planned and implemented with strong intersectoral convergence involving ICDS, Education, and Panchayati Raj Institutions (PRIs). Referral linkages with higher healthcare centres were established to facilitate continuity of care.

Community Platforms – VHSNCs, MAS and JAS

- VHSNCs, MAS, and JAS have been constituted as per guidelines and were found to be functional across most areas. Regular meetings were conducted, and funds were utilised for activities such as cleanliness drives, minor repairs, nutrition support, and local health actions.
- Community processes, including health promotion, awareness generation, and mobilisation activities, were being implemented through these platforms. However, variations in documentation quality and record-keeping were observed across districts.
- JAS were functional at facility level, with regular review meetings and documentation. In selected facilities, patient support groups have been formed, particularly for elderly and NCD patients, supporting adherence and follow-up.
- Convergence of MAS with door-to-door outreach activities was noted as a good practice, contributing to improved immunisation coverage and ANC uptake, particularly among migrant and vulnerable populations.

Sikkim

ASHAs – Community Mobilisation and Service Linkage

- The state had near-complete coverage of ASHAs against sanctioned norms, with appropriate deployment in rural, tribal, and difficult-to-reach areas. Vacancies were minimal, and ASHAs were well accepted within communities, contributing to strong last-mile service linkage.
- ASHAs were actively engaged in delivery of maternal health services, including maintenance of updated line lists of pregnant and high-risk women, facilitation of service access (including abortion services), and follow-up care. All mandated registers (ANC/PNC, immunisation, NCD screening, home visits, and VHSND records) were found to be maintained.
- In Mangan district, structured community-level communication by ASHAs, including advance dissemination of information on outreach sessions to PRI members/local leaders, immunisation days, NCD screening, and family welfare activities through

door-to-door visits and village coordination, was observed to improve service uptake and community participation.

- ASHAs were involved in wide range of public health programmes, including menstrual hygiene promotion (sanitary napkin distribution and IEC), TB awareness and sputum collection (Nikshay), leprosy surveillance (ABSULS), NCD-related referrals (including eye care for diabetics), fluorosis surveillance, salt testing, palliative care home visits, and vector-borne disease control activities, indicating expanded roles under Comprehensive Primary Health Care (CPHC).
- Incentives were generally regular, though temporary delays occurred during SNA-SPARSH transitions, which had subsequently stabilised.
- ASHAs have received trainings in Modules 6 and 7, and key programme components such as NCD screening and follow-up, HBYC, and expanded CPHC service packages (oral health, eye care, ENT, mental health, elderly care, palliative care, and emergency care).
- A structured training system was in place, with annual training calendars, availability of master trainers, and cluster-based trainings conducted closer to villages. Regular on-site mentoring by CHOs and ANMs supports skill strengthening.
- Strong convergence and teamwork between ASHAs, ANMs, and CHOs was observed, with joint microplanning and coordinated field activities for VHNDs, outreach sessions, and health camps. CHOs were found to be actively providing on-the-job support, particularly for NCD screening and service delivery.
- Performance monitoring mechanisms were functional, with grading of ASHAs based on defined indicators at block level. A majority of ASHAs were reported to be performing in higher categories, indicating good overall performance.
- As a good practice, use of digital communication platforms (e.g., WhatsApp groups involving ASHAs and PRI members) was observed for dissemination of information on outreach activities and mobilisation of communities.
- Supportive supervision mechanisms were functional, with ASHA Facilitators (AFs), Block Community Mobilisers (BCMs), and District Community Mobilisers (DCMs) undertaking regular reviews and field-based supervision.
- Social security coverage of ASHAs under schemes such as PMJAY, PMJJBY, PMSBY, and PM-SYM was observed; however, enrolment under pension scheme (PM-SYMY) requires further strengthening.
- Grievance redressal mechanisms were functional at district level, with institutional linkages to support systems such as Sakhi Centres. Convergence for addressing gender-based violence and awareness on POCSO provisions was also noted.

VHSNDs – Village Health, Sanitation and Nutrition Days

- VHNDs and UHNDs were being conducted as per micro plans, with participation of ASHAs, ANMs, CHOs, AWWs, and PRI members, reflecting effective intersectoral convergence.
- Services delivered during outreach sessions included maternal and child health services (ANC/PNC), immunisation, nutrition counselling, family planning services, NCD screening, and management of communicable diseases.
- Community feedback indicated overall satisfaction with service delivery, supported by regular outreach activities (including VHSNDs and health camps), strong last-mile connectivity, and active involvement of PRI members in health system functioning.

Community Platforms – VHSNCs, MAS and JAS

- Community platforms, including VHSNCs, MAS, and JAS, were being effectively utilised for health promotion, awareness generation, and identification of vulnerable households. Regular meetings were conducted, with discussions focused on sanitation, nutrition, and service uptake.
- JAS were actively engaged in facility-level governance, including maintenance of infrastructure, sanitation, and local resource mobilisation.
- PHCs showed effective community engagement supported by ASHA and PRI coordination, with infrastructure, diagnostics, immunisation services, yoga and wellness activities, adequate drug availability, and functional teleconsultation services.
- As a good practice in district Soreng, active participation of PRI members in facility upkeep and infrastructure development through JAS platforms was noted, reflecting strengthened community ownership and accountability.

Tamil Nadu

ASHAs (and Village Health Nurses) – Community Mobilisation and Service Linkage

- The frontline workforce in Tamil Nadu comprises ASHAs, Village Health Nurses (VHNs), Women Health Volunteers (WHVs), and Mid-Level Health Provider (MLHP) who continue to serve as the primary interface between the community and the public health system.
- VHNs were a regular part of the state cadre, with a salary of approximately Rs 14,000 (contractual) and were a core of the maternal health system, managing complex digital registries including the PICME portal.
- In rural and tribal blocks of Tenkasi and Salem, ASHAs were actively engaged in outreach, immunisation, mobilisation, and referrals, with timely incentive payments reported.

- Weekly trainings were provided to ASHAs at the facility level, ensuring a high degree of competency in maternal and child health protocols.
- Under urban Makkalai Thedi Maruthuvam (MTM) scheme, Women Health Volunteers (WHVs) play a critical role in doorstep NCD screening, drug delivery and digital reporting.
- Field observations indicate a substantially increased workload of WHVs, covering 25–30 households daily and managing large volumes of digital entries. This suggests the need for workload rationalisation and incentive revision to sustain motivation and service quality.
- ASHA incentive payments were timely and paid through SNA SPARSH by adding Accounts details at IFHRMS portal of treasury.

Community Platforms – VHSNCs, MAS and JAS

- Community governance platforms such as JAS and MAS were functional, though documentation quality and regularity remain uneven across districts. MAS platforms in Salem were active in organising health melas and counselling sessions, demonstrating strong community mobilisation.
- Transition from RKS to JAS was underway, with enhanced untied funds for AAM-SHCs supporting local facility improvements. However, gaps in regular JAS and DQAC meetings were noted in parts of Tenkasi.
- Effective utilisation of untied funds was observed in some tribal facilities, driven by proactive local leadership. Yet, regular quorum-based meetings and public expenditure reporting were not uniformly institutionalised across all facilities, indicating scope for strengthening governance practices.

Telangana

ASHAs – Community Mobilisation and Service Linkage

- Telangana had built a strong frontline network of about 28,000 ASHAs, actively engaged in community mobilisation and service delivery.
- ASHAs were actively engaged in providing counselling to families on nutrition, maternal and child health (MCH) care, treatment adherence and in facilitating community awareness about teleconsultation under e-Sanjeevani.
- ASHAs were also engaged in public health interventions such as salt iodine testing in endemic districts for the prevention of iodine deficiency disorders.
- ASHAs mobilise women for Arogya Mahila Clinics, which offer fixed-day specialist services for cervical and breast cancer screening, menstrual health, and other unmet healthcare needs of women from economically weaker sections.
- Health workers, including ASHAs, have facilitated availability of condoms at grocery and ration shops for industrial workers and labourers, ensuring last-mile delivery

of family planning commodities — noted as a good practice enhancing accessibility and convenience.

VHSNDs – Village Health, Sanitation and Nutrition Days

- Strong coordination was observed among ASHAs, ANMs, and Anganwadi Workers during VHSNDs for growth monitoring, early identification of SAM/MAM children, and referral to appropriate nutrition and health services.
- The Seemantham (Baby Shower) ceremony had been adapted as a community outreach initiative, conducted at VHNDs or health facilities, to counsel pregnant women on nutrition, birth preparedness, danger signs, and government scheme entitlements

Community Platforms – VHSNCs, MAS and JAS

- State had 10,431 functional VHSNCs, 7,531 MAS and 4,474 JAS, which conduct regular meetings and support community mobilisation, health awareness, local health planning, and promote women-led participation and community oversight.

Uttar Pradesh

ASHAs – Community Mobilisation and Service Linkage

- ASHAs were present and actively engaged in field-level activities, contributing to community mobilisation and service delivery. However, limited literacy among some ASHAs affects quality of documentation and effectiveness of counselling, including awareness generation on beneficiary entitlements under schemes such as JSY and JSSK.
- Delays in disbursement of ASHA incentives were reported, affecting their motivation and effectiveness as a critical link between community and health facilities, particularly for maternal health services. Timely payment of incentives remains a key area for strengthening.
- Gaps in zoonotic disease awareness were also noted among ASHAs and other frontline workers.

Community Platforms – VHSNDs, VHSNCs, MAS, and JAS

- Counselling services at the community level were found to be suboptimal, partly due to non-availability of RMNCH+A+N counsellors at several facilities. Strengthening handholding, training, and mentoring of ASHAs, with emphasis on counselling skills and accurate documentation, was required.
- Community interactions in the aspirational district of Balrampur highlighted gaps in key social determinants, including sanitation, electricity, waterlogging, and access to basic services, along with persisting gender-related barriers affecting health-seeking behaviour. Strengthening behaviour change communication through VHNDs, community platforms, and locally appropriate IEC strategies is required.

Uttarakhand

ASHAs – Community Mobilisation and Service Linkage

- The State had achieved near-universal ASHA deployment (12,000 in position against 12,018 sanctioned), with 1,205 ASHAs in urban areas.
- A structured supervisory mechanism was in place with ASHA Facilitators, Block and District Community Mobilizers. However, Community Health Officers (CHOs) have limited role in supportive supervision and mentoring of ASHAs, indicating scope for better convergence at AAM level.
- ASHA selection processes were community-driven, with participation of VHSNCs and MAS platforms, contributing to transparency and local acceptability.
- ASHAs were actively engaged in service delivery, including HBNC and HBYC visits, nutrition counselling, NCD screening mobilisation (30+ population), TB services, menstrual hygiene promotion, and referral of high-risk cases.
- Timely disbursement of incentives was largely reported; however, backlogs due to SNA-SPARSH platform issues and fragmented payment entries affect transparency. Awareness about certain incentives (e.g., PMSMA, PNC optimisation, HRP tracking) remains limited. In addition, incentive payments were sometimes received in multiple instalments/entries, making it difficult for ASHAs to track individual components.
- The State had introduced additional financial support of Rs 3,500 for ASHAs. However, gaps exist in incentive structures, particularly lack of incentives for follow-up of NCD patients, despite incentives for CBAC activities.
- ASHAs have received training across multiple modules (Induction, Modules 6 & 7, CPHC, NCD, Gender-Based Violence, Mobile Academy), and majority have completed ASHA certification (NIOS). However, clarity on training under Expanded Package of Services (EPS) was lacking, and need for refresher trainings was highlighted.
- PLA platforms and District ASHA Training centres were found to be functional and supportive of capacity-building processes. Monthly PHC and block-level review meetings were being effectively utilised for ASHA performance review and thematic capacity building.
- Context-specific innovations, such as provision of Palki transport support with incentives for carriers and accompanying ASHAs in difficult terrains of Chamoli district, were observed to facilitate access to services in hard-to-reach areas.
- Digital reporting remains a challenge, as smartphones provided earlier were largely non-functional, affecting real-time reporting. The proposed “ASHA Sangini App” was a promising initiative for performance tracking and incentive transparency.
- Social security coverage was strong, with high coverage under PMJAY, PMJJBY and PMSBY.

- Grievance Redressal Committees exist but were poorly functional, and SAKHI Centres and POCSO-related support systems were not operational as intended.
- Community feedback highlighted high trust in ASHAs, particularly for RCH services, though broader health system utilisation remains influenced by perceived quality gaps in public facilities.

VHSNDs – Village Health, Sanitation and Nutrition Days

- Anganwadi centres were functioning from the Govt. owned buildings and were providing nutrition services to pre-school children and take-home ration for Pregnant women and children aged 6 months to 3 years.
- Home Visits were also being undertaken by AWWs to counsel the mothers for HBYC, but these visits were not coordinated with ASHA & ANM.
- Anganwadi workers reported that RBSK teams visit the Anganwadi centres for health screening of children, however their visit plan/schedule was not communicated to AWC in advance due to which they face challenge in mobilizing the parents & children to AWCs.

Community Platforms – VHSNCs, MAS and JAS

- The State had constituted 14,915 VHSNCs, with recent elections completed. However, capacity building remains a key gap, with limited training and orientation of VHSNC members.
- Irregular fund flow and delays in release of untied funds have constrained VHSNC functionality.
- Under Community Action for Health (CAH), CHOs have been trained as Block Trainers and were monitoring VHSNCs linked to 5–6 ASHAs-a promising initiative for strengthening community accountability.
- MAS and JAS platforms were constituted and functional, with regular meetings and utilisation of untied funds. However, instances of procurement inefficiencies (e.g., inflated pricing) were observed under JAS.
- District ASHA Resource Centres (DARC) and Social Action Groups (SAGs) were reported to be non-functional in recent years, and Patient Support Groups (PSGs) have not yet been constituted, indicating weakening of institutional community processes under CAH.

^[1] The state specific findings are as observed and reported by the CRM teams. Minor variations in data points between state reported data and data presented in National Overview through portals may be due to different sources of data and variable timing of reporting.

^[2] As per data reported in the AAM portal, JAS in AAM PHC is 83% against state reported target.

^[3] As reported in September MIS, VHSNC constitution is 98% and MAS constitution is 99% against state target.



TOR-3
SECONDARY CARE

17th

CRITICAL CARE

NATIONAL OVERVIEW

Critical care services constitute a fundamental component of secondary healthcare, providing structured and timely management for patients with life-threatening conditions requiring close monitoring and advanced clinical support. These services encompass emergency departments, Intensive Care Units (ICUs), High Dependency Units (HDUs), Labour Delivery Recovery (LDR) complexes, operation theatres, Special Newborn Care Units (SNCUs), neonatal and paediatric intensive care units, and supporting systems such as oxygen infrastructure, sterilization services, and infection prevention mechanisms.

At the secondary care level, Community Health Centres provide initial stabilization, while Sub-District Hospitals and District Hospitals function as referral centres for comprehensive emergency and critical care management. The effectiveness of these facilities is determined by the availability of trained medical and nursing personnel, functional triage and zoning systems, ventilator-supported beds, continuous oxygen supply through PSA plants or liquid medical oxygen systems, operational surgical services, newborn and paediatric critical care capacity, and adherence to infection prevention and control protocols.

During the 17th Common Review Mission (CRM), the assessment focused on the availability, functionality, and operational status of critical care services across visited states and districts. Observations included evaluation of emergency preparedness, ICU/HDU infrastructure, surgical and obstetric critical care services, newborn and paediatric care units, oxygen generation and supply systems, CSSD and laundry services, documentation and reporting practices, referral mechanisms, and compliance with Indian Public Health Standards (IPHS). The review documented service strengths, infrastructure readiness, human resource deployment, equipment functionality, and areas requiring operational attention within secondary healthcare facilities.



KEY OBSERVATIONS

1. Emergency & Critical Care Services

Across states, emergency services were largely functional at District Hospital (DH) level, with availability of oxygen supply, multipara monitors, basic resuscitation equipment, and designated emergency areas. However, the degree of structuring and protocol adherence varied significantly.

States such as Kerala and Madhya Pradesh demonstrate structured triage systems with defined red/yellow zoning and functional monitoring systems. In contrast, several facilities in Assam, Bihar, Chhattisgarh, Maharashtra (RH level), and Meghalaya reported weak or non-functional triage systems, lack of color-coded zoning, absence of displayed emergency protocols, and inconsistent crash cart standardization.

Human resource constraints were a recurring issue, particularly at SDH and CHC levels, where emergency MOs often manage multiple units simultaneously. Formal training in emergency medicine, BLS/ACLS, trauma care, and shock management was limited in multiple states.

Availability of critical care capacity remained uneven. While ICUs were functional in Kerala and Madhya Pradesh, several states such as Chhattisgarh (district level), Maharashtra (RH level), and some parts of Meghalaya lacked fully functional ICU/HDU services. In some districts, ICU infrastructure existed but remains non-functional due to HR shortages. Equipment availability was optimal, but preventive maintenance, calibration, and documentation systems were weak.

Stock-outs of emergency drugs, non-functional PSA plants, inadequate fire safety systems, incomplete emergency trays, and lack of expiry monitoring registers were observed in multiple states. Biomedical waste handling through public corridors and non-compliance with BMW norms was also reported.

Overall, emergency care is transitioning from basic service provision toward structured critical care networks, but standardization, training, and infrastructure alignment with IPHS norms remain inconsistent.

2. Operation Theatres (OT) and Surgical Services

OT functionality varied significantly across states. Proper zoning and unidirectional flow were well maintained in Kerala and Madhya Pradesh. In Chhattisgarh and Bihar, partial zoning or absence of HVAC systems affected sterility assurance. In Maharashtra and Meghalaya, OT services were functional but often constrained by shortage of anaesthetists and surgeons, leading to cancellation of procedures, particularly postpartum sterilizations.

High surgical load was noted in states like Chhattisgarh and Madhya Pradesh, creating scheduling pressure. In some facilities, modular OTs were available but non-functional due to HR constraints.

Preventive maintenance, calibration records, and AMC tracking were inconsistent across multiple states. Equipment availability is generally adequate, but maintenance gaps undermine readiness.

Family planning surgical services were limited in several facilities due to specialist shortages. Operation cancellations in sterilization services were observed in Meghalaya and Bihar.

Overall, surgical infrastructure existed across most secondary facilities, but specialist shortages and maintenance gaps restrict optimal utilization.

3. Labour Delivery Recovery (LDR) & Maternal Health Services

Labour rooms were functional in all states, with essential drugs, SBA-trained nurses, partograph usage, and Safe Birth Checklist implementation in several facilities. LaQshya certification was reported in selected districts (e.g., Chhattisgarh).

However, triage in labour rooms was inconsistently practiced. Many facilities lacked designated triage spaces and proper zoning. Infection prevention practices, sterilization processes, and crash cart maintenance required strengthening in states such as Bihar, Chhattisgarh, and some facilities in Meghalaya. High C-section rates were noted in certain districts (e.g., Madhya Pradesh). Regular audits were being conducted in some states but require standardization.

Birth companion practices were being implemented in several states. However, infrastructure constraints, non-availability of septic labour rooms, and limited LDR beds were observed.

SUMAN notification and Mera Aspataal registration gaps were noted in Bihar. Documentation practices were generally maintained but quality varied.

Overall, maternal services were operational but require stronger infection control, triage standardization, and specialist strengthening.



4. Special Newborn Care Units (SNCU), NBSU and Neonatal Services

SNCUs were functional in all reviewed states. Equipment such as radiant warmers and phototherapy units was largely available and functional. Kangaroo Mother Care (KMC) practices were observed in multiple states. However, critical neonatal care capacity remains limited. Absence of ventilators, CPAP, ABG machines, and NICU-level care was noted in Chhattisgarh and several other states. Referrals for preterm, LBW, and ventilator-dependent neonates were frequent. Human resource shortages, particularly paediatricians and trained neonatal nurses, were observed. HDU functionality was sometimes affected due to lack of trained staff. High bed occupancy (e.g., Maharashtra) indicated strain on neonatal infrastructure. Data reporting gaps (FBNC portal, SNCU portal malfunction) were reported in Bihar and Chhattisgarh. Newborn screening practices were not uniformly implemented as per Comprehensive Newborn Screening guidelines.

Overall, SNCUs were functional but advanced neonatal critical care and manpower augmentation remain priority gaps.



5. Paediatric HDU/ICU & Child Health Services

Paediatric ICU availability varied across States. Functional PICUs were available in Madhya Pradesh. In contrast, several states lacked paediatric HDU/ICU facilities (Chhattisgarh district level, Maharashtra RH level). Paediatric wards were functional but lack of critical equipment in certain facilities was observed. Referral dependency to medical colleges remained high.

NRCs were functional in Bihar and Chhattisgarh, with generally satisfactory cure rates. However, low admission rates due to weak ICDS convergence and poor follow-up compliance were observed.

6. Blood Bank & Diagnostic Services

Blood banks were functional in most DHs, with availability of Packed Red Blood Cells, fresh frozen plasma, and platelets. However, component usage was not universal; whole blood use persists in some states.

Shortage of lab technicians and limited availability of microbiology/histopathology services affected timely diagnosis in multiple states. Blood storage units were not uniformly available.

Linkage for transfusion transmissible infections positive donors was weak in some districts. Diagnostic services such as CT scan, USG, and ECG were available in some districts but limited in others due to technician shortage or equipment downtime.

7. PSA Plants & Oxygen Systems

PSA plants were available in multiple states but show operational gaps. Non-functional plants, low oxygen purity levels (Madhya Pradesh), absence of AMC/CMC, incomplete logbooks, and safety hazards (transformer proximity, exposed wiring) were reported. Operator training was inadequate in some facilities. Noise exposure and fire safety systems required strengthening. Central oxygen supply was generally available, but redundancy systems needed improvement.

8. CSSD, Laundry & Support Services

Dedicated CSSD was not available in several facilities. Laundry systems existed but faced issues such as inadequate segregation, improper storage, lack of maintenance logs, poor ventilation, and PPE non-compliance (Chhattisgarh, Madhya Pradesh). In some states (Kerala, Maharashtra), mechanized laundry and CSSD services were functional and better structured. Infection control risks due to poor linen management were observed in selected facilities.

9. Dietary & Kitchen Services

Dietary services were available across states, often through PPP or NGO models. However, documentation gaps, absence of dieticians, improper storage, lack of food testing records, inadequate PPE usage, and missing cleaning schedules were observed (Chhattisgarh, Madhya Pradesh).

Kitchen infrastructure gaps including non-functional RO systems, absence of refrigeration,

fire safety non-compliance, and lack of monitoring mechanisms were observed. Patient feedback systems for diet services were weak.

KEY CHALLENGES

- Persistent shortage of specialists including anaesthetists, paediatricians, intensivists, surgeons and obstetricians at secondary care facilities, resulting in partial functionality or non-operational status of ICU, OT and critical care services in several districts.
- ICU and HDU infrastructure available in some district hospitals but remained underutilized or non-functional due to absence of trained critical care staff, defined doctor-to-bed ratio and round-the-clock specialist availability.
- Ventilators and advanced life-support equipment supplied under various initiatives were not utilized in certain facilities due to missing accessories, lack of trained operators, calibration delays or absence of preventive maintenance contracts.
- Structured triage systems were either absent or inconsistently implemented at emergency units, particularly at SDH and CHC levels, leading to compromised patient prioritization and stabilization.
- Emergency departments in some facilities handling both OPD and emergency cases simultaneously without defined zoning, affecting quality and timeliness of care.
- Space constraints in high patient-load facilities affecting patient segregation, infection control, SNCU expansion, labour room organization and emergency area functioning was observed.
- Infection prevention and control practices were inconsistently adhered to, including suboptimal sterilization processes, irregular monitoring of autoclave cycles, and inadequate biomedical waste segregation practices.
- Delays in repair, calibration and preventive maintenance of biomedical equipment affecting continuity of surgical and emergency services.
- Non-functional or underutilized operation theatres at CHC and SDH level due to specialist vacancies, equipment deficiencies or inadequate HVAC and sterility systems.
- High surgical load in certain district hospitals creating scheduling pressure and affecting quality assurance in operative care.
- Labour rooms were functional across the states, but gaps noted in triage within LDR complexes, equipment upkeep, infection control zoning and crash cart standardization.
- Elevated caesarean section rates in selected districts indicating potential need for clinical review and rationalization of obstetric practices.
- Obstetric ICU services largely unavailable at district level, limiting management capacity for severe maternal complications at point of care.

- SNCUs were operational in most districts but faced challenges such as overcrowding, high bed occupancy rates and limited advanced neonatal critical care capacity.
- Shortage of dedicated paediatricians and trained neonatal nurses in SNCUs and NICUs affecting quality of neonatal management.
- High LAMA rates and weak referral tracking systems for newborn follow-up impacting continuity of neonatal care.
- Limited availability of PICU services in multiple districts leading to dependence on referral to tertiary medical colleges for paediatric critical cases.
- Blood banks functional at district level in many states had gaps such as non-functional blood component separation units, expired licenses, inadequate storage space and limited specialist supervision.
- Presence of blood storage units instead of full-fledged blood banks in certain districts restricting component separation and transfusion capacity.
- PSA oxygen generation plants installed in several facilities but facing operational gaps including low oxygen purity levels, absence of AMC/CMC contracts, safety compliance issues and lack of trained operators.
- Mechanized laundry and centralized CSSD services not uniformly available across facilities, resulting in reliance on small-capacity systems and delayed sterilization turnaround time.
- Use of outdated or poorly maintained autoclaves and lack of standardized sterilization logbooks in certain facilities.
- Dietary and kitchen services were operational but infrastructure gaps including absence of dietitians, improper food storage, inadequate ventilation, incomplete documentation and weak monitoring systems were observed.
- Inconsistent maintenance of equipment registers, expiry tracking systems and duplication between manual registers and online reporting portals.
- Infrastructure in some facilities not fully aligned with IPHS norms, including incomplete MCH wings, dilapidated buildings and pending civil works.
- Connectivity, power supply and water availability interruptions in remote facilities affecting service continuity.

KEY RECOMMENDATIONS

- States to strengthen recruitment, rational deployment and retention strategies for specialists and trained nursing staff at secondary care level, with priority allocation to high-burden and remote districts.
- States to ensure full functionalization of ICU, HDU and PICU services through structured staffing norms, competency-based training and defined clinical governance mechanisms.

- States to establish mandatory preventive maintenance systems including active AMC/CMC contracts, periodic calibration audits and equipment uptime monitoring dashboards.
- States to institutionalize structured triage systems across all emergency departments with standardized zoning, training modules and periodic simulation exercises.
- Strengthen infection prevention and control mechanisms through regular audits, sterilization monitoring protocols and biomedical waste management compliance reviews.
- States to expand establishment of obstetric ICU services at district hospitals to strengthen maternal emergency preparedness and reduce avoidable referrals.
- States to conduct periodic clinical audits of caesarean section rates and operative procedures to ensure adherence to evidence-based guidelines.
- Augment SNCU capacity in high-load districts through infrastructure expansion, additional sanctioned beds and enhanced neonatal HR deployment.
- States to ensure availability of dedicated paediatricians and trained neonatal nurses in SNCUs and NICUs through targeted HR planning.
- Strengthen newborn referral tracking and follow-up mechanisms to reduce LAMA rates and improve continuity of care.
- States to operationalize blood component separation units across districts and ensure timely renewal of blood bank licenses and regulatory compliance.
- States to improve functionality and safety compliance of PSA plants through trained operators, routine purity monitoring and formal maintenance contracts.
- Establish and standardize CSSD services and mechanized laundry systems in all district hospitals to ensure sterility assurance and reduce infection risks.
- There is a need to standardize sterilization turnaround time and implement instrument tracking systems for OT efficiency.
- States to ensure dietary services comply with national nutritional guidelines, including appointment of dieticians, maintenance of hygiene standards and periodic food quality monitoring.
- Strengthen facility-level infrastructure upgrades in alignment with IPHS norms through phased planning and monitoring of civil works.
- Improve digital reporting systems to reduce duplication of manual registers and enhance real-time data accuracy.
- Enhance supportive supervision, internal quality audits and periodic CRM follow-up reviews to monitor corrective actions.

- Strengthen referral transport coordination and service networking particularly in geographically difficult and remote districts.

STATE-SPECIFIC FINDINGS

Andhra Pradesh

Secondary care facilities demonstrated service availability across emergency, OT, obstetric and newborn care; however, specialist vacancies, particularly anaesthetists and paediatricians affected optimal functioning. Structured triage systems were not uniformly implemented. ICU infrastructure existed in selected facilities but was constrained by trained human resource gaps. Documentation and reporting processes reflected duplication between manual and digital systems. Equipment maintenance and preventive monitoring required strengthening to ensure uninterrupted service delivery.

Assam

Facility-level services were operational, but standardization of emergency triage and critical care protocols varied. Infection prevention practices required closer monitoring in high-load units. HR constraints at secondary facilities impacted service delivery, particularly in specialist-led care. Infrastructure upgradation was ongoing but not uniformly aligned with IPHS norms.

Bihar

SNCUs and labour rooms were functional; however, absence of dedicated CSSD units in some facilities affected sterilization workflow. Infection control practices and equipment maintenance documentation required strengthening. Family planning surgical services were constrained by specialist availability. Biomedical waste management and emergency preparedness need closer compliance monitoring. Data reporting systems show duplication across multiple registers.

Chhattisgarh

High patient load was observed in district hospitals in emergency, surgical and neonatal care units straining these critical service delivery units. Additionally, Space constraints affected patient flow and segregation, particularly in SNCU and emergency areas. HDU/ICU services were limited in certain districts. Structured triage and infection control practices require standardization. Infrastructure in some facilities did not fully meet IPHS norms, with need for renovation and strengthening.

Kerala

Emergency services demonstrate structured triage and defined zoning in assessed facilities. Critical care units were functional with centralized oxygen systems and monitoring protocols. Surgical and labour services were operational with adherence to infection control standards. PSA plant functionality and maintenance oversight require periodic monitoring. Service organization reflected stronger alignment with standard protocols compared to several other states.

Madhya Pradesh

Availability of functional secondary and critical care services at district level, with structured triage systems, operational emergency units, functional OTs with HVAC, active LDR models within dedicated MCH wings, and established ICU/HDU and paediatric critical care services were observed in both Mandsaur and Vidisha districts. SNCU services were functional with satisfactory bed utilization and advanced newborn care support, though NICU services were absent and require phased strengthening. While infrastructure and specialist availability were generally adequate but gaps were observed in infection prevention practices, documentation burden within ICUs, stock-outs of selected emergency medicines, and safety concerns in PSA plant installations, particularly in Mandsaur district. High C-section rates in Mandsaur warrant continued clinical audit. Laundry and dietary services show inter-district variation, with stronger compliance in Vidisha and quality gaps in Mandsaur. Overall, the state reflected reasonable critical care capacity at DH level, but quality assurance, equipment maintenance, safety compliance, and peripheral strengthening remain priority areas for sustained improvement.

Maharashtra

Secondary facilities provide routine surgical, obstetric and newborn services; however, ICU and paediatric critical care capacity varied across districts. High bed occupancy in neonatal units indicated service demand pressure. Certain equipment and ventilator functionality gaps were observed at peripheral levels. Referral dependency for advanced paediatric cases remains a concern. Documentation and infection control systems require periodic audit and reinforcement.

Meghalaya

Emergency services were available but structured triage implementation was inconsistent. HR gaps, including specialists and technical staff, affected services at district facilities. Infrastructure in remote areas faces connectivity and utility challenges. Referral linkages, supportive supervision and skill-based capacity building were areas require strengthening.

Nagaland

Central oxygen systems were functional in selected facilities but non-functional in others due to leakage and plant issues. ICU utilization was low, and intensivists were not available. ECRP-II ventilators and equipment were found unused in certain facilities. LDR concept was not implemented, and NBSU utilization was limited due to paediatrician and trained nurse vacancies. SNCU lacked MusQan certification and fire safety documentation.

Odisha

Odisha showcases effective implementation of the Nirmal Scheme, functional IPHL and BPHU units aligned with IPHS standards, assured availability of ARV and ASV, operational dialysis services under PMNDP, and rollout of AB PMJAY-GJAY enhancing financial protection. However, critical gaps persist, including high caesarean section rates in selected districts, non-operational Critical Care Blocks, inadequate blood storage upgrades, limited telemedicine integration, weak AERB compliance, and infection prevention deficiencies in

critical care areas. Strengthening MCCD reporting, biomedical waste management, oxygen safety systems, and institutionalization of Respectful Maternity Care remain priority areas. While foundational systems were in place, operationalization of critical infrastructure and quality compliance require focused attention.

Punjab

Punjab reflected relatively strong secondary care capacity at district level, with functional emergency services, operational ICU/HDU units, established SNCU/NICU services, active surgical facilities, and adequate oxygen infrastructure supported by MGPS and PSA plants. Specialist availability was robust in major facilities, and digital monitoring practices were in place. However, gaps remain at CHC level, where critical care services were limited. Infrastructure deficiencies such as non-functional ventilators, absence of HVAC systems in OTs, lack of CSSD and mechanized laundry in certain facilities, high C-section rates in selected districts, and non-functional PSA plants required corrective action. Expedited implementation of PM-ABHIM projects and strengthening of peripheral facilities are essential to ensure uniform critical care access across districts.

Rajasthan

District-level variation in secondary and critical care capacity was observed in Rajasthan. In Nagaur district, the absence of a functional ICU/HDU, non-compliance with the LDR model, and gaps in infection prevention and CSSD services limited comprehensive care delivery, despite operational CCU, SNCU, PICU, functional OTs, and adequate oxygen infrastructure through PSA plants. Blood bank services were functional but lacked component separation facilities. In contrast, Jhunjhunu district reflected stronger compliance with IPHS norms, with functional ICU/HDU, well-zoned OTs with HVAC, adequate specialist availability, structured triage systems, operational neonatal and paediatric critical care units, and improved digital monitoring practices. Overall, while critical care services were available, disparities in infrastructure, infection control, and specialist availability highlight the need for targeted district-level strengthening to ensure uniform secondary care access across the state.

Sikkim

Basic readiness in emergency stabilization and routine maternal services, supported by a functional triage system, organized red and yellow zones, continuous oxygen supply through a 200 LPM PSA plant with MGPS connectivity, and adherence to sterilization protocols through a functional CSSD were observed. Labour room services were operational with essential equipment, point-of-care diagnostics, 24*7 laboratory support, and respectful maternity practices such as birth companionship. However, critical service gaps significantly limit comprehensive care delivery: the Operation Theatre was non-functional due to lack of essential equipment and specialist availability (anaesthesiologist, surgeon, Orthopaedician), C-sections could not be conducted locally, and ICU/HDU, SNCU/NICU, and paediatric critical care units were not available. The labour room's fourth-floor location without lift access further constrained emergency obstetric transport. Approximately 70 referrals in the past three months reflects continued dependency on higher centres, primarily Gangtok, increasing time-to-care and out-of-pocket expenditure. While infrastructure for oxygen

and sterilization was adequate, the absence of surgical and critical care capacity, specialist shortages, and limited neonatal services collectively restricted the hospital's ability to provide comprehensive secondary-level care, especially in the context of hilly terrain and referral challenges.

Telangana

Emergency triage practices were not uniformly followed, and HDU services were absent in certain facilities. Several ventilators and C-PAP machines were non-functional. PSA plants lacked AMC support and were non-operational in assessed centres. High LSCS rates persisted despite promotion of midwifery-led normal deliveries. Area Hospitals were largely limited to minor surgical procedures, affecting full FRU functionality.

Uttar Pradesh

District hospitals were heavily burdened due to high OPD load and referral inflow from primary-level gaps. Critical care and ICU services were limited due to HR constraints. Referral to tertiary facilities was frequent for complex cases. Road traffic injuries significantly contributed to caseload and mortality patterns. Resource optimization was challenged by the inverted pyramid model of service utilization.

Uttarakhand

Emergency services operated 24*7; however, red/yellow/green zoning was not demarcated. HVAC systems were absent in assessed facilities, and infection control compliance gaps were observed. Certain OTs were non-functional or lacked adequate equipment for anaesthesia administration. PSA plants were non-operational in some districts due to unavailability of technician and expired MoUs with service provider. Neonatal protocol training gaps were identified among SNCU staff.



NATIONAL HEALTH PROGRAMMES AT SECONDARY LEVEL

17th

NATIONAL HEALTH PROGRAMMES AT SECONDARY LEVEL

OVERVIEW

The 17th CRM assessed the implementation of key National Health Programmes¹ including Maternal & Child Health, Communicable Diseases and Non Communicable Diseases Management at the secondary level healthcare facilities across 17 states.

The assessment documented detailed observations, identified critical gaps across infrastructure, human resources, service delivery, and generated actionable recommendations to address these gaps. Findings revealed that secondary care services under National Health Programmes were largely operational across District Hospitals, Sub-District Hospitals, and Community Health Centres, with visible improvements in programme outreach and service delivery demonstrating successful program rollout and institutionalization. Significant infrastructure investments under the NHM have resulted in the establishment of specialized units (ICU, NICU, SNCU, blood banks, and NCD clinics) at most district hospitals. Essential health services were available at the secondary care level across all states, with high institutional delivery rates, functional emergency services, and expanding specialized services. However, several systemic gaps persist, including suboptimal integration across programmes, inadequate trained human resources, particularly in specialized areas. Referral linkages and follow-up mechanisms remain weak, affecting continuity of care.

KEY OBSERVATIONS

MATERNAL HEALTH

- It was observed that maternal health services, including institutional deliveries and caesarean section services were available across secondary care facilities.
- Availability of specialists at the secondary care level was inadequate in Assam and some facilities in Odisha, Rajasthan, Sikkim affecting comprehensive emergency obstetric care services.
- Respectful maternity care practices, including birth companion and early initiation of breastfeeding, were consistently observed in Chhattisgarh, Madhya Pradesh, Maharashtra, Punjab and Sikkim, indicating good quality practices.

Family Planning

- Family planning services with basket of choice were available across facilities in Kerala, Odisha, Punjab, Nagaland, Meghalaya, and Sikkim, with availability of sterilization and contraceptive services.
- Stock-outs of family planning commodities were reported in Uttarakhand, Madhya Pradesh, and Nagaland, affecting service delivery.

¹RMNCH+A, RBSK, RKSK, SUMAN, PMSMA (e-PMSMA), JSSK, NVBDCP, NLEP, NRCP, PPCL, NPPCSE, NTEP, IDSP, NVHCP, NACP, NP-NCD, PMNDP, NPPCD, NPHCE, NPPC, Trauma & Burn Injuries, NPCBVI, NPPCF, NTEP, NIDDCP, NOHP, NPCCHH, NMHP etc.

- Postpartum and post-abortion counselling were inconsistent in Andhra Pradesh and Madhya Pradesh.

Child Health

- Functional SNCUs, NBSUs, and paediatric services were observed in Andhra Pradesh, Assam, Kerala, Odisha, Madhya Pradesh and Nagaland, indicating the availability of child health services.
- Shortage of paediatricians, and lack of critical care facilities were reported in Chhattisgarh, Sikkim and Nagaland, affecting the quality of care.
- Late referrals leading to critical admissions were observed in Bihar.
- NBSU was not functional in Uttarakhand. Poor infrastructure and low utilization of NBSUs were noted in Chhattisgarh and Nagaland, despite the availability of units.

Universal Immunization Programme

- Immunization services with functional cold chain systems and trained staff were observed in Chhattisgarh, Kerala, Meghalaya, Odisha, Punjab, Sikkim, Uttarakhand and Madhya Pradesh.
- Internet connectivity issues affecting cold chain and digital reporting were reported in Assam and Chhattisgarh, impacting real-time data entry.
- Duplication of data entry and reporting burden was noted in Kerala.

Child Nutrition

- NRCs were functional with adequate infrastructure and therapeutic feeding services in Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Maharashtra, Uttar Pradesh and Meghalaya.
- Moderate bed occupancy and weak follow-up of SAM children was observed in Chhattisgarh and Madhya Pradesh.
- Child Lactation Management Centres (CLMCs) were either non-functional or absent in Chhattisgarh, Madhya Pradesh, Maharashtra, Sikkim and Nagaland, limiting lactation support services.



RBSK



- RBSK screening services through Mobile Health Teams were operational in Chhattisgarh, Madhya Pradesh, and Meghalaya.
- Non-functional or limited DEIC services were reported in Chhattisgarh, Punjab, Sikkim, Uttarakhand, Uttar Pradesh and Nagaland, affecting early intervention.
- Significant human resource gaps in Mobile Health Teams (MHTs) were observed in Chhattisgarh and Madhya Pradesh.

Adolescent Health

- AFHC services were functional with counsellors in Andhra Pradesh, Madhya Pradesh, and Meghalaya, indicating availability of adolescent services.
- Dedicated AFHC clinics were non-functional or merged with other programmes in Chhattisgarh, Madhya Pradesh, and Nagaland, limiting service delivery.
- Lack of trained counsellors and diversion of staff were observed in Chhattisgarh and Madhya Pradesh.

TB Mukh Bharat Abhiyaan (NTEP)

- Diagnostic infrastructure under NTEP was widely established across states, with availability of NAAT/CBNAAT/TruNAAT, microscopy, and X-ray services at multiple levels; however, utilisation efficiency remained suboptimal in some states due to continued reliance on sputum microscopy and incomplete universal upfront NAAT.
- Sample transport and laboratory referral systems were increasingly structured with CHO/ASHA-supported collection networks, route mapping, and DMC linkages improving turnaround time and Anti-TB drug supply chains remained largely stable nationwide through Nikshay Aushadhi.
- Patient support systems through Nikshay Poshan Yojana and Nikshay Mitra had expanded across several states but coverage gaps and delayed payments due to SNA SPARSH integration issues were reported



in states like Andhra Pradesh, Bihar, Uttar Pradesh, Tamil Nadu, Maharashtra, and Uttarakhand.

- Treatment adherence and follow-up mechanisms supported by ASHAs, CHOs, and DOTS networks were relatively strong in Kerala; however, gaps in follow-up sputum examination, counselling, and contact tracing persisted in Andhra Pradesh, Bihar, and Uttarakhand, affecting continuity of care.
- Preventive TB care including TPT, contact tracing, and vulnerable population screening showed stronger institutionalisation in some states, while incomplete coverage and weak systematic screening of high-risk groups were observed in states like Assam and Bihar.
- Digital surveillance and reporting systems via Nikshay were largely operational across states, improving real-time monitoring; however, intermittent portal disruptions were reported in some states like Uttarakhand.
- Drug-resistant TB (DR-TB) services were broadly functional with established referral and differentiated care pathways across most states.

National Leprosy Eradication Program (NLEP)

- Diagnostic confirmation capacity for leprosy remained uneven across states, with availability of Slit Skin Smear (SSS) and confirmatory testing services reported in states like Odisha, Chhattisgarh; however, decentralised diagnostic gaps and absence or limited availability of SSS testing at secondary level facilities were observed in some states like Bihar, and Uttarakhand.
- Multidrug Therapy (MDT) drugs availability remained largely uninterrupted across most of the states, ensuring continuity of treatment.
- Post-exposure prophylaxis (PEP) and contact management systems showed partial implementation across some states.
- Digital surveillance and reporting through Nikusth 2.0 remained operational across states like Punjab and Chhattisgarh, while non-functional systems, limited familiarity, and continued reliance on manual records were specifically observed in states like Nagaland, and Uttarakhand affecting real-time programme monitoring.
- Late detection with Grade II disability remained a persistent concern indicating delayed diagnosis and ongoing community transmission. IEC, stigma reduction, and community awareness activities remained inconsistently implemented, with stigma-driven delays in care-seeking and under-reporting observed.

National Aids Control Program

- HIV testing and counselling services were widely operational across states, with functional ICTC networks and integration into secondary care facilities, however, linkage and service consolidation at peripheral levels remained uneven in states like

Assam, Meghalaya, and Odisha due to dependence on tertiary centres.

- Prevention of mother-to-child transmission (PMTCT) and routine antenatal screening for HIV and syphilis were consistently implemented across states with universal ANC testing using dual kits in several states.
- ART linkage and treatment continuity were largely functional in states like Madhya Pradesh, Rajasthan, and Punjab, ensuring initiation and continuation of care.
- Diagnostic infrastructure (rapid tests, ELISA, and serum-based kits) was available and functional across States.

National Viral Hepatitis Control Program

- Antenatal screening for Hepatitis B and C under NVHCP was widely institutionalised across States with routine HBsAg testing forming the primary test for case detection; however, expansion of screening beyond ANC into structured high-risk and general population groups remained limited in some states like Bihar.
- Prevention of mother-to-child transmission (PMTCT) of Hepatitis B was operational across most states through institutional delivery linkages and newborn prophylaxis; however, gaps in 'HBIG' availability and administration were reported in states like Uttarakhand, while referral-based management of HBsAg-positive pregnancies without uniform decentralised protocols persisted in Madhya Pradesh and Nagaland.
- Diagnostic capacity for Hepatitis B and C (RDT/ELISA) was functional across most of the states with routine screening services established at district and sub-district levels. Hepatitis B vaccination of healthcare workers was consistently implemented across most of the States.
- Viral load testing and advanced molecular diagnostics were available through referral systems, state laboratories, or PPP models across the states.

NVBDCP

- Strong surveillance and reporting systems were functional across most states like Tamil Nadu, Punjab, Rajasthan, Uttarakhand, and Andhra Pradesh, with effective use of IHIP, IDSP, and district surveillance units.
- Diagnostic systems using RDT, microscopy, NS1/IgM, and ELISA were widely available across most of the states. Molecular and advanced diagnostic capacity (CBNAAT, NAAT, sentinel surveillance labs) was established in some states like Kerala, Uttarakhand, and Odisha.
- Treatment services for vector-borne diseases, including ACTs, anti-malarials, dengue case management protocols, and supportive care, were largely functional across states; however, intermittent gaps in ACT availability and dengue surge management capacity were reported in some states like Chhattisgarh.

- Vector control and outbreak response mechanisms were relatively strong in most of the States, supported by IRS, fogging, larval source reduction, and intersectoral coordination.

Integrated Disease Surveillance Program

- IDSP reporting through the IHIP platform was largely functional, with routine submission of P, S and L forms from public health facilities. While some states demonstrated relatively stable digital reporting systems, others continued to face challenges related to timeliness, completeness, and effective use of the platform, particularly at peripheral facilities where gaps in staffing, training, and connectivity were observed in states like Andhra Pradesh and Madhya Pradesh.
- States like Kerala, Punjab, Uttarakhand, Madhya Pradesh, Meghalaya and Odisha demonstrated more consistent real-time reporting and structured surveillance processes. Vaccine-preventable disease surveillance continued under IDSP in most states, including AFP and measles reporting.
- Outbreak detection and response mechanisms were functional across most states, with rapid response teams actively conducting investigations following alerts.
- Laboratory support under IDSP has expanded, with District Public Health Laboratories functional in several states, alongside functional inter-sectoral coordination mechanisms through District Task Forces in states such as Meghalaya and Madhya Pradesh.

National Rabies Control Program (NRCP)

- Anti-Rabies Vaccine (ARV) availability under the National Rabies Control Programme (NRCP) was largely widespread and functional at district and sub-district levels supporting routine post-exposure prophylaxis (PEP) delivery; however, consistency of availability at peripheral levels remained uneven in some states like Uttar Pradesh, and Bihar, leading to delayed initiation of treatment in some cases.
- Rabies Immunoglobulin (RIG/ARS) availability remained a major system gap, being absent across all facility levels in Bihar and inconsistently available or restricted to higher-level facilities in some states.
- Animal bite management services were integrated into emergency and outpatient care, however, dedicated rabies clinics and structured wound-washing stations remained inconsistently available, with absence of dedicated infrastructure or reliance on general dressing areas.
- Administration of RIG/ARS for Category III exposures was largely aligned with clinical guidelines in most states.

Programme for prevention and control of Leptospirosis (PPCL)

- Diagnostic capacity for leptospirosis (ELISA and confirmatory testing) was well established from PHC level upwards in Kerala enabling routine confirmation and

timely management; however, confirmatory testing remained largely restricted to higher-level or selected laboratories in some states like Uttar Pradesh and Uttarakhand.

- Availability of doxycycline ensured functional treatment and prophylaxis capacity across states like Kerala, Punjab, and Uttarakhand as per Essential Medicines List at PHC/CHC/SDH levels
- Seasonal preparedness during monsoon periods was relatively variable in states like Uttar Pradesh and Nagaland.
- Integration of leptospirosis surveillance into broader disease reporting platforms was observed in Kerala and Uttar Pradesh (UDSP-linked), though reporting completeness and sensitivity remained suboptimal in Uttar Pradesh due to weak clinical suspicion and frontline identification gaps.

National Programme for Prevention and Control of Snakebite Envenoming (NPPCSE)

- Across states, Anti-Snake Venom (ASV) was available at district and secondary-level facilities while PHC-level availability was additionally reported in some states like Bihar and Rajasthan, supporting early management of snakebite cases.
- Clinical protocols for snakebite management (neurotoxic and haemotoxic envenomation) were available across States, supported by training of healthcare providers including Medical Officers, Nurses, CHOs, MPWs, and ASHAs on case management.
- Referral systems for complicated snakebite cases were functional in most states, with escalation pathways to higher facilities and medical colleges.
- Emergency management integration for snakebite cases was operational across states supported by trained healthcare staff and standard protocols.
- Community awareness regarding first aid, early reporting, and avoidance of traditional practices remained limited in some states.

NP-NCD

- Dedicated NCD clinics were functional daily in most of secondary facilities of the visited States, with exceptions including Meghalaya, where the clinics were functional on alternate days. Follow-up and continuum of care was observed to be weak across most of the visited States.
- Screening for NCDs at the secondary level was largely limited to hypertension & diabetes, except in States like Chhattisgarh, Maharashtra, Madhya Pradesh & Uttarakhand. Additionally, even for cancer screening, focus remained mostly on oral and breast cancer screening.
- DCCCs were established in Assam, Kerala, Chhattisgarh, Odisha, Punjab, Tamil Nadu & offering comprehensive chemotherapy and cancer care services. In Tamil Nadu's

Salem district, the DCCC was functional at the medical college. In Uttarakhand DCCC was established but was non-functional.

- STEMI services were being provided in Kerala, Maharashtra, Nagaland, Odisha, Punjab, Rajasthan, Tamil Nadu & Uttar Pradesh, though gaps persisted. Service provision at the secondary care level for COPD, NAFLD, CKD, stroke was limited across visited States. In Kerala, 'SWAAS' clinics were functional at GH/DH level, providing asthma, COPD and smoking cessation services.

PMNDP

- Dialysis services were being provided through both in-house and PPP modes across the visited States; free drugs and diagnostic services were being provided for dialysis patients across most of the States, however, in Nagaland, free drugs and diagnostics services were available only for PM-JAY or CMHIS enrolled beneficiaries; shortage of trained HRH was observed across States.
- Peritoneal dialysis was not reported across most of the States except Kerala & Meghalaya (OPD basis in Meghalaya); in Bihar & Kerala, viral markers (HIV, Hepatitis B and C) were being tested routinely for dialysis patients; RO water testing was being done regularly for the dialysis unit across most of the visited States, however, the report was found to be unsatisfactory in Meghalaya.



NPCBVI

- Ophthalmic surgeries were being conducted in most of the visited States, except Tamil Nadu, where surgery patients were being referred to medical college due to lack of specialists. In Uttarakhand, major surgeries remained limited at SDHs and CHCs due to lack of specialists.
- In Maharashtra's Satara district, a Memorandum of Understanding (MoU) had been signed with an eye hospital in Pune to support Retinopathy of Prematurity (ROP) screening under NPCBVI.
- Regular eye screening outreach camps were organized in collaboration with the RBSK in US Nagar district of Uttarakhand. At the sub-district level, the village blind register was maintained.

NPPCD

- Audiometric screening was reported to be well functioning in Kerala, Maharashtra, Nagaland, Rajasthan & Uttarakhand. In Uttarakhand, the services were being provided in collaboration with RBSK.
- In Maharashtra, cochlear implants were being undertaken through an MoU with a hospital in Nashik, post which speech therapy was being provided in the district.

NOHP

- Dental services at the secondary level were being provided across all of the visited States, however, X-Ray for dental imaging was not available in Chhattisgarh & Maharashtra. Hepatitis B vaccination of dental staff was found to be incomplete in Tamil Nadu.

NTCP

- Tobacco cessation centres were observed and functional in Kerala, Madhya Pradesh, Maharashtra, Nagaland, Odisha, Punjab & Uttarakhand.
- Awareness campaigns for tobacco control were being conducted in most States & a high burden of tobacco consumption was observed in Chhattisgarh.
- COTPA was generally being enforced across States, however, some packets of tobacco were observed within health facility premises in Chhattisgarh, indicating violation of the act.
- Challans were also being issued for violation of COTPA Act. In the visited districts of Uttarakhand, more than 2200 offenders were fined from April to September 2025 for smoking in public places.

NPHCE

- Implementation of geriatric services varied across States, with separate geriatric OPD available in Kerala, Madhya Pradesh, Odisha & Tamil Nadu, while the services were largely unavailable in Bihar; separate IPD beds were also available for elderly patients in Kerala, Madhya Pradesh, Maharashtra, Meghalaya, Nagaland, Odisha & Punjab.
- In one district of Uttarakhand, beds were earmarked for elderly patients in the IPD of the DH & SDH, but were not functional; yellow Elderly Health Cards were being issued to older persons, however, program visibility was low due to absence of IEC materials and signage, in Chhattisgarh.

NPPC

- Palliative care services were unavailable or limited across most States, except Kerala, Meghalaya, Odisha, Punjab & Tamil Nadu. Kerala had built a comprehensive palliative care network integrating government, traditional medicine system and community-based organisation, called the Kerala Care Grid.
- In Uttarakhand, the existing Day care cancer centre at DH was functional as palliative care ward with suboptimal Utilization; in Odisha, round-the-clock availability of analgesics, including Tramadol, was ensured.

NPPCF

- NPPCF was being implemented in selected districts of Andhra Pradesh, Assam, Bihar, Chhattisgarh, Kerala, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana & Uttar Pradesh.

- Fluorosis control was observed to be limited at the secondary care facilities in endemic States. Additionally, HR shortage was observed in Chhattisgarh & Rajasthan, and existing HR were not adequately trained and sensitized on the program.

NIDDCP

- For Iodine control programme, endemic districts visited included Kanker in Chhattisgarh, Kottayam and Kasaragod in Kerala, East Khasi Hills and North Garo hills in Meghalaya, Bargarh in Odisha, Mangan and Soreng in Sikkim, Salem in Tamil Nadu, Muzaffarnagar in Uttar Pradesh & Chamoli in Uttarakhand.
- Salt testing was being done regularly in the visited endemic States from the primary level facilities, however, in Rajasthan, salt testing kits were not adequately available.

NMHP

- Mental health services at the secondary level were functional in most States, with dedicated staff and infrastructure; DMHP was functional across most visited States.
- Dedicated psychiatric OPD was being conducted in States including Chhattisgarh, Kerala, Madhya Pradesh, Meghalaya, Nagaland, Odisha, Punjab & Uttarakhand; HR shortage was common across the visited States.
- Tamil Nadu's DMHP was active and provides wide outreach through satellite clinics, mobile follow-ups, and integration with jails and institutional homes; outreach camps in jails were also observed in Chhattisgarh & Uttarakhand.
- Tele MANAS functionality varied across States, with weak referral linkages. Most states reported underutilisation of the services, as well as lack of well-displayed IEC in some States.

NPCCH

- In Punjab, activities planned included Climate Change Knowledge Centre (Jalandhar), sustainable agriculture, Sustainable habitat, increasing green cover, renewable energy for health sector- HVAC, LED lighting etc.
- In Uttarakhand, an action plan and LED display were available at the DH. At the SDH, a poster with the helpline number was displayed. However, no task force has been formed, and designated beds for heat-related illness or ARIs were not identified.
- In Meghalaya, conventional light sources were replaced with energy efficient light source (LED); solar panels were installed in the FHC visited in the aspirational block, and an energy audit of visited health facilities was observed.

RECOMMENDATIONS

- There is a need to strengthen human resource availability across secondary care facilities, with priority on specialists, paediatricians, anaesthetists, and trained nurses to ensure comprehensive service delivery. Programme management HR

recruitment should be expedited by the States, to ensure streamlined provision of services and strengthened capacity.

- States to ensure the quality of care through strict adherence to clinical protocols, including use of partograph, Safe Birth Checklist, infection control practices, and standard treatment guidelines across programmes.
- Strengthening of supply chain and logistics management systems, including full operationalisation of digital platforms (FPLMIS, e-VIN, U-WIN) and maintenance of stock registers, is required to ensure uninterrupted availability of commodities.
- There is a need to enhance infrastructure and equipment availability, particularly for critical care services (SNCU, NBSU, HDU/ICU), cold chain maintenance, and diagnostic services such as ultrasound and POCT.
- States to strengthen data quality, reporting, and monitoring systems by addressing connectivity issues, reducing duplication, and ensuring regular review of programme indicators for evidence-based decision-making.
- Referral systems and continuum of care should be strengthened through improved transport, tracking mechanisms, and coordination between facilities to reduce delays and prevent avoidable morbidity and mortality.
- Capacity building through regular refresher trainings, mentoring, and supportive supervision should be institutionalized to improve provider skills across all RMNCH+A programmes.
- Convergence and community linkage mechanisms should be strengthened, including coordination with ICDS, schools, and outreach platforms, to improve service uptake, follow-up, and continuity of care.
- States to strengthen decentralised diagnostic capacity across programmes by ensuring universal upfront NAAT (CBNAAT/TruNAT) for TB and expanding access to molecular diagnostics for HIV, viral hepatitis, and other priority diseases at the district level.
- There is a need to expand chest X-ray coverage, including deployment of mobile and handheld X-ray units for vulnerable, remote, tribal, migrant, and urban poor populations to improve early case detection.
- States to strengthen sample transport and laboratory referral networks using structured routing, CHO/ASHA-supported systems, and hub-and-spoke models to reduce delays in diagnosis, especially in hard-to-reach areas.
- Strengthen DBT and patient incentive systems through regular audits, digital tracking, and end-to-end monitoring to ensure timely benefit transfer and reduce loss to follow-up.
- States to institutionalise comprehensive vulnerable population mapping (tribal, tea

garden, migrant, urban slum, remote areas) to guide targeted active case finding, outreach, and service delivery planning.

- Scale up active case finding and community-based screening across programmes (TB, leprosy, NCDs, vector-borne diseases) through contact tracing, school-based screening, and targeted high-risk interventions.
- Expand decentralised viral load and advanced diagnostic testing capacity at district level (IPHL or equivalent), supported by hub-and-spoke laboratory models for timely clinical decision-making.
- States to improve digital surveillance systems (IHIP, Nikshay, NVHCP-MIS, Nikusth) through strengthened data quality audits, improved capacity building of frontline workers, and real-time reporting validation mechanisms.
- Ensure uninterrupted availability and rational distribution of critical emergency commodities including ARV, RIG, and ASV, supported by strengthened supply chain systems and peripheral-level availability.
- Follow-up and continuum of care for NCD services from primary to secondary facilities needs to be ensured by States, with comprehensive screening of all beneficiaries aged 30 years and above, especially enhancing focus on cancer screening.
- Implementation of PMNDP needs to be strengthened across the secondary care facilities, with provision of free drugs and diagnostic services. Provision of peritoneal dialysis needs to be ensured across the district hospitals. Monitoring and data entry into the portal needs to be ensured across all facilities.
- Service provision for expanded range of services for NCDs, including Stroke, NAFLD, COPD & CKD to be expedited across States, ensuring a comprehensive coverage for beneficiaries.
- States to focus on implementation of the Tele MANAS programme through IEC display, awareness generation and HR strengthening.
- Elderly & Palliative care needs to be strengthened across secondary level facilities. Establishing dedicated OPD & IPD should be ensured. Additionally, medicines and therapeutic equipment should be made available for elderly and palliative equipment.
- States should focus on ensuring strict adherence to COTPA act at health facilities, as well ensuring reduction in tobacco consumption by improving tobacco cessation and counselling services.
- Provision of adequate equipment for dental care services at the secondary care facilities should be mandated, and linkages with oral cancer screening should be strengthened.

- States need to effectively implement the relevant components of National Programme for Climate change and Human health.

STATE SPECIFIC FINDINGS

Andhra Pradesh

Maternal Health

- Maternal health services were available at secondary care facilities, with LaQshya certification achieved in several hospitals, particularly in Chittoor district.
- Labour rooms in Chittoor were clean, spacious and equipped with essential protocols, partographs, newborn care corners and emergency obstetric drugs.
- The PPP-managed labour room in Chittoor demonstrated strong operational efficiency and high patient satisfaction.
- Labour rooms in Parvathipuram Manyam were functional but lacked uniformity in layout, triage systems, infection control practices and patient privacy.
- Postnatal care areas documented systematic monitoring of vitals and counselling on exclusive breastfeeding and contraception.

Child Health

- Special Newborn Care Units were functional in District Hospital Parvathipuram Manyam and Area Hospital Chittoor.
- SNCU in Chittoor demonstrated active Kangaroo Mother Care support, clinical protocols and well-maintained registers.
- SNCU in Parvathipuram Manyam had limited monitoring of newborns with sepsis risk.
- Postnatal Care (PNC) areas in both districts documented systematic vitals monitoring and counselling on exclusive breastfeeding and contraception.
- Discharge counselling varied across facilities, with structured follow-up for high-risk newborns and postnatal mothers not always ensured.

Adolescent Health

- Adolescent Friendly Health Centres were well functioning across the secondary Care facilities visited, supported by trained counsellors.

TB Mukh Bharat Abhiyan (NTEP)

- Screening of presumptive pulmonary TB cases was routinely conducted across OPDs, emergency wards, and inpatient wards, with testing facilities available at district hospitals.

- Upfront NAAT for all presumptive TB cases was not universally implemented; sputum microscopy continued to be used as the first-line test in many cases, contributing to diagnostic delays.
- Linkages between secondary facilities and NTEP units were functional; however, gaps existed due to the lack of counsellors and dedicated staff for contact tracing and treatment adherence.
- Although MDR-TB identification and referral mechanisms were functional, but post-referral follow-up at AAM-PHCs and secondary facilities was not consistently ensured.
- DBT support for TB patients was delayed, primarily due to integration issues between Nikshay and IFMS, SNA SPARSH.

NLEP

- Leprosy services were functional across both districts and Multidrug Therapy (MDT) drugs were available across the visited facilities. However, Social stigma continued to hinder case reporting and early treatment initiation, particularly in tribal and semi-urban areas.
- Routine skin patch examinations and nerve assessments were not consistently documented in general OPDs and disability prevention and rehabilitation services were minimal.

NVBDCP

- Malaria reporting and treatment protocols were followed, but active observation units for dengue management were not consistently functional, resulting in lengthier ER occupancy during peak seasons.
- Secondary hospitals reported seasonal spikes in malaria, dengue, and chikungunya cases during monsoons.
- Case management protocols were available in most facilities, but adherence was inconsistent; timely platelet monitoring was noted in Chittoor. In Parvathipuram Manyam, frequent platelet shortages and lack of component separation led to referrals to tertiary hospitals.
- Early warning mechanisms functioned effectively through the District Surveillance Unit. However, delays in data entry and case confirmation in remote tribal areas hindered timely public health responses.

IDSP

- IDSP reporting was regular across secondary hospitals; however, the timeliness of outbreak alerts was influenced by internet connectivity and staff strength.

- Coordinated outbreak investigations involving environmental teams, entomology teams, and clinicians were observed in some instances, but were not systematised across the state. However, limited local microbiology capacity contributed to slower outbreak detection and response.
- Event-based surveillance was better institutionalised in Chittoor, with prompt reporting of rising fever clusters and diarrhoeal cases.
- Delays in sample transport to the district laboratory and dependence on tertiary facilities for confirmatory testing were observed in Parvathipuram Manyam.

NRCP

- Availability of Anti-Rabies Vaccine (ARV) was largely consistent across district and area hospitals, while Rabies Immunoglobulin (RIG) availability was variable.
- Dog bite cases were routinely managed in emergency units; however, tracking of vaccination schedules was not uniform.
- Many hospitals lacked a recall mechanism to ensure completion of the full vaccination course.
- A higher percentage of follow-up doses were patient-initiated rather than system-tracked.

NPPCSE

- Snake bite cases were frequently managed in Parvathipuram Manyam and intermittently in Chittoor, with well-maintained records observed in both.
- Availability of Anti-Snake Venom (ASV) in the secondary hospitals visited was satisfactory; however, occasional delays in resupply were reported during high-incidence months.
- Clinical protocols for management of neurotoxic and haematotoxic envenomation were available, though adherence varied depending on staff experience.

NP-NCD

- Secondary facilities acted as referral points for advanced NCD cases, yet multidisciplinary care remained limited. Clinics for diabetic foot care, stroke risk management, diabetic retinopathy, CKD and thyroid disorders functioned variably. Facilities without specialists conducted only episodic & limited follow-up counselling & physiotherapy support.

NMHP

- Secondary care hospitals provided outpatient psychiatric consultations only where psychiatrists were posted, mental health screening at NCD clinics was low. Tele-MANAS had not yet been meaningfully integrated into hospital workflow.

- Shortage of dedicated counsellors, social workers and psychiatric nurses limited the ability to deliver holistic care at district level. Follow-up was family initiative dependent.

Assam

Maternal Health

- Labour rooms at District Hospital/Sub-District Hospital levels were functional with provision of 24x7 delivery and caesarean section services.
- Cashless maternal entitlements under JSY and JSSK were being implemented at secondary care facilities.
- Specialist availability at CHC/SDH level was inadequate, affecting comprehensive emergency obstetric care services.

Family Planning

- Family planning services were available at secondary care facilities with display of IEC materials and self-care kits.
- Facilities displayed information related to services, improving transparency and awareness.

Child Health

- Special Newborn care Units (SNCUs) and newborn care units were present at secondary care facilities.
- Innovative practices such as Kangaroo Mother care and newborn stimulation techniques were observed.
- SNCU and NBSU rooms were available with equipment, but the number of functional units was lower than the need for timely care.
- Management of sick newborns required referral due to limited functional units.

Child Nutrition

- NRCs at the DH/SDH level were functional and linked with WCD for SAM referrals;
- Coordination with ICDS for IFA syrup, deworming and growth monitoring was in place, and nutritional counselling was integrated with paediatric OPD and PNC wards.
- However, delays in IFA and deworming supplies, inconsistent health–ICDS coordination, limited household counselling, and weak anaemia management protocols (especially for pregnant women) blunt the impact of these services.

Universal Immunization Programme (UIP)

- Cold-chain points were well maintained across secondary facilities.
- Digital platforms for reporting were in use for immunization

Adolescent Health

- Medical Officer at SDH was trained in Adolescent Friendly Health Services (AFHS), and an AFHC room was available,
- Despite this, overall programme performance remains poor with high teenage pregnancies
- indicating gaps in life-skills education, contraceptive information and access.
- Uptake and awareness of the Antara self-care platform was low among both community members and facility staff.

TB Mukht Bharat Abhiyan (NTEP)

- The TB programme was operational in both districts and formed an integral part of the secondary-care service package, with functional sputum collection points at primary facilities and sample transport systems to SDHs for TruNAAT testing.
- Two TruNAAT machines were available and functional in Charaideo, enabling rapid molecular diagnosis and early initiation of appropriate treatment.
- Reported TB treatment success rates in Dibrugarh and Udalguri were high and, in some instances, exceeded national targets, reflecting a strong emphasis on treatment completion and cohort monitoring.
- Vulnerable-population mapping had been completed in Charaideo but remained pending in Udalguri, and high-risk groups including tea-garden workers, tribal communities, migrants, and the urban poor—were not uniformly covered under active case finding and contact screening.
- The diagnostic network remained largely facility-based, with TruNAAT machines located at SDHs and no availability of portable X-ray machines in either of the visited districts; while mission-mode X-ray screening campaigns were conducted from SDHs, regular decentralised access was limited, particularly in remote tea-garden and tribal areas.
- There was no designated full-time District TB Officer (DTO) in Udalguri, affecting programme leadership, supervision, and field-level monitoring.
- Integration of TB services with other programmes at the secondary level was limited, with systematic screening among NCD, HIV, antenatal, and undernourished populations not institutionalised, and bidirectional screening for TB-diabetes and TB-HIV not uniformly practised.

NLEP

- Leprosy services were available at the secondary level and supported by active case finding, with Patsaku Model Hospital in Charaideo conducting slit-skin smear examinations and ASHAs demonstrating awareness of key symptoms and participation in ABSULS activities.
- However, many cases continued to be detected late, often presenting with Grade-2 disability or visible deformities, indicating gaps in early detection and referral pathways from the community and primary level to SDH/DH.

NACP

- NACP staff at the district level were trained and were delivering services effectively, with HIV testing and counselling services available and secondary-level facilities aligned with national guidelines.
- Link ART services were primarily accessed from nearby medical colleges, resulting in dependence on tertiary centres and increased travel burden for patients.

NVBDCP

- Secondary-level facilities were involved in management of malaria, JE, and dengue, with RDT-based malaria screening by ANMs supporting early detection and effective monitoring of *P. falciparum* burden in Charaideo.
- JE treatment was available at SDH level with notification linkages to the Veterinary Department during suspected rises in cases.
- Dengue incidence, particularly among migrant populations, was addressed through fogging (Malathion) and larvivorous fish deployment in selected areas.
- However, vector control systems remained weak overall, with limited entomological surveillance, absence of reported LLIN distribution, and inadequate integration of facility-based case management with community-level prevention, especially in tea-garden and peri-urban settings.

NP-NCD

- At the secondary level, NCD clinics were functional with a dedicated staff nurse and data entry support at SDH and DH. New DCCC had been sanctioned for Udalguri.
- Counselling sessions by Assam Cancer Care Foundation took place on fixed days and PMNDP services for dialysis and Hepatitis C were available in PPP mode.
- Cervical cancer screening was sporadic and, in some places, patients were purchasing pap smear kits. NCD emergencies (for example, acute coronary syndrome or stroke) did not have a clear, protocol-based pathway.

NPHCE

- NPHCE was visible only through home-based delivery of NCD drugs to bedridden elderly; no separate geriatric clinic, no functional line-listing of older adults and

no structured assessment of elderly health conditions at the secondary level was observed.

NOHP

- Under NOHP, SDH Sonari had a functional dental chair and provided basic oral health services and occasional school dental camps; at DH Udalguri, the dental chair was non-functional, which restricted specialist oral health services.

NTCP

- “No Smoking” signage was observed to be largely absent, tobacco cessation cells were either not established or not well linked with SDH/DH and staff had not received systematic training on brief intervention and cessation protocols.

NMHP

- Tele MANAS helpline numbers were displayed in facilities, and counselling services were provided at the civil-hospital (DH) level. Despite this, staff orientation on mental health was found to be limited.
- No dedicated mental health counsellor was posted at SDH or DH, psychotropic drug availability was inconsistent due to EDL misalignment, and data on counselling of inpatients was not being systematically captured, despite high suicide rates in the districts.

Bihar

Maternal Health

- More than half of all institutional deliveries were conducted at three institutions, (DH Munger, SDH Tarapur and CHC Haveli Kharagpur) showing high referral and burden on secondary care services.
- C-section services were available at SDH & DH. Non-availability of blood storage unit at SDH was major concern for conducting C-section deliveries.
- Birth companions were allowed in all the delivery points (DH, SDH, CHCs).
- Maternal case sheets were found to be filled at all the health facilities. However, baby notes were not filled at most of the facilities
- Critical equipment and drug, point of care test kit were available.
- Identification of High-Risk Pregnancies at PMSMA and E-PMSMA was being done at DH and SDH, however, follow-up of HRP need close monitoring and focused action plan to prevent pregnancy complications and maternal deaths

Family Planning

- Condom boxes/self-care kits were available across facilities. Sterilization services were provided through an outsourced system on a fixed weekly schedule.

- Pregnancy testing kits were not available in the family planning room in Saran.
- Comprehensive Abortion Services (CAS) were available across facilities with all required medicines and equipment in Saran. Though CAS were available at DH Munger but were not available in SDH Tarapur in Munger.

Child Health

- A 32-bedded paediatric care unit in Munger was functional with 24×7 services; however, the paediatric ICU within the unit was non-functional.
- A 42-bedded Paediatric and NRC complex in Saran had a functional NRC, while the paediatric ICU was ready but not operational.
- A 70-bedded MCH hospital in Saran was providing 24×7 services including deliveries and OPD services.
- Late referral from periphery was usually seen due to which newborns were admitted in the critical conditions.

Immunization

- Immunization services were found to be functioning adequately at DH, SDH and CHCs.
- Birth-dose and Td vaccination for pregnant woman were provided daily in Munger.
- Cold chain points were available at DH, SDH and CHCs, vaccines were found to be correctly stacked in the ILR and contingency plan for the cold chain was well displayed outside all the cold chain points.
- All the ILRs were connected to e-VIN.

TB Mukht Bharat Abhiyan (NTEP)

- Opportunistic screening for tuberculosis was conducted across all levels of healthcare facilities, with NAAT testing available up to the block level and sputum samples transported from AAM-PHCs and SHCs.
- Anti-tuberculosis drugs were available and were being dispensed to patients in a timely manner across facilities.
- Gaps were observed in follow-up sputum examinations for patients undergoing treatment, and screening of household contacts along with provision of Tuberculosis Preventive Therapy (TPT).
- Direct Benefit Transfer (DBT) payments were being processed; however, delays in disbursement were noted, and Nikshay Mitra support was not available for the majority of patients.
- TB death audits were not being conducted.

NLEP

- Active case finding was conducted annually, and MCR footwear and self-care kits were available for patients.
- However, Slit Skin Smear (SSS) testing was not available at the District Hospital or Sub-District Hospital in Saran, indicating a gap in diagnostic capacity at the secondary level.

NACP

- Pregnant women were being tested for HIV and syphilis across all levels of healthcare facilities.

NVHCP

- Pregnant women were screened for HBsAg up to the AAM-SHC level, and administration of HBIG for newborns of HBsAg-positive mothers had been initiated at the District Hospital, Saran.
- Most healthcare workers were found to be vaccinated against hepatitis B.
- Molecular testing (viral load) for hepatitis B and C was not available at the district hospital, with patients referred to Patna for further evaluation; despite availability of drug regimens for uncomplicated cases, no patients had been initiated on treatment at the district hospital.
- Screening for hepatitis B and C was not being conducted among patients at ICTC centres and high-risk groups at Targeted Intervention sites, and relevant screening and service delivery data were not being captured in the NVHCP-MIS portal.

NVBDCP

- Malaria: RDK kits for malaria diagnosis were available at all facilitating early detection of cases. Anti-malarial drugs were also available across all visited facilities.
- Dengue: Both NS1 and IgM RDT kits were available at the facilities.
- Kala-azar: No new cases were reported during the current year; however, PKDL cases were treated. Liposomal Amphotericin B was available at DH and SDH levels and was stored in ILR.
- Lymphatic Filariasis: One round of Night Blood Survey had been conducted during the year. Vector control measures, including insecticide spraying, larvicidal activities, and distribution of bed nets, had been undertaken.
- IEC materials related to vector-borne diseases were available at health facilities; however, limited awareness among community members regarding prevention and control measures was observed, indicating the need for strengthened health education and awareness efforts.

IDSP

- P and L forms were being reported through the IHIP portal up to the PHC level, while S forms were reported at the SHC level. Vaccine Preventable Disease (VPD) cases, including AFP cases, were being investigated.

NRCP

- Anti-Rabies Vaccines (ARV) were available up to the PHC level, with high utilisation observed in certain CHCs such as Revilganj and Amnour.
- Rabies Immunoglobulin (RIG) was not available at any of the DH, SDH, CHC, AAM-UPHC, AAM-PHC.

NPPCSE

- Anti-Snake Venom (ASV) was available up to the PHC level in both districts.
- Not all Medical Officers, Staff Nurses, CHOs, and ASHAs at the sub-district level were trained in the management of snakebite envenoming.

NP-NCD

- Dedicated NCD clinic was available at DH & SDH levels. NCD screening corners were found at CHCs with regular entries in the NCD portal; cervical cancer, oral cancer and breast cancer screening was being carried out at DH Chappra.
- People suspected of cancer were being referred to tertiary care hospitals. DH Munger had initiated training of periphery level staff in screening for cancers under CPHC.

PMNDP

- Viral markers (HIV, Hepatitis B and C) were being tested routinely for dialysis patients. Data was being captured in the PMNDP portal.

NOHP

- Functional dental chairs were found to be available in each of the visited DH, SDH, CHC. Autoclave was available for sterilization. Dental specialists were not available in any of the visited facilities. Only service of tooth extraction was being provided.

NPHCE

- NPHCE had not been initiated at any level in the district, including DH, SDH and CHCs. Dedicated geriatric clinics and wards were not available across visited facilities.

NMHP

- Tele-MANAS linkages were not observed at DH and SDH level, & RMNCAH+N counsellor was serving as multi-purpose counsellor for various programs. The platform was reported to be underutilised. No mental health outreach activities

were observed in the community, limiting early detection and intervention for mental health issues.

Other NCD programs

- Not all the health staff in the districts visited had been oriented & sensitized about other NCD programs, including NPPC, NPCBVI, NPPCD and NPCCHH.

Chhattisgarh

Maternal Health

- All the facilities visited were providing round-the-clock institutional delivery services.
- Labour rooms and PNC wards were functional and well-maintained. NBCCs and radiant warmers were available but non functional in Mahasamund district.
- Early initiation of breastfeeding was practised in labour rooms, with counselling provided by on-duty staff. Respectful maternity care practices were followed in labour room.
- Accommodation was arranged for mothers whose newborns were admitted in SNCUs.
- JSSK entitlements were provided free of cost and prominently displayed across facilities.
- Designated biomedical waste storage areas as per norms were not available in most facilities.
- Point-of-care testing (POCT) within labour rooms has not been initiated in several CHCs and district hospitals.
- Ultrasound services were limited and not universally available across CHCs. Out-of-pocket expenditure was mainly related to accessing ultrasound services.
- Ambulance services (102 and 108) were widely utilised for referral and transport of pregnant women. Caesarean section audit forms ensured for all C-section deliveries at District Hospital Kanker.
- Maternal death and child death reviews were conducted at district level.

Family Planning

- The family planning basket was incomplete in several facilities. Antara injectable contraceptive was unavailable at some locations.
- Family planning surgical services were not uniformly conducted due to non-availability of specialists.
- FPMIS stock visibility was inconsistent, leading to delays in timely replenishment of commodities.

- The Family Planning Unit was fully functional with adequate infrastructure. One minor operation theatre and one major operation theatre were available for sterilization services to provide service regularly.
- Four RMPs, including one specialist, were available to provide Comprehensive Abortion Care (CAC) services. Four providers were trained in Medical Termination of Pregnancy (MTP).
- Adequate stock of family planning commodities, including PTK, Antara injectable contraceptive, and condoms, were available.
- Service delivery records for family planning and MTP were maintained. However, stock-out registers were not maintained.
- Comprehensive abortion services available at DH/MC and CHCs. However, CAC services not available in CHC Pithora due to non-availability of gynaecologist.
- MVA tray was available at the visited health facilities, DH and CHCs. Medical officers were trained on MTP and services were provided.

Universal Immunization Programme:

- The Immunization unit was functional and staffed with ANMs.
- ANMs demonstrated good knowledge of immunization schedules and vaccine handling practices.
- One Ice Lined Refrigerator (ILR) and one Deep Freezer (DF) were available and found to be functional.
- Birth dose vaccinations were routinely administered. Adolescent immunization was being conducted through the School Health Programme.
- AEFI committee meetings were held during the year 2024–25, indicating active monitoring of adverse events.
- Stock-out registers for vaccines and immunization logistics were not maintained. Staff showed reluctance toward regular and timely online data entry.
- Technical issues were reported in the U-WIN portal, particularly in areas with poor network connectivity.
- Spare parts for ILR and Deep Freezer supplied by the manufacturer (Godrej) were reported to be not readily available in the local market, this poses a risk of prolonged cold chain disruption in case of equipment breakdown.

Child Health:

- Paediatric OPD services were regularly conducted at district hospitals; paediatricians and senior residents were available, and facilities were attached to medical colleges.

- Paediatric wards were operational with adequate bed strength and moderate bed occupancy. One SNCU was available at the medical college; however, it faces shortage of paediatricians, poor infrastructure, and non-functional equipment.
- Critical care equipment such as CPAP machines and ventilators were not available in the district.
- Paediatric HDU/ICU facilities were not available; only SNCU, NBSU, and paediatric wards were present.
- NBCCs were functional at all delivery points with essential equipment including radiant warmers. NBSUs at CHC level were functional but have poor infrastructure, inadequate equipment, lack dedicated staff and paediatricians, and have low admissions due to absence of required services.
- Child death cases being reported and entered in the MPCDCR portal, but overall reporting quality remains weak.
- A high burden of child deaths has been reported during the review period, though Child Death Review (CDR) meetings were not conducted regularly.
- Secondary-level newborn care services (SNCU) were weak, with shortage of paediatricians and absence of critical equipment such as ventilators and phototherapy units.

Child Nutrition

- Child Lactation Management Centres (CLMCs) were not operational, and staff were not trained to provide lactation management services.
- Nutrition Rehabilitation Centres (NRCs) were established as a key state initiative, with availability at district hospitals and selected CHC levels.
- NRC infrastructure was adequate and well maintained, with good cleanliness, child-friendly IEC displays, dedicated kitchens, toilets, play areas, and designated feeding spaces.
- Medical Officer/Paediatrician presence at NRCs was inadequate. Only limited staff have received NRC-related training, while several staff nurses posted at NRCs remain untrained.
- NRC performance indicators show moderate bed occupancy, high cure rates, and satisfactory average weight gain among admitted SAM children.

RBSK

- The RBSK programme was operational through Mobile Health Teams (MHTs), with tertiary-level management support, but District Early Intervention Centres (DEICs) were not functional.

- Significant human resource gaps exist in MHTs, particularly vacancies of Laboratory Technicians and ANMs, mainly due to regularization under NHM.
- Although DEICs have been approved under NHM PIP and land has been identified, construction was delayed due to pending administrative approvals, affecting early intervention services. In the absence of DEICs, children identified by MHTs were directly referred to higher facilities for diagnosis and treatment, coordinated through district RBSK teams.
- Introduction of online approval systems for Category A treatments has improved case tracking and reduced delays.

Adolescent Health

- Counselling services for adolescents were being provided through RMNCH+A counsellors, but dedicated AFHC clinics were not functional.
- Adolescents referred from OPD and field outreach were counselled; however, services were not structured as per AFHC guidelines.
- Counsellors were not trained specifically on AFHC/AFHS, resulting in limited technical knowledge on adolescent-specific issues.
- Adolescent-specific IEC materials, posters, and family planning materials were largely absent, and no separate AFHC registers were maintained in some facilities.

TB Mukht Bharat Abhiyan (NTEP)

- CHCs functioned as key nodal centres for sputum collection and sample referral, with structured sample transport systems, route mapping, travel incentives, and dedicated sputum collection staff in place; however, availability of CBNAAT/TruNAT at the CHC level was uneven, leading to dependence on District Hospitals, particularly in Mahasamund.
- District Hospitals were relatively well equipped with functional CBNAAT/TruNAT laboratories, X-ray facilities, and adequate consumables; in Kanker District Hospital, two NAAT laboratories were operational, with an average turnaround time of approximately 40 minutes and same-day reporting in most cases.
- The Nikshay portal was operational across CHCs, District Hospitals, and medical colleges in both districts; however, inconsistencies, delays, and data accuracy issues were observed, with TB notification performance in Mahasamund reaching 87% of the target.
- Drugs and diagnostic services were generally available, with DOT centres effectively managing medicine distribution; drug-resistant TB cases were identified and followed up regularly, and integration with allied services such as HIV, diabetes, and nutrition rehabilitation centres was evident, particularly in Kanker.
- Nikshay Mitra engagement was active in Mahasamund, with 62 Mitras providing nutritional and financial support through distribution of 172 food baskets; Poshan

benefits, toll-free dosage reporting, and both digital and manual adherence mechanisms were functional, though occasional delays were reported.

- Tracking mechanisms for migrant populations were in place in Kanker; however, active screening activities remained limited, particularly in Kanker.
- Infrastructure-related issues, including inconvenient placement of X-ray and laboratory services, were observed affecting patient flow.

NLEP

- A functional referral mechanism for leprosy suspects was in place in both districts, with NLEP services available at CHCs and District Hospitals; Mahasamund had a dedicated leprosy OPD supported by a Non-Medical Assistant (NMA).
- Active case detection remained limited and largely OPD-based, particularly in Mahasamund; while Kanker conducted periodic screening through schools, community camps, and LCDC campaigns, structured and routine community or household-level screening was not uniformly implemented across blocks, despite frontline workers (Mitans/ASHAs) demonstrating basic knowledge of symptoms.
- MDT blister packs were generally available and patient support materials (MCR footwear, self-care kits, assistive devices) were provided; however, MDT shortages were noted in Kanker.
- Slit Skin Smear (SSS) testing was available at selected CHCs in Mahasamund but was not performed regularly and was not available at District Hospital Kanker.
- Prevention of Disability (POD) camps were conducted regularly at CHCs in Mahasamund with physiotherapist-led disability assessments, and patients with lepra reactions were referred to RLTRI, Raipur; reconstructive surgeries were performed in Kanker, whereas no Grade-2 Disability corrective surgeries were conducted at District Hospital Mahasamund despite eligible cases.
- IEC materials were available but had limited visibility in facilities and community settings, and although patient details were updated on the Nikusth 2.0 portal, intermittent portal-related issues were reported.
- Staff shortages and lack of essential equipment were observed in some facilities, affecting service delivery.

NACP

- HIV testing and counselling services were functional in both districts, with ICTC services providing pre-test counselling and testing.
- Serum-based HIV testing kits were available; however, dual whole-blood rapid testing kits were not available in Mahasamund, limiting point-of-care and outreach testing.

- TB screening among HIV-positive patients was being conducted in line with HIV-TB collaborative guidelines. Syndromic management kits were available but insufficient, and spill management kits were not available.
- Healthcare staff demonstrated limited hands-on knowledge of centrifuge operation, handling, and maintenance, potentially affecting sample quality and turnaround time. Additionally, awareness regarding needle-stick injury prevention and post-exposure prophylaxis protocols was low among healthcare staff in Mahasamund.
- Space constraints and improper storage of biomedical materials were observed, increasing the risk of contamination and non-compliance with infection prevention and control norms.

NVHCP

- Viral hepatitis services were functional at District Hospitals in both districts, with routine screening for Hepatitis B and C (including antenatal screening), availability of HBsAg and HCV test kits, and provision of counselling on prevention and transmission; positive cases were referred appropriately.
- Antiviral drugs were available, and in Kanker, screening and treatment services were co-located; however gaps in the supply of drugs and consumables were observed.
- Biomarker and viral load testing were not available at the district level, with samples referred to medical colleges, and testing facilities for Hepatitis A and E were also not available.
- Hepatitis B vaccination among healthcare staff had been undertaken, though documentation was not uniform across facilities.
- Screening of high-risk groups, such as truckers and jail inmates, was being conducted at the CHC level in Mahasamund.

NVBDCP

- NVBDCP implementation was functional across facilities, with availability of RDT kits, microscopy services, adequate drug supplies, and regular conduct of Filariasis MDA and morbidity management activities.
- Long-Lasting Insecticidal Nets (LLINs) were distributed, with use of mosquito nets observed for inpatients in Kanker, and malaria indicators showed a declining trend over the past three years, with no malaria-related deaths reported.
- At the CHC level, malaria services were operational in both districts, with IDSP reporting being carried out; Kanker, being malaria endemic, reported 2–10 OPD cases per month, with local slide preparation, though slide quality was noted to be suboptimal.
- Staff training had been conducted; however, documentation and verification of training records were inconsistent.

- Advanced diagnostic testing, such as viral load testing for dengue, was not available at the district level.

IDSP

- IDSP was operational in both districts, with regular online reporting through S, P, and L forms from both public and private sectors; however, reporting volumes varied across facilities and data discrepancies were observed between facility records and portal entries.
- District Public Health Laboratories had been initiated, though integration with IPHL systems remained incomplete.
- Outbreaks were reported and investigated in Mahasamund (four outbreaks in 2025), while no outbreaks were reported in Kanker during the same period.
- Healthcare Staff had received training on VPD surveillance; however, the need for refresher training was identified.

NRCP

- Anti-Rabies Vaccine (ARV) and Rabies Immunoglobulin (RIG) were available at District Hospitals and CHCs, with Category III cases largely managed at the CHC level; CHCs in Kanker had a dedicated rabies room and trained healthcare staff.
- Medical Officers, Staff nurses, and MPWs had received orientation on post-exposure prophylaxis (PEP), and wound washing practices were being followed; however, in Mahasamund, these were often conducted in general dressing rooms due to lack of dedicated space.
- There was no structured follow-up mechanism in place to ensure completion of the full rabies vaccination schedule.

NPPCSE

- Anti-Snake Venom (ASV) was available up to the CHC level in both districts, including at district stores/pharmacies, with IEC materials on snakebite prevention and management displayed at health facilities.
- Medical Officers, Staff Nurses, MPWs, and CHOs had been trained or sensitized under emergency care modules; at the CHC level in Kanker trained healthcare staff were available, while in Mahasamund, snakebite management protocols were followed, though minor gaps in healthcare staff training were observed.

NP-NCD

- NCD screening and diagnostic services for hypertension, diabetes, oral, breast, and cervical cancer were functional at CHCs and DHs in both districts; NCD clinics were functional across facilities, with space constraints reported at CHCs; gaps in referral linkages and follow-up mechanisms for hypertension and diabetes were observed,

with incomplete updating of monthly registers; DCCC was available and functional in Kanker.

- In Mahasamund, shortage of VIA kits and essential medicines for hypertension and oncology care was reported; chemotherapy services were being provided without a dedicated chemo ward.
- Equipment-related gaps persisted, including lack of stadiometers, inadequate BMI assessment skills among staff, and absence of documented calibration records for BP apparatus.
- Counselling and IEC activities related to lifestyle modification, yoga, and tobacco cessation were being conducted, though documentation and impact monitoring was limited.
- Monitoring, evaluation, data analysis and innovation activities under NP-NCD remained inadequate in both districts.

PMNDP

- Dialysis services were operational at District Hospitals through PPP/outsourced model, providing free dialysis services including medicines; nephrology consultation support was limited, with specialist visits occurring once in 3–4 months.
- The visited DHs had multiple dialysis machines installed, with separate machines for hepatitis patients as well; PMNDP portal was being regularly updated; Peritoneal dialysis services were not available at either district.
- Water quality management systems, including RO plants, were in place at DH Kanker with quarterly testing; microbiological surveillance reports were available at DH Mahasamund but not available at DH Kanker at the time of visit.
- Physical accessibility remained a concern at DH Kanker, as the dialysis unit was located on the first floor, causing difficulty for patients.

NPCBVI

- Functional ophthalmic OPD and OT services at DH, MCs and CHCs, though overcrowding was found to be an issue; most ophthalmic cases in Kanker were managed at district level, with minimal referrals to regional centres; corneal collection was very limited (1–2 per year); Separate registers for estimation and monitoring of cataract blindness and visual impairment were not uniformly maintained.
- Outreach eye camps were minimal in Kanker, though coordination with RBSK existed for middle school screening; free spectacles were being provided to operated patients from DBCS funds; diabetic retinopathy screening was available in both districts.
- Slit lamp examination was limited in functionality and availability, limiting detailed retinal and diabetic eye disease assessment.

- Tonometry services for glaucoma were available, management of ocular trauma was limited to basic primary care.

NPPCD

- Ear care and surgical services were being provided in both districts; only basic logistics and equipment for ear examination were available; audiometry services were non-functional or not available at the secondary facilities; newborn hearing screening services were not available due to non-availability of OAE testing facilities; essential HRH for audiometry was not in place, and staff training was found to be inadequate.
- Outreach hearing screening camps were not being conducted regularly.

NOHP

- NOHP was operational in both districts, with functional dental units and adequate human resources. Basic services were being provided, however, digital dental imaging services were missing; absence of a district dental laboratory necessitated referrals to Government Dental College, Raipur; outreach dental camps were being conducted in schools and institutional settings such as central jails.

NTCP

- Use of tobacco products including smokeless tobacco, gutkha, and pan masala was prevalent in communities across both districts. COTPA 2003 was being stringently implemented.
- “No Tobacco” and tobacco-free signage was displayed at health facilities and public institutions; tobacco awareness activities were being conducted to promote behaviour change.
- State-level and district-level coordination committees under NTCP were constituted.
- Despite tobacco-free declarations, tobacco wrappers and gutkha packets were observed within the premises of some health facilities, however, sale near schools was not observed.

NPHCE

- Dedicated geriatric OPDs were largely absent at CHC level in both districts, elderly patients were being managed through general OPDs in both districts; Yellow Elderly Health Cards were issued to older persons; however, program visibility was low due to absence of IEC materials and signage; no dedicated geriatric IPD or wards were available at DHs or MCs in both districts; elderly friendly infrastructure largely missing.
- Physiotherapy services were available only at DHs; CHCs lacked physiotherapy units and trained personnel; community-based geriatric services, including domiciliary and home-based care, were minimal due to high patient load and limited manpower.

NPPC

- Dedicated palliative care OPDs and registers were not available at CHC or DH levels; palliative care services were provided on an ad-hoc basis through general OPDs or emergency services; essential palliative care supplies were partially available, specialized equipment and trained personnel were lacking; community outreach, home-based care, and follow-up for palliative patients was limited.

NPPCF

- NPPCF was implemented at district and sub-district levels in both districts, with surveillance, prevention and mitigation activities in place; NGO involvement was visible in fluorosis control activities; CHC-level coordination with RBSK supported screening, referral, and follow-up of mild to moderate fluorosis cases. HRH availability was limited, with a single staff member managing district-level NPPCF activities in Kanker.

NIDDCP

- Salt & urine sample testing and reporting though Mitranins was done regularly in State; IEC & BCC was lacking for the program, staff nurses were not aware of program activities.

NMHP

- DMHP team available and functional in both districts, undertaking rotational visits to CHCs, outreach services extended to schools, campuses, jails, armed forces units, orphans, and special camps for children; dedicated psychiatry OPD in both DHs was available, but IPD not available; supply of psychotropic medicines was observed to be inconsistent; limited IEC activities were observed, and stigma affected identification, treatment adherence and follow-up of cases.
- Mental health activities were being conducted in schools, and intellectual disability certification services were available at district level; Tele-MANAS services were available but remained under-utilized.

NPCCHH

- State level Governing body had been constituted. Multi-level task force along with state level EHC had also been formulated. District level multi-sectoral task force had also been constituted.
- No training had been provided regarding air pollution related diseases; Digital thermometers were available for core body temperature monitoring; no separate data for mortality of suspect cases & death line listing was available; IEC material for NPCCHH lacking across visited facilities.

National Program for Prevention and Management of Trauma & Burn Injuries

- Only emergency services were available, no burn and trauma centre at the district level in one of the visited districts.

Kerala

Maternal Health

- Institutional deliveries were being conducted at secondary care facilities, contributing to high institutional delivery rates in the state.
- Maternal death audit was being done quarterly. However, Data entries are not being done on the MPCDSR portal.
- Functionality of services was affected due to preference of beneficiaries for private sector facilities leading to under-utilisation of public health facilities.

Family Planning

- Family planning services including basket of choice were available across facilities including referral linkage to higher centres.
- Medical Termination of Pregnancy (MTP) services were available at General Hospitals up to 12 weeks and at Medical Colleges up to 24 weeks.
- Facilities were approved as per MTP Act and legal framework was in place.

Universal Immunization Programme (UIP)

- Cold chain and logistics management systems such as e-VIN were functional at facility level.
- Immunization services were supported by adequate infrastructure and established protocols.
- Duplication of data entry in multiple portals and registers increased workload and affected efficiency.

Child Health

- Child health services including newborn care were supported by infrastructure such as SNCU, NBSU, and paediatric services at secondary care level.
- Diagnostic and treatment services were available at District Hospitals and General Hospitals.

Adolescent Health

- A well-maintained AFHC clinic was running with all necessary equipment.
- Registers were available and data entry was updated.

TB Mukh Bharat Abhiyan (NTEP)

- Vulnerable populations had been mapped and line-listed as per programme guidelines; under the 100-day campaign, all identified groups were screened symptomatically and tested using NAAT, though chest X-ray coverage remained low.

- Rifampicin-resistant TB prevalence was low, with MDR-TB constituting less than 1% of total cases.
- Diagnostic services were well established, with NAAT/CBNAAT available across District Hospitals, Government Hospitals, and Taluka hospitals and CHCs (BPHUs) in Kasaragod, and in-house chest X-ray services at DH, GH and Taluka Hospitals in both the districts; however, utilisation of X-ray, particularly among vulnerable populations, was suboptimal.
- Case detection was carried out through both passive OPD-based screening and active case finding, including ASHA-led community visits among migrant and other vulnerable populations; contact tracing and daily treatment adherence were ensured through ASHAs and JHIs under the DOTS strategy.
- A dedicated TB unit with key human resources was in place in Kasaragod, supporting programme implementation, with functional TB notification, treatment, and follow-up systems and a reported treatment success rate of approximately 85%.
- Drug and diagnostic supply chains were robust, managed through Nikshay Aushadhi, with no stock-outs observed and supplies maintained through a structured distribution system supported by NHM funds.
- Patient support mechanisms were functional, including DBT under Nikshay Poshan Yojana and linkage of patients to Nikshay Mitras, with Local Self Government Department (LSGD) involvement strengthening nutritional support and inter-departmental coordination.
- TB death audit mechanisms were in place with structured review processes, identifying undernutrition, comorbidities, and alcohol use as major contributing factors to mortality.
- Training on differentiated TB care had been recently initiated, contributing to improved quality of care.

NLEP

- A total of seven leprosy cases had been diagnosed at District Hospital Kasaragod to date, and all identified patients were on treatment; patients with disability were being provided primary and secondary palliative care services through frontline workers.

NACP

- Rapid diagnostic test kits for HIV/AIDS and syphilis were available from the AAM-SHC level upwards across healthcare facilities, with ELISA-based diagnostic testing available at District and Sub-District Hospitals.

NVHCP

- Public health facilities had provision for testing of HBsAg and HCV, with 29 treatment centres (including 3 model treatment centres) operational in the state; viral load

testing centres were identified in all districts and linked to the State Public Health Laboratory, Trivandrum.

- Healthcare workers had been vaccinated against Hepatitis B in a phased manner.

NVBDCP

Malaria

- Malaria diagnostics and drugs were available across all visited facilities, with healthcare staff trained in diagnosis and treatment; focal Indoor Residual Spraying (IRS) was conducted, covering households within a 500-meter radius of reported cases.
- No malaria-related deaths had been reported in the last three years, and the district was in the process of preparing a dossier for sub-national verification of malaria elimination under the supervision of the State VBD unit.

Kala Azar

- Facilities for diagnosis and treatment of kala-azar were available at the District Hospital.

Lymphatic Filariasis

- Mass Drug Administration (MDA) had been stopped in the district since 2018 following completion of TAS-3, with Transmission Assessment Surveys and night blood surveys being conducted regularly.
- Microfilaria positivity was primarily observed among migrant populations, with the microfilaria rate consistently below 1%, and complete treatment was being provided to all individuals testing positive.

Dengue & Chikungunya

- Diagnostic facilities for dengue were available across all health facilities up to the PHC level, with ELISA testing at the District Hospital and IPHL and rapid test kits at Taluka hospitals, Block PHCs, and FHCs; regular entomological surveillance and vector control measures were being conducted in the districts.
- No chikungunya cases had been reported in the district, while dengue cases were reported without any surge or dengue-related deaths.

IDSP

- The district was fully onboarded to the IHIP portal, with regular reporting through S, P, and L forms across all visited facilities, including reporting from 22 private sector units in Kasaragod district.
- In 2025, one outbreak alert (food poisoning) was reported on the IHIP portal, which was investigated and resolved in a timely manner; no vaccine-preventable disease cases were reported during the year.

NRCP

- A separate and dedicated wash area for animal bite patients had been established at Taluka Hospitals, Block PHCs, and AAM-FHCs, physically segregated from the main casualty area to reduce overcrowding and ensure uninterrupted wound management.
- Anti-Rabies Vaccine (ARV) and Rabies Immunoglobulin (RIG) were available at District Hospitals, Taluka Hospitals, and Block PHCs; however, ARV was not available at the FHC level.

PPCL

- Testing for leptospirosis was available from the PHC level upwards, with doxycycline tablets available at the FHC level as per the Essential Medicines List.
- Suspected cases were regularly tested and those found positive were treated, with a low number of positive cases reported across the visited facilities.

NPPCSE

- Anti-Snake Venom (ASV) was available at District and Taluka Hospitals; however, it was not being administered at the Taluka level in Kasaragod district.

NP-NCD

- DCCC was fully operational at the DH; NCD clinics were operational at DH, GH and CHC level. However, cancer screening records were not being maintained under NCD clinic.
- STEMI: A Cath lab unit with CCU and HDU unit was operational at DH Kasaragod. The cardiology OPD, ECG, TMT facilities were managed by the same cardiologist operating and managing the CATH Lab unit. The Cath-lab had adequate load and full bed occupancy was observed on the day of visit to the DH.
- Stroke: DHs and GHs had functional CT scan services with tele-reporting of CT scan; patients were being referred to higher facilities for further treatment.
- COPD/SWAAS Clinics: SWAAS clinics were functional at GH/DH level, providing asthma, COPD, and smoking cessation services. These services were not available at the CHC in the Kottayam district.

PMNDP

- Haemodialysis services were operational in-house at DHs, GHs and selected CHCs, free for all beneficiaries, though with long waiting times; no provision for Sero-positive cases was found in facilities, however, nephrologists were unavailable. PMNDP data was being consistently uploaded; multi-use dialyzer protocols and routine viral marker testing were followed; use of CAPD programme was inadequate among patients despite availability. Water quality testing was being regularly conducted through IPHL.

NPCBVI

- The programme was implemented well in the visited districts with trained personnel, though spectacle distribution and screening documentation was weak. Fixed-day outreach camps for eye diseases supported by a functional Mobile Ophthalmic unit were also observed.

NPPCD

- HR were available as per the IPHS norms. Audiometric screening was being conducted across all age groups. The sound-proof audiometry unit was functional. Medical and surgical interventions provided.

NOHP

- Dental services were available at DH, GH and CHCs/UHCs level through in-house mode. Common dental services such as extraction, scaling were available at CHCs and RCT conducted at DHs level. Two dental chairs were available at DHs/GH level.

NTCP

- State and National Tobacco Control Programs were functioning synergistically in Kerala. Health Kerala/Safe Kerala ensured COTPA compliance through regular inspections by state and district task forces. TCCs were established in visited districts.

NPHCE

- Dedicated weekly geriatric OPD were being conducted in all hospitals, with availability of geriatric wards and physiotherapy units. Queue management system for elderly patients visiting health facilities was in place.
- A comprehensive scheme addressing the physical and mental health of the elderly, including components like Mandahasam (free dentures) and Vayomadhuram (free glucometers for BPL senior citizens with diabetes) was implemented in the State.
- Karunya Arogya Suraksha Padhathi (KASP): This health insurance scheme (converged with Ayushman Bharat – PMJAY) provides a health cover of ₹5 lakhs per family per year for secondary and tertiary care hospitalization to eligible poor and vulnerable families, without age restrictions

NPPC

- The State had a palliative care policy in place. The program was running well in all the visited facilities both for primary and secondary care.
- Home based care was available for patients with serious health related needs. Fixed outreach days for secondary care were observed at all visited health facilities.
- The State has built a comprehensive palliative care network integrating government, traditional medicine system and community-based organisation, called the Kerala Care Grid.

NMHP

- Dedicated Psychiatric OPD was functional at DH level. Essential psychotropic medicines were available. IEC on Tele-MANAS services and helpline was displayed at secondary facilities. DMHP team was also collaborating with AFHC clinics for providing targeted services to adolescents.

National Program for Prevention and Management of Trauma and Burn Injuries

- Patients were referred to medical colleges for treatment. There was no specific Trauma and Burn injury unit seen in the Kasaragod district.

Madhya Pradesh**Maternal Health**

- Maternal health services were functional across assessed facilities, with availability of Caesarean section services, reporting a 45% C-section rate in Mandsaur and 28% in Vidisha.
- High-risk pregnancy identification and tracking were systematically conducted in Mandsaur; however, the process was weak across most facilities in Vidisha.
- Labour rooms were equipped with partographs, Safe Birth Checklists, oxytocin, antibiotics, and birth-dose vaccines across facilities.
- Birth Waiting Halls were operational, with 20 beds in Mandsaur and 10 beds in Vidisha, facilitating access to institutional deliveries.
- JSSK entitlements, including free transport, drugs, diagnostics, and diet, were being provided to beneficiaries.
- Maternal deaths were reported, with eight cases in Mandsaur and two cases in Vidisha, and FBMDRs were completed for all cases.
- SUMAN certification was achieved in facilities, and respectful maternity care practices were observed. PMSMA sessions were conducted regularly on fixed days ensuring ANC service delivery.

Child Health

- Newborn care services were functional with operational NBCCs up to PHC level and functional NBSU units.
- Child mortality was reported with 36 deaths over three months and 10 outborn deaths in a single month.
- Major causes of death included respiratory distress syndrome and Hypoxic-Ischemic Encephalopathy.
- Facility-based and community-based child death reviews were conducted.

Family Planning

- The PPIUCD insertion rate stood at 22.32% at the state level, with Mandsaur (33%) performing above average and Vidisha (16%) remaining below the state benchmark.
- A total of 45,130 sterilizations were conducted statewide, comprising 456 male and 44,674 female sterilizations—reflecting continued reliance on female-centric permanent methods.
- Mandsaur recorded 6 NSVs and 1,497 female sterilizations, while Vidisha reported 3 NSVs and 336 female sterilizations.
- Distribution of Antara injectable doses totalled 49,530 across the state; Mandsaur contributed 451 doses, whereas Vidisha provided 2,210 doses.
- Operationalization of FP-LMIS reached 60% of registered facilities statewide, with Mandsaur at 68% and Vidisha at 64%. Family planning equipment, including IUCD kits, minilap kits, laparoscopes, and Boyle's apparatus, was available. Self-care kits were displayed but were incomplete due to the absence of Emergency Contraceptive Pills.
- Postpartum and postnatal family planning counselling was weak due to limited IEC materials and inadequate counselling engagement.

Universal Immunisation Programme (UIP)

- Cold chain systems were functional with proper temperature monitoring and trained handlers.
- e-VIN system was functional across facilities.
- Infection control practices during immunisation sessions were suboptimal, with non-use of gloves observed.
- Td vaccination coverage was low at 30% for 10-year-olds and 25% for 16-year-olds in Vidisha.
- Birth-dose vaccination coverage was reported at 45% in Vidisha. Dropouts were observed between DPT-1 and DPT-2, between MR1 and MR2 in Vidisha.

Adolescent Health

- Adolescent Friendly Health Clinics (AFHCs) were functional in Mandsaur with daily footfall of 12–15 adolescents.
- Counselling services were provided in Mandsaur with repeat visits observed. Dedicated counsellors were available in Mandsaur AFHCs.
- Medicines and sanitary pads were not available in Mandsaur AFHCs. AFHCs in Vidisha were merged with other programmes resulting in limited-service availability and absence of a comprehensive basket of adolescent-specific services.

- Dedicated counsellors were lacking in Vidisha. Sanitary napkin supply was not available in Vidisha.

RBSK

- DEICs were functional across districts but had human resource shortage in Vidisha .
- Mobile Health Teams were partially functional with staffing shortages in Mandsaur.
- Newborn and child screening were ongoing, but follow-up of children identified with 4D conditions was weak.

TB Mukh Bharat Abhiyaan (NTEP)

- Diagnostic services were largely functional, with availability of TruNAAT/CBNAAT at District Hospitals and operational laboratory services; however, gaps such as non-functional X-ray machine at certain CHCs affected diagnostic efficiency.
- Management of drug-resistant TB was largely effective, with all patients assessed for differentiated care, high coverage of DBT under Nikshay Poshan Yojana, and universal linkage to Nikshay Mitra support in Vidisha district.

NLEP

- Active case finding activities were conducted, including campaigns such as “Kushth Pakhwada,” with new cases detected and initiated on treatment.
- No Grade-II disability cases were reported and the Nikushth 2.0 portal was functional at the district level for case reporting and monitoring.
- Post-Exposure Prophylaxis (PEP) was being provided to eligible contacts with adequate drug availability; however, capacity gaps were noted, with a need for refresher training of Non-Medical Assistants (NMAs) on updated PEP eligibility guidelines.

NACP

- ICTC services were functional across the districts, with availability of HIV diagnostic and treatment services at the District Hospital level; HIV testing was conducted routinely, including among antenatal beneficiaries, with effective linkage of identified positive cases to treatment.
- PMTCT services were effective, with no HIV-positive cases reported among tested ANC women, and service delivery systems were stable with regular reporting and follow-up mechanisms in place.

NVHCP

- Viral hepatitis services were available at District Hospitals, with both screening and treatment largely concentrated at higher-level facilities; screening at peripheral levels remained limited, indicating restricted decentralisation of services.

- Viral load testing services were either available at District Hospitals or facilitated through outsourcing mechanisms (in Vidisha District) to Delhi, with defined sample transport systems and timely reporting within 48 hours.
- Hepatitis B vaccination among healthcare workers, had been undertaken.

NVBDCP

- Incidence of vector-borne diseases remained low, with minimal malaria cases reported and continued progress towards malaria-free status; diagnostic and treatment services were available at the district level, supported by adequate logistics and medicines.
- Dengue cases were reported; however, diagnostic capacity was limited to NS1 antigen testing, with absence of IgM/IgG testing restricting confirmation of secondary infections.
- Capacity-building initiatives had been undertaken, with a substantial number of healthcare workers trained in malaria prevention, diagnosis, and management.

IDSP

- All healthcare facilities had been mapped and integrated into the surveillance system, with regular reporting through the IHIP portal supporting real-time data capture and analysis; reporting performance was generally good, with P and L form reporting levels above 85%, though gaps in completeness and timeliness persisted.
- Outbreak investigations were actively conducted by Rapid Response Teams, indicating a functional and responsive field surveillance mechanism, and district-level coordination mechanisms, including District Task Force meetings, were operational.
- The transition of responsibilities to the Integrated Disease Surveillance Programme (IDSP) was still in progress, with vaccine-preventable disease (VPD) surveillance currently being managed by WHO staff, highlighting partial dependence on external technical support.

NRCP

- Anti-Rabies Vaccine (ARV) was available across all levels of service delivery, including District Hospitals, Civil Hospitals, CHCs, and PHCs, while Rabies Immunoglobulin (RIG) was available at higher-level facilities (DH and CHCs), enabling management of Category III exposures and supporting timely case management and continuity of care.
- Utilisation of rabies prophylaxis services was evident, with substantial administration of ARV and RIG doses, indicating active case management and consistent demand; this highlighted the need for continuous stock monitoring to prevent potential shortages.

NPPCSE

- Anti-Snake Venom (ASV) was available across all levels of healthcare facilities, ensuring readiness for prompt management of snakebite cases, with District Task Force Committees constituted and functional to provide oversight, coordination, and periodic review of programme activities.
- Healthcare workers, including frontline staff (ASHAs, ANMs, CHOs), had been trained in standard snakebite management protocols through multiple training batches.

NP-NCD

- Dedicated NCD clinics were available at the visited districts, however, screening activities focused on breast and cervical cancer, with limited focus on oral cancer. Overall, the screening coverage was low, despite availability of equipment.
- Gaps were observed in documentation, with NCD cards and standard registers missing in some facilities; follow-up adherence was weak.
- Stroke care readiness was observed only in one of the visited districts, with good functioning of the thrombolysis services in Vidisha.

PMNDP

- Dialysis services in the visited districts were operational under PPP mode.
- RO plant was functional in Vidisha; water quality was being monitored through monthly TDS and quarterly bacterial culture, though documentation was observed to be inconsistent.
- Shortage of trained dialysis technicians and staff was noted, affecting streamlined and regular service delivery.

NPCBVI

- Outreach camps were being conducted regularly in schools by PMOAs, ensuring active community screening. Cataract surgeries were being conducted at the District Hospital, along with comprehensive diagnostic services. In Mandsaur, three private hospitals were empanelled under the programme for cataract surgery support.

NPHCE

- Dedicated Geriatric OPD was functional at both the visited District Hospitals. In Vidisha, 16 beds were dedicated for geriatric inpatients. Physiotherapy unit was operational in Mandsaur; equipped with a CSR-supported physiotherapy machine.
- Routine diagnostic investigations were not being conducted without ABHA ID generation in Vidisha, leading to service delays.

NPPC

- Programme had not been rolled out in the visited districts, and no separate palliative OPD or IPD was available at DH; no dedicated palliative care register was being maintained.

NTCP

- District Tobacco Cessation Centres were functional in both the visited districts. A dentist was serving as the nodal officer in Vidisha, ensuring continuity of services; however, footfall tracking and referral linkages require strengthening.
- No dedicated counsellor was available in Vidisha, affecting comprehensive cessation support.

NMHP

- Psychiatric OPD was functional at the visited DHs. 'Man-Kaksh' was functional in both the districts, with the availability of a psychiatrist. 'Man-Hit app' was functional in the State for mental health support. IPD services for mental health were unavailable, with patients being referred to medical college for admission.
- Clinical psychologist was not available in Vidisha, leading to service gaps in counselling and psychotherapy.
- Tele MANAS IEC material was displayed at the facilities, however, their visibility was not optimal.

NPCCHH

- Conventional light sources were replaced with energy efficient light source (LED) Solar panels were installed in the FHC visited in the aspirational block. An energy audit of visited health facilities was observed.

Maharashtra

Maternal Health

- ANC, PNC, and delivery services were available across secondary-care facilities in both districts, with HRP marking being practiced consistently, particularly at SDH and DH level.
- It was observed that RHs in Satara had non-functional or underutilized labour rooms, whereas RHs in Nandurbar reported a high institutional delivery load aided by boat ambulance connectivity from remote tribal areas.
- Respectful maternity care—birth companion, early initiation of breastfeeding, counselling—was consistently practiced at DH/SDH across both districts.
- While Satara district reports zero maternal deaths and no home deliveries in the past year, Nandurbar continues to experience high maternal deaths despite high institutional delivery rates.
- Several RHs in Nandurbar lack functional C-section capability, such as RH Dhadhgaon where LSCS services was unavailable despite the presence of a gynaecologist- leading to delays and avoidable referrals.

- Conversely, DH Satara reported a very high LSCS rate of 58% with most being planned C-sections, despite conducting monthly C-section audits.
- Construction of a 100-bedded MCH hospital was underway in Satara, which was expected to strengthen referral maternity care.

Child Health

- NBSU services were functional in both districts. Paediatric service areas, including wards (DEIC, NRC) and Outpatient Departments (OPDs), were designed to be bright and welcoming, featuring child-friendly decor like cartoon illustrations to create a positive and reassuring environment for children.
- DEIC at DH Satara was well-staffed (audiologist, optometrist, psychologist, physiotherapist), with a good daily footfall and regular MHT outreach.
- In District Nandurbar, the district team highlighted that the current RBSK vehicle cost norms were not sufficient for the procurement of an RBSK vehicle in the hilly/tribal areas.

Family Planning

- In Nandurbar, NSV uptake was high, reflecting positive male engagement at the RH/DH level. However, uptake of temporary spacing methods was low, compounded by supply gaps at the secondary level.

Adolescent Health

- Non-availability of sanitary napkins at secondary level facilities was reported across both districts, impacting menstrual hygiene.
- A dedicated counsellor was available at the AFHC in the DH in both districts, ensuring linkage with mental health, FP, NTCP, RBSK, and ANC services.
- In Nandurbar the RSKSK counsellors were also available at the RHs.

Child Nutrition

- Satara DH was preparing to operationalize a Comprehensive Lactation Management Centre (CLMC). The equipment has been provided but the required RO plant was currently under construction.
- Secondary-care facilities in Nandurbar report a high burden of malnourished mothers and children, severe anaemia, and teenage pregnancies, leading to higher HRP caseloads and neonatal complications at the DH level.
- NRCs at the DH level function well in both districts.
- Referral losses were reported along the way from the community to the NRC/DEIC, indicating a challenge in effectively tracking patients and ensuring continuity of care.

NP-NCD

- Dedicated NCD clinics with designated staff were functional across the secondary-level facilities in both districts, however, proper longitudinal tracking of NCD patients at the secondary care facilities was not being undertaken. Follow-up mechanisms were weak, although NCD registers were being maintained.
- The State's STEMI initiative, which facilitates ECG screening through a hub-and-spoke teleconsultation model, was observed to be functioning effectively, with portable machines at RH; ECG reports were being shared via the CardioNet application for rapid review by specialists to enable decisions on referrals.
- Chemotherapy services had been recently initiated at DH Satara. The Paediatrician had been given charge of the unit but since therapy protocols were not intimated, the services were being provided to patients who were already receiving chemotherapy at other hospitals, including private hospitals and medical colleges. Chemotherapy services were not yet available in Nandurbar district.
- The construction of a Critical Care Unit and Cath lab at DH Satara was in progress.

PMNDP

- Dialysis services were available at both visited district hospitals, but not at SDH level, through both PPP and in-house modes. No waiting list was reported at the facilities visited.

NPCBVI

- Cataract services were available at district hospitals conducted by Ophthalmic Surgeons in both districts, and no pendency in cataract surgeries was reported.
- A Memorandum of Understanding has been signed by Satara district with an eye hospital in Pune to support Retinopathy of Prematurity (ROP) screening under NPCBVI.
- An eye donation counsellor was posted at DH Nandurbar, however, the counsellor was engaged in organ donation counselling.
- The need for a designated room for eye screening at PHCs when the ophthalmic assistant from RH/DH visits the peripheral facilities was highlighted.
- The funds towards cataract operations to Kantalakshmi NGO were not disbursed in the last year, impacting service delivery in Nandurbar.

NPPCD

- The post of ENT was vacant at DH, but other HRH was available. As a good measure, all admitted babies were being screened for ear problems, including deafness. Disability certificate was also being provided at DH itself. BERA facility was also available at District Hospitals. Screening camps were also being undertaken at SDH and RH by the NPPCD team.

- Cochlear implants were being undertaken through an MoU with a hospital in Nashik, post which speech therapy was provided in DH Nandurbar.

NOHP and NTCP

- Dental services including root canal treatment, extractions, scaling and minor surgeries were being performed at the DH level, however dental services at the DH and RH levels were limited or absent.
- At RH Dhadhgaon, a newly posted dentist was bringing consumables from his personal supply to ensure service provision until the supply of consumables is received from district. The dentist also requested for a dental X-ray setup.
- Counselling related to tobacco cessation was being provided by the NTCP counsellor, and the Tobacco Cessation Clinic was functional at the district hospital in Satara but not functional at DH Nandurbar.
- Community members completing tobacco cessation were being recognised through certificates and appreciation letters, indicating initiatives toward behaviour change. Enforcement squad visits under NTCP were being undertaken in both districts.

NPHCE & NPPC

- In both district hospitals, 10 beds had been exclusively reserved for geriatric patients; dedicated physiotherapy services were not available below DH level facilities in both districts; physiotherapist hired under NPHCE was undertaking visits to SDH twice in a month in Nandurbar district.
- Although morphine licences had been issued to RH and SDH facilities, the drug was not available in Satara district.
- In DH Nandurbar, an occupational therapist was posted but the lack of occupational therapy equipment has led her to only undertake physiotherapy services.

NMHP

- A service gap was observed in the availability of emergency transport for psychiatric patients.
- The psychiatrist post was vacant at DH Satara. In DH Nandurbar, a regular cadre psychiatrist has been posted and given the charge of DMHP, but, other HR was posted; dedicated psychiatry ward was not available at the district hospitals; DMHP team (except the psychiatrist) undertook monthly visits to RH for mental health service provision.
- The DMHP team in Nandurbar reported the high burden of alcoholism and emphasised the need for a deaddiction centre.

NSCAEM

- Nandurbar District Administration was setting up a control room for sickle cell

counselling and grievance redressal. The district had also received an award from NITI Aayog for its efforts to address sickle cell anaemia.

NPCCHH

- A district-level task force committee under NPCCHH had been established, and more than 90% of health facilities were submitting heat-related illness reports in the IHIP portal. No heat stroke cases were reported in the districts visited.

Meghalaya

Maternal Health:

- High delivery load was observed at DH level due to HR gaps at CHC level. Emergency obstetric care was limited in CHCs. ANC services were being provided through daily OPD basis at Ganesh Das Hospital, Shillong.
- ANC clinics were well equipped with required logistics like pregnancy testing kits, digital hemoglobinometer, BP apparatus, weighing scale, stethoscope etc.
- High risk pregnancies were being detected and tracked by using digital initiative Mother's App. Partograph were being used for most of the labour cases. Each of secondary and tertiary care facilities was well equipped with functional birth waiting home known as Transit homes locally.
- MDSR was being conducted to review each of the maternal death reported.

Family Planning:

- Basket of choices were available at all facilities but acceptability was low due to cultural and religious barriers. Safe Care kits/ Condom box available at CHC and DH placed at locations providing easy visibility and accessibility.
- Facilities were well equipped with family planning IEC materials in local language. Medical officers have been trained on MTP.
- Most MOs and staff nurses were trained in PPIUCD/IUCD, however, there was a very poor intake of PPIUCD services due to cultural barriers.
- Acceptance of injectable contraceptives was good and improving in East Khasi District. With instruments and kits available at the facility to provide family planning services.
- Comprehensive abortion services were available at the Ganesh Das Hospital. Trained medical officers on abortion services and MTP were available.

Universal Immunization Programme:

- Immunization services at Ganesh Das Hospital, Shillong were provided on daily basis while at CHC Mawphlang bi-weekly fixed day approach was used to provide the services.

- Due lists were updated and tracker bags were available and utilised efficiently. Facilities were practicing zero dose vaccination with OPV, BCG and Hepatitis B to all delivered babies.
- Cold chain points were well maintained- temperature recording, stock registers, vaccine distribution registers were updated. Open vial policy was followed properly at all cold chain points.
- Use of e-VIN and U-WIN at all facilities was observed. Micro-plans for immunization session were available.
- AEFI kits and Anaphylaxis kits were available at all facilities visited. ANMs possess good knowledge about the UIP schedule.
- Immunization section at Ganesh Das Hospital, Shillong was upgraded to well-baby clinic.

Child Health

- NBCC were functional and well equipped with new born tray, functional radiant warmers. Clinical protocols for newborn resuscitation were available at NNCC.
- Staff was trained on NSSK. KMC need to be strengthened with proper monitoring and record keeping at NBSU, MNCU and PNC wards.

Child Nutrition

- The Anaemia Mukht Bharat programme was implemented across the facilities. IV Iron sucrose was administered to moderate to severe anaemic pregnant women.
- Blood transfusion was given to anaemic mothers as per AMB guidelines. Single dose Ferric Carboxymaltose was introduced in the State and given in the moderate to severe anaemic mothers after clinical evaluation. A detailed review need to be taken up to address the reliability issue of Digital Hemoglobinometer.
- 10 bedded NRC was functional at Ganesh Das Hospital. NRC has good infrastructure providing adequate space for counselling room, separate kitchen and patient area. Consistent poor bed occupancy at NRC below 50% despite of having good infrastructure.
- Staffs have received 4 days training of IYCF and ensuring the early initiation of the breastfeeding for every newborn delivered in the hospital. However, percentage of exclusive breastfeeding was low Cultural beliefs, misconceptions were hindering the exclusive breastfeeding practices. Breastfeeding corners were established to provide the dedicated space for the visiting lactating mothers
- Considering high burden SNCU and NICU at Ganesh Das Hospital, state should establish Comprehensive Lactation Management Centre to ensure availability of expressed breast milk to the newborns not able to breastfeed directly.

- Facility level child death audits were done regularly ensuring all the CDR forms were filled. Follow up of the action points discussed during the previous meeting should be made regular agenda point for the review during child death review meetings.

RBSK:

- Screening was happening regularly, but secondary and tertiary referrals face delays due to absence of transport guarantees and specialist services.
- Mobile health teams were visiting the schools and Anganwadi alternate day as per tour plan. Follow up of the referred cases after screening need to be improved by Mobile Health Teams. Screening for 4Ds was less than 50% of the target through Mobile health teams (MHTs).
- Congenital Heart Defects cases were 1452 from year 2011-2025, of which only 457 have been managed surgically. Intersectoral coordination with education department was required at state level for better coordination. There was a need to actively search the CHD cases considering the high home delivery rates in the state.
- DEIC at Gopal Das Hospital, Shillong was a well maintained having all good infrastructure. There was no DEIC in North Garo hills. Total 3 DEICs were available for 11 districts in the state. DEIC staff were trained and maintaining the records properly. DEIC staff was visiting SNCU on regular basis to assess the sick newborns. No implants were available for hearing impairment at the DEIC. Laboratory at DEIC was not fully functional.

Adolescent Health

- AFHCs were equipped with dedicated counsellor and commodities offering adolescent health services and counselling at CHCs and District Hospital. AFHC achieved footfall of more than 150 per month.
- Low coverage of AFHC services was reported at CHCs as compared to District hospital.
- High teenage pregnancies and anaemia prevalence was seen among the adolescents highlighting the need of improving utilization of AFHC services along with community awareness.

TB Mukht Bharat Abhiyan (NTEP)

- Active TB case finding was being undertaken; however, challenges in sample transport and limited access to CBNAAT/NAAT services in remote blocks were observed, despite the presence of multiple NAAT centres.
- Diagnostic services such as the CDST laboratory were functioning well, and referral institutions including Reid Provincial Chest Hospital and the District TB Cell in East Khasi Hills were providing both OPD and inpatient services.
- Logistical and financial constraints affected programme implementation, including additional burden on staff due to discontinuation of advance payments under SNA

SPARSH and costs incurred for sample transport to C&DST Shillong and IRL Guwahati.

- Beneficiaries faced out-of-pocket expenditure, including a cost of ₹100 for chest X-rays and other diagnostic tests, contributing to financial strain.
- Coverage of patient support initiatives was suboptimal, with only about 13% of beneficiaries receiving full DBT benefits, limited engagement of Nikshay Mitra, and challenges in mobilising donors for Poshan kits.
- Uptake of Tuberculosis Preventive Therapy (TPT) was low, with poor patient acceptance reported and concerns regarding sensitivity of Cy-TB testing noted.
- Shortage of handheld and fixed X-ray machines was observed, limiting screening capacity, particularly for asymptomatic cases.

NLEP

- Active case searching for leprosy was not being conducted; however, focal leprosy campaigns were undertaken.
- Training had been provided to healthcare staff under the programme and MDT drugs were available only at district headquarters.

NACP

- ICTC services were available and functional at the General District Hospital (GDH).
- HIV-positive antenatal cases were on treatment at GDH; however, not all general HIV-positive patients were enrolled for treatment due to patient refusal and loss to follow-up after referral.
- TB-HIV collaborative activities were functioning well across all levels of healthcare facilities.

NVHCP

- Screening and treatment services for viral hepatitis were being provided at Civil Hospital, Shillong.
- All antenatal cases were being screened; however, no positive cases for HBV or HCV were reported.
- Healthcare workers were fully vaccinated against Hepatitis B and screening and treatment services for both HBV and HCV were being conducted.

NVBDCP

- Active screening for malaria was conducted for all fever cases using RDTs, with microscopy facilities available at Civil Hospital, Shillong.
- Medical Officers and ANMs were trained in malaria management, and ACT blister packs along with parenteral anti-malarial drugs were available at secondary-level facilities.

- Domestic Breeding Checkers were engaged in monitoring vector breeding sites, and IEC materials in local language were available at facilities.
- Rapid diagnostic kits for dengue and chikungunya were available at Gopal Das Hospital, Shillong.
- Sentinel surveillance for JE and dengue was established with three sentinel sites in East Khasi District.
- Contingency plans for epidemic preparedness were in place.
- In North Garo Hills district, insecticide-treated nets were distributed and were being effectively utilised.

IDSP

- Reporting through P and L forms was being carried out across all visited secondary care facilities, with both public and private sector units reporting on the IDSP-IHIP portal.
- Commonly notified diseases through L forms included typhoid, scrub typhus, and rickettsial infections. Frequent outbreaks reported in East Khasi District included mushroom poisoning, measles, and food poisoning.
- The IDSP-DPHL laboratory was functional and integrated with IPHL in East Khasi District.
- District Task Force for Immunization (DTFI) meetings were conducted regularly.
- Vaccine Preventable Disease (VPD) surveillance was being conducted routinely through the IHIP platform, with 55 measles cases confirmed in 2024.

NRCP

- Awareness activities for bite prevention were limited and required strengthening, particularly in endemic areas.
- Intradermal (ID) vaccination regimen was not being followed at CHC and PHC levels, leading to wastage of vaccine and increased out-of-pocket expenditure for patients due to reliance on intramuscular (IM) regimen.
- Deviations from standard treatment protocols were observed, including inappropriate administration of ARV and ARS across bite categories (e.g., some Category III patients not receiving ARS, while Category II and even Category I patients were administered ARV unnecessarily).
- Training and supportive supervision of Medical Officers and staff were required to ensure rational use of ARV and ARS across all levels of healthcare facilities. However, a good practice of adherence to the intradermal regimen was observed at the District Hospital level.

NP-NCD

- Screening of all OPD patients for NCD was being done at DH, but NCD clinic was functional on alternate days only, leading to loss of follow up of patients for initiating treatment at DH. Follow up for complications was symptom based. Symptom based oral, cervical cancer and breast cancer screening of high risk groups was observed at the visited DH. Training of staff for screening of complication was also found to be lacking.

PMNDP

- Dialysis unit was undergoing renovation work with patients admitted. RO water quality and bacteriological test report were not satisfactory at DH, which is a point of concern. Peritoneal dialysis was being done on OPD basis. Data was not being updated on portal. No waiting time was reported at the facilities.

NPCBVI

- Diagnostic services for eye services were available at Civil Hospital, Shillong & functional OT was available for cataract surgeries; facilities were also conducting regular outreach camps for cataract and other eye diseases along with distribution of spectacles. Services for only refractive errors for children were available in North Garo.

NOHP

- Eight dental chairs were functional at Civil Hospital, Shillong offering common dental and oral health services; shortage of dentists in North Garo district was observed. Only passive screening was being done.

NTCP

- The state faces high burden of substance abuse and tobacco-related health issues like oral and oesophageal cancer. To address this, regular IEC awareness and activities were conducted.
- Compliance with COTPA was satisfactory with all healthcare facilities displaying “No Tobacco” and “Tobacco-Free Area” signage in local language at prominent location.
- Counselling and outreach activities were conducted to increase the awareness against the tobacco use.

NPHCE

- Elderly care was integrated with NCD clinic at DH in East Khasi district.
- 9 bedded ward was available at DH and Physiotherapy is provided to elderly patients.
- Comprehensive geriatric assessment was not being carried out at DH. Also no separate OPD was there for elderly.

NPPC

- Palliative care services were being provided at Civil Hospital, Shillong through earmarked beds at oncology and nephrology department; no dedicated wards were available.
- Morphine and Tramadol were available along with basic procedures like catheterization and nasogastric feeding.

NPPCF

- Fluorosis screening activities were limited at secondary facilities.

NMHP

- DMHP was well established in EKH; NGH had minimal outreach. District mental health unit was functional with designated psychiatric OPD. CHCs lacked trained counsellors. Essential medicines for the programme were available.
- Tele-MANAS information was displayed; rallies, media coverage, and awareness programs on mental health issues were organized to sensitize the community.
- Suicide prevention strategies, coping mechanisms, prevention of drug abuse among college students along with promotion of the Tele-MANAS helpline were conducted.

NPCCHH

- ARI Sentinel Site for reporting on 'NOADS Application'. 3 Health Facilities were identified for green and climate resilience in 1st Phase. District Task Force was yet to be formed at East Khasi District.
- Despite heavy rainfall, almost all facilities suffered from water shortage during dry seasons. Even after heavy rain, water generally drains out quickly; rainwater was collected in some facilities to tide-over acute crisis.

Nagaland

Maternal Health:

- High Risk Pregnancy (HRP) line listing and follow-up monitoring during the antenatal (ANC) and postnatal (PNC) period were maintained under PMSMA and E-PMSMA. But it was not being conducted on the 9th of every month due to financial constraints at both the DHs.
- Pregnancy testing kits, testing kits for HIV and Syphilis, IFA and Calcium tablets were available.
- BEmONC (Basic Emergency Obstetric & Newborn Care) and CEmONC (Comprehensive Emergency Obstetric & Newborn Care) trained MOs were available. Daksh/Dakshita trained Skilled Birth Attendants (SBAs) were also available.
- 24*7 lab services were available, and USG was available during OPD. C-Section services were available at both the DH.

- Partograph and safe birth checklist and safe surgical checklist was used to monitor progress of labour.
- Two Maternal deaths were reported in the facility in the year 2024-25. One facility based and one community-based review for the same has been conducted. However, no record was shared.
- Birth Waiting Homes were available in the district of Mon, providing pregnant women, especially those from remote and hard-to-reach areas a place to stay near health facilities in the weeks close to their expected date of delivery.
- State-specific High-risk Pregnancy (HRP) tracking format and system were in place, facilitating systematic identification, line listing, and follow-up of HRP cases, with documented referral linkages to First Referral Units (FRUs) to ensure timely institutional delivery and management of complications.

Family Planning:

- The basket of choice was available at both district hospitals however, Antara was not available at both the District Hospitals.
- Condom box and self-care kits were displayed. Family Planning services were provided at the facility level only. No Camp mode services were provided.
- Sterilization services for female were available at both the DHs. However, no records of male sterilization were found.
- There were trained service providers including nurse trained on IUCD insertion and MPA injection and MO trained on PP-IUCD/PA-IUCD insertion for family planning.
- There was a dedicated person responsible for managing the FPLMIS portal at DH Mon. There were incidences of stockout of FP commodities such as DMPA, OC pills and PT kits in the past.
- Counselling services were not available in the facility as trained counsellor and models/tools for providing counselling services were not available.
- At DH Mon, DEPO injection was not available in-house, and the expenses had to be paid by the beneficiaries. Both districts were providing abortion services and medical practitioners were trained as per the MTP Act.
- There were no MTP cases reported in the facility in the last year. There was no earmarked area for providing abortion services in Mon district

Universal Immunization Programme

- Due list, MCP cards were maintained and updated. Awareness of ANMs on vaccination schedule was good and were trained in 4 key messages.
- Placement of vaccines on the ice pack/ VVM status on the vaccine vials was found to be satisfactory.

- Adolescents were immunized with Td vaccine under school health program as reported by health staffs.
- Electronic Vaccine Intelligence Network (e-VIN) was in place but not functional due to technical issue. There was one Ice Lined Refrigerator (ILR) with non-functional e-VIN in each of the district hospitals.
- AEFI cases were registered, investigated and data was uploaded on SAFEVAC in the facility.

Child Health

- NBCC was established and functional in the labour room. In DH Mon, 6 bedded SNCU was functional having 1 Paediatrician, 1 MOs and 5 Staffs Nurses in place. SNCU had functional radiant warmer, resuscitation bag, mucous extractor, suction machine, inj. Vit K1.
- In DH Zunheboto, only 4 bedded NBSU was established but not fully utilized due to vacant position of paediatrician and trained staff nurses in newborn care.
- Comprehensive Newborn Screening for birth defect was done at DHs. During the year 2024-25, a total of 6 newborns and 11 paediatric deaths were reported, and one death was reviewed by the child death review committee in Mon district
- The staff at DH Mon were trained on IYCF under MAA Programme but not trained at DH Zunheboto.

Child Nutrition

- Comprehensive Lactation Management Centres (CLMC) was not available at both the DHs.
- Lactation support staff and paediatrician were available at DH Mon. Visiting mothers were counselled on early initiation and exclusive breastfeeding.
- There was no nutrition rehabilitation centre in both the DHs. There was provision for transfusion of iron sucrose and blood transfusion for treatment of severe/moderate anaemia in both the DHs.

RBSK

- There was no District Early Intervention Centre (DEIC) in both the DHs. RBSK Mobile Health Team conducts screening for the 4D's and refer the identified children to DIEC Dimapur.

Adolescent Health

- There was no dedicated space for adolescent friendly health clinic (AFHC) at both the DH, however services to the adolescents were provided by the AFHS counsellor. Records of counselling services were available, and outreach services were carried out in school and youth clubs.

TB Mukht Bharat Abhiyaan (NTEP)

- NAAT laboratories were functional, operating in two-hour shifts, with an average turnaround time of approximately 3 hours for test results.
- Fixed X-ray facilities were available, with an average of 40–50 X-rays conducted daily at District Hospital Mon.
- Anti-TB drugs were available at facilities as per DVDMS, with no major stock-related issues observed.
- Drug-resistant TB cases were identified and managed at District Hospital Mon, with 100% of DR-TB patients assessed for differentiated care and receiving DBT under Nikshay Poshan Yojana.
- Coverage of Nikshay Mitra support was approximately 50%.
- In Zunheboto district, sputum samples were collected at the District Hospital and transported to the District TB Unit at the CMO office for TruNAAT testing, with anti-TB treatment available at the DTU level.

NLEP

- Presumptive case register were maintained, MDT drugs were adequately available and IEC/BCC activities for leprosy awareness were being conducted. Nikusth 2.0 portal was not functional.

NACP

- Diagnostic and treatment services for HIV/AIDS were available at both District Hospitals.

NVHCP

- Screening for Hepatitis B and C was being conducted at both District Hospitals, including among antenatal cases, surgical patients, and vulnerable populations, with referral mechanisms in place for HBsAg-positive pregnant women.
- TruNAAT was not being utilised for Hepatitis 'B' and 'C' diagnosis at District Hospital Mon due to non-availability of diagnostic chips.
- Healthcare workers were vaccinated against Hepatitis B, and Hepatitis B Immunoglobulin (HBIG) was available at facilities.
- CD4 count testing was conducted for approximately 85% of positive cases, and all identified patients were on treatment.

NVBDCP

- Diagnostic services included use of RDT kits and microscopy, with blood slide examination results available within 24 hours.

- Treatment services were available, including ACT blister packs for *P. falciparum* malaria and parenteral anti-malarial drugs at both District Hospitals.
- Malaria data was being reported on the IHIP portal by the District Vector Borne Officer and IEC materials on malaria were displayed at health facilities; however, gaps in training of healthcare workers on malaria management were noted.
- Vector-borne disease transmission was noted to coincide with the monsoon season, during which poor road connectivity and difficult terrain posed challenges for field activities and supervision in remote areas.

IDSP

- District Hospitals were reporting weekly data through P and L forms on the IDSP-IHIP portal; however, reporting from the private sector was not available.
- IDSP-DPHL was functional at District Hospital Mon but not at DH Zunheboto.
- No outbreaks were reported during the time of visit in either district, and the District Task Force on Immunization had been reconstituted with the District Surveillance Officer as a member.
- Vaccine Preventable Disease (VPD) surveillance had been transitioned in the districts, with no reported cases of AFP or fever with rash.
- Scrub typhus remained a significant public health concern in Mon district. Challenges in controlling scrub typhus included widespread presence of mites in rural areas, difficult terrain, and increased transmission during monsoon and agricultural activities.
- Co-infections with diseases such as dengue and typhoid, along with gaps in diagnostic capacity, infrastructure, and trained manpower, further hindered effective containment efforts.

NRCP

- Anti-Rabies Vaccine (ARV) and Rabies Immunoglobulin (RIG) were available at both District Hospitals and training of staff on animal bite management and post-exposure prophylaxis had been conducted at state and district levels.

NPPCSE

- Anti-Snake Venom (ASV) was available at both District Hospitals, and health staff had been trained in appropriate snakebite management.

NP-NCD

- NCD Clinic was functional at both DHs, providing screening and treatment services; no critical care unit for NCD patients; both DHs had basic NCD screening instruments & drugs. Basic cardiac monitors were available in ICU, however facility did not have CT/MRI. Basic STEMI services were available at the facility.

- There was no district day care cancer centre at either of the DHs. The entire staff was not trained in NCD protocols, screening, data management and counselling.
- The NCD portal and CBAC app was not being updated in real time at the point of care due to poor internet connectivity.

PMNDP

- Services were being provided in-house, with trained health staff and haemodialysis beds were available at both DHs, including one separate bed for isolation cases; nephrologist was not available in both districts; PMNDP portal was functional and was being used by the health staff; viral markers (HIV, HBV) were being conducted for the patients. There were no peritoneal dialysis services being provided at the facility.
- The RO water plant was kept in a nearby room; however, the room was also being used as storage for other items.
- Free drugs and diagnostics were available only for PM-JAY and CMHIS enrolled beneficiaries.

NPCBVI

- Ophthalmic diagnostic services with functioning OT and equipment including SLIT lamp, tonometer, USG scan were available at DH Mon. However, in Zunheboto, the OT for ophthalmic cases was not functional due to lack of eye specialist. Diabetic patients were screened for diabetic retinopathy as part of routine eyecare services at the facility.
- Outreach camps were conducted in collaboration with RBSK programme.
- The DH Mon provided cataract surgery services. Under the programme, spectacles were provided to school children and the elderly.

NPPCD

- ENT Services were provided in Zunheboto district as ENT surgeon was available. Audiometric screening were conducted and basic ENT equipment were available.

NPHCE

- There was no separate geriatric OPD at both the DHs. But some in-patient beds were dedicated to geriatric population; physiotherapy unit with physiotherapists was functional but only basic and limited equipment for physiotherapy were available at both the DHs.

NPPC

- No dedicated palliative OPD conducted in both the district hospitals; analgesics were available and basic procedures like Ryles tube insertion, urinary catheter, ascites tapping, wound dressing were being done.

NOHP

- Functional Dental Clinic were available at both the DHs with adequate HR and dental equipment. In-house dentists were available at both DHs; basic services were being provided.
- Oral camps & school awareness programmes were being conducted in both the districts, with a strong focus on proper tooth brushing practices and the importance of maintaining good oral hygiene among children.

NTCP

- At both the DHs, TCC was functional and counselling on tobacco cessation was being provided. TCC was not established at CHC level; IEC activities were being conducted for awareness generation in the community; Nicotex gum 4mg and 2mg were given to tobacco users accordingly.

NIDDCP

- IEC activities under the programme was conducted by the facility to create awareness about regular consumption of iodised salt.

NMHP

- Mental health services were being provided by the trained clinical psychologist and psychiatric social worker at DHs, however psychiatrist was not available; records and registers were also being maintained. Essential psychotropic medicines were available and severe cases were being referred to other DMHP units with psychiatrists for advanced evaluation and care.
- Tele MANAS helpline number (14416) was displayed.

NPPMT& BI

- DH Mon had a functional trauma care and burn unit with ambulance linkages for emergency services. DH Mon had trained healthcare professional to provide the services under the programme; in Zunheboto, trauma and burn cases were dealt in common emergency.

Odisha

Maternal Health

- Secondary care hospitals were providing maternal and child health services with specialist care.
- District Hospital (DH) has newly constructed functional MCH wings for maternal and child health.
- Some secondary care facilities lacked Gynaecologists limiting specialist services for referrals.

- Caesarean section rates were high, ranging from 60% to 90% at secondary care public health facilities.
- The few CHCs did not conduct deliveries at night due to lack of security guards, posing safety concerns.

Child Health

- SNCUs were functional at both districts, with paediatricians available round the clock.
- Both DHs were LaQshya certified and SUMAN notified facilities.
- Labor rooms were well-equipped, maintained, and include Newborn Care Corners (NBCCs).

Family Planning

- The contraceptive corners were available at the visited health facilities (basket of choice) for the community and details were recorded in the digital platform.

Universal Routine Immunization

- DH had a dedicated immunization room within the MCH wing.
- ILRs were functional, and temperature monitoring was conducted twice daily; Cold Chain Point (CCP) for DH was CHC.
- Birth dose vaccines were administered to all newborns at public and private facilities.
- Routine Immunization (RI) sessions were conducted every Wednesday.
- AEFIs, including minor cases, were recorded in registers but not reported on the U-WIN platform.
- Open vial policy was not followed during the visit to the facility and vaccine storage practices were not as per the GoI guidelines.

Child Nutrition

- The Lactation Management Unit was present in DH in the MCH Wing with lactation support staff. The mothers were being counselled on early initiation and exclusive breastfeeding.
- NRCs have been established at both district SDH & DH levels. NRCs were functional 24*7 and well equipped with an infantometer, weighing machine, and stadiometer.
- DEIC was well established at DH. There was inadequate HR in DEIC. The daily Footfall at DEIC was around 10-12 patients per day.

TB Mukht Bharat Abhiyaan (NTEP)

- The Medical College and District Headquarter Hospital were co-located with shared human resources, including a pulmonologist, Senior Resident, Assistant Professor, and PG Resident, managing an average OPD load of 30–40 patients per day.

- Diagnostic services were well established, with both CBNAAT and TrueNAAT facilities available, supported by 30 NAAT centres across the district, no sample pendency, and an average turnaround time of 3 hours.
- Anti-TB drugs were available, and comprehensive patient care was ensured through free investigations, specialist-led pre-treatment assessments, and availability of additional services such as cardiac consultations.

NLEP

- No leprosy cases were detected; suspect register was maintained and Nikshay 2.0 entries were completed.
- Diagnostic and treatment services were functional with availability of SSS testing, MDT drugs, PEP-SDR (Rifampicin 150 mg and 450 mg), IEC activities, and a referral transport system.
- DPMR and MMDP services were reported to be integrated and available at CHCs; however, gaps were observed in service continuity, including non-functional MMDP clinics at some CHCs and absence of wax bath and MCR footwear in DPMR clinics, with procurement gaps reported for the past six months in one CHC.
- Slit Skin Smear testing was being conducted at SDH level, though quality assurance mechanisms for diagnosis were noted to be inadequate.
- Some DPMR services were being provided despite infrastructure constraints, including operation from an unsafe building at one location.

NACP

- Diagnostic and treatment services were available at the District Hospital (DH).
- NVBDCP
- Malaria diagnostic services were available through RDT kits and microscopy facilities, with reporting turnaround time within one hour, and anti-malarial drugs were available in sufficient quantity across facilities.
- Surveillance and reporting were being carried out through the IHIP portal, with Mass Drug Administration (MDA) conducted.

NRCP

- Infection control infrastructure was partially in place with a separate handwashing area; however, essential supplies such as soap were not available. Staff had also received training on rabies management.
- Anti-Rabies Vaccine (ARV) and Rabies Immunoglobulin (RIG) were available at the facility for post-exposure prophylaxis.

NPPCSE

- Anti-Snake Venom (ASV) was available at the facility, and staff had received training on snakebite management.

NP-NCD

- The District NCD Clinic and NCD Cell at the DH coordinated all secondary-level NCD activities. Fourteen CHC NCD clinics were providing follow-up care and referrals.
- The DH also hosted programmes for COPD, STEMI, and stroke. However, data integration between these disease-specific programmes and the NCD Cell was found to be limited, and inter-facility referral documentation remained weak.
- The district had implemented the STEMI programme with one hub (VIMSAR Burla) and eight spokes (DH, SDH, and six CHCs). STEMI identification and referral pathways were functional, but timely thrombolytic administration post-diagnosis remained inconsistent.
- Stroke management had been rolled out but required structured data reporting. Diabetic retinopathy screening with the ophthalmologist not was found to be irregular.
- DCCCs were established in both the districts. The facilities cater to referred patients from all blocks and offers palliative care in the same unit. Sessions were restricted to the first half of daytime because of staffing shortages, and there were limited trained oncology nurses too.

PMNDP

- Adequate infrastructure was available, including 7 Haemodialysis (HD) machines, an RO plant, a dialyzer reprocessing unit; functional in Public-Private Partnership (PPP) mode.
- RO water quality test reports were available, covering 13 parameters.
- Trained Medical Officers (MOs) and human resources were available; free drugs and diagnostic services were available; peritoneal dialysis was not available; a mechanism was in place to manage the waiting list.

NPCBVI

- Outreach camps for eye diseases & conditions including cataract were being conducted, also in coordination with RBSK; referral linkages to Medical Colleges and Regional Institutes of Ophthalmology were available.

NOHP

- Dental services were available at the DH and SDH with dental surgeons and functional equipment. The patient load remains high, especially for extractions and scaling, though intermittent supply gaps in consumables affected service delivery.

NTCP

- Counsellors were available; nicotine gums were being provided to the patients; the DH-based Tobacco Cessation Centre supervised counselling and enforcement activities. During the first half of FY 2025–26, 159 violations were recorded and ₹29,310 in fines collected.

NPHCE

- OPD and IPD services were available at the District Hospital (DH).
- A dedicated physiotherapy unit was available along with domiciliary services.
- 10-bedded geriatric ward at the DH was established to provide elderly-care services and was supported by integrated physiotherapy units at CHCs. Geriatric Health Card as a good initiative was observed.

NPPC

- Palliative care services were being provided. Round-the-clock availability of analgesics, including Tramadol, was ensured.
- Facility-based palliative care was integrated with the Day Care Cancer Chemotherapy Centre at the DH, where drugs including analgesics were available.

NMHP

- District Mental Health Unit was functional. Dedicated psychiatric services were available in the OPD; IPD services were also available. Essential psychotropic medicines were available and DMHP team operated fixed-day OPDs at CHCs as well as conducting outreach camps, providing counselling, medication, and tele-psychiatry services. Although specialist availability was limited, tele-mental health consultations and community sessions maintained continuity of care. Tele-MANAS and the toll-free number were displayed.

Punjab

Maternal Health

- The gynaecologists were confident of conducting LSCS in both the districts. The LSCS rate of Punjab was in the range of 50%. During visit of team to MCH wing it was observed that all the cases in the MCH wing of the DH were post LSCS cases.
- In both the districts, Respectful maternity services were available. Birth Companion was allowed to accompany in the labour room and RMC was observed.
- Labour room and PNC ward was well maintained. Labour tables and newborn care corner were available and all the NBCC has warmer facility.
- Most of the Staff nurse, Staff nurses were trained in SBA, PPIUCD and NSSK however the training was done many years back.

- Most of the essential medicines, kits and equipment were in place and all the protocols were displayed and followed. Partograph was used in most of the facilities,
- The majority of the tests were being done free of cost for pregnant women in the hospital. The AAM Admi clinics provides all the test free of cost through outsourcing, the payment of the same was being done by the state government.
- JSSK and JSY implemented and it was observed that no OOPE was being incurred by beneficiaries. There was a trend of using personal vehicle for going home from facility after childbirth. Therefore, the JSSK drop-back was low. In Faridkot district 2941 institutional deliveries out of which only 456 availed free drop back facility.
- All delivery points were SUMAN notified. In Faridkot district, SUMAN Notified facilities CEmONC – 03 Facility and BEmONC – 02 Facility
- Unique Public Private Partnership model established in Faridkot district wherein Obstetricians/ physicians from private sector was encouraged to provide voluntary services at designated public health facilities.
- Mother's Absolute Affection (MAA) programme was implemented in both the districts to revitalize efforts towards promotion, protection and support of breastfeeding practices. Maternal death reviews were being conducted at DH level, actions were followed up and documentation was being maintained.
- Blood storage unit was not functional at CHCs, but blood was available as and when needed from the district hospital.
- USG facilities were available at urban CHCs by a trained MO. The state government has recently rolled out empanelled clinics to provide antenatal USG, to reduce Out of pocket expenditure.

Family planning

- Awareness about the family planning methods was adequate among health care staff.
- Display of basket of choice was not found in majority of places. Sugam Model was not found at the facilities in both the districts.
- As per the data of family planning program the major focus of the state was still on the terminal methods, primarily the female sterilization. The uptake of spacing methods like injectables was very low.
- All method of contraception were available at the visited facilities, but uptake of the community was poor regarding the newer methods of contraception like Inj. MPA (Antra).
- PPIUCD kits were found in all the centres visited. Staff Nurse and Medical Officers were trained in the procedure of PPIUCD insertion. Adequate number of PPIUCD insertion was noted, however retention of PPIUCD was less and need to be strengthened.

- Post Abortion IUCD use was found minimal, likewise interval IUCD uptake was also less, these need to be strengthened.
- Condom box found installed in the facilities. There was a practice of maintaining the record of the beneficiary taking condom from the condom boxes. There was a need to place these condom boxes more discretely to facilitate more uptake. Equipment and supplies were adequate in the visited facilities.
- CAC services were available at DH level only. District can explore scope to initiate first-trimester medical abortion services at more secondary-level facilities with trained MOs.
- No of centres registered in Faridkot district was 40, Registered Ultrasound Centre-19, MTP centres-40, Number of centres sealed- 4.

Universal Immunization program

- Birth dose vaccination was given universally in both the districts and across facilities.
- No stock out of vaccine and logistics found. All vaccines and diluents were available at cold chain points. VVM found good in all vaccines.
- Cold chain equipment's found working properly. There was no problem of power cuts in the state.
- e-VIN was functional and IEC was displayed; however, the Contingency plan was not in place.

Child Health

- Early initiation of Breast feeding was being done. Staff nurses were aware of the newborn baby corner use. Cord tie, mucus extractor found and was being used in all facilities. Child death reviews were being conducted regularly.
- Iron sucrose being used as per need. There was ample supply of Iron sucrose injections along with 100 ml normal saline.
- SNCU in Jalandhar was functional with survival rate of 87%. SNCU in Faridkot was working in the medical college setup.
- Around 8 NBSUs were functional in the district and 1 SNCU was linked with the medical college at Faridkot. Newborn baby corners were found and functional.

Child Nutrition

- Moderate and severe malnutrition cases were uncommon at secondary facilities. Growth monitoring and anaemia detection carried out, but follow-up on nutritional counselling requires strengthening.

RBSK

- Referral cases from RBSK screened at Anganwadi centres, school health programs and secondary care facilities were directed to District hospital and GGMC medical

college Faridkot/Civil Hospital Jalandhar, where surgeries for cleft lip and heart diseases were being performed.

- Lack of DEIC in the district limits comprehensive follow-up and rehabilitation.

Adolescent Health

- AFHC functional at secondary level reported low footfall probably due to limited IEC and poor adolescent awareness of available services in Faridkot district.
- Under RKSK programme 04 'UMANG' Clinics were established in Faridkot district DH-1, SDH-1, CHC Block Jand Sahib & CHC Block Bajakhana each.
- AFHC clinic in Jalandhar district was 8 and average client load per clinic was around 112.
- Total registered 105 Adolescents for FY 2025-26 (Till Oct.) at UMANG Clinic at DH Faridkot.
- Services more often utilized by Adolescents were regarding menstrual problems, RTI/STI, Skin, Nutrition, IFA tablets.

TB Mukht Bharat Abhiyan (NTEP)

- Active TB case finding was observed across both the districts. Screening was conducted primarily for presumptive symptomatic TB cases at DH and CHC levels, supported by handheld X-ray machines and NAAT laboratories functioning in 2–3 shifts, with NAAT facilities available up to CHC level.
- Anti-TB drugs were available with no stock-outs reported, and supplies were being monitored through DVDMS.
- Drug-resistant TB management was functional, with 20 DR-TB cases initiated in Faridkot and 100% of diagnosed patients on treatment.
- Nikshay Mitra support system was active, with 20 registered Mitras in Jalandhar supporting 2,554 patients.
- TB mortality audit mechanisms showed gaps, with no audit reports available in Faridkot, while Jalandhar reported 104 death audits covering 51% of deaths.

NLEP

- Active case finding for leprosy was being conducted at community level with support from DH, SDH, and CHC facilities, and programme records/registers were maintained across facilities.
- No Grade II disability cases were reported in either district; hence, no reconstructive surgeries were being conducted.
- Single-dose Rifampicin was being administered as preventive therapy for eligible populations, and Nikusth 2.0 portal was being used for data entry.

NACP

- HIV care services were functional across both districts, with ART services operational.
- Pregnant women were routinely tested for HIV and syphilis using dual kits during antenatal care, while TB-HIV collaborative testing coverage remained suboptimal, with inadequate tracking of TB patients tested for HIV across facilities in both districts.

NVHCP

- Screening for Hepatitis B and C was conducted among the general population and high-risk groups at DH/SDH/CHC levels, ART centres, and prisons, with routine testing of all pregnant women. Diagnostic services included availability of HBsAg and anti-HCV RDTs at these levels, along with free baseline and viral load testing.
- Treatment services were provided free of cost, including mandatory institutional delivery for Hepatitis 'B' and 'C' positive pregnant women and HBIG administration to newborns within 12 hours of birth, with SVR testing for Hepatitis C planned at three months post-treatment completion.
- Unsafe syringe reuse by informal providers was observed, contributing to increased risk of transmission.

NVBDCP

Malaria:

- Malaria transmission remained low in both districts, with no malaria-related deaths reported, supported by robust diagnostic capacity with availability of RDT and microscopy and slide results reported within 24 hours.
- Treatment services included availability of parenteral anti-malarial drugs; however, ACT blister packs for *P. falciparum* were inconsistently available and required ensured continuity.
- Healthcare workers were trained, with near real-time case-based reporting on the IHIP portal, and community engagement was supported through ASHA incentives and IEC activities promoting early care-seeking.

Dengue:

- Dengue notification mechanisms were in place across public and private healthcare providers to ensure timely reporting of suspected cases to district health authorities, with free diagnostics and drugs available in government hospitals.
- Diagnostic services relied on ELISA-based NS1 and IgM testing, with confirmations routed through DPHL, while daily line-listed reporting continued via IHIP/VBD and IDSP L forms.

- Blood Component Separators were available in District Hospitals in both districts, and private laboratory ELISA testing rates were fixed at ₹600 per test.

Chikungunya:

- Chikungunya sentinel surveillance was being done through a designated sentinel surveillance hospital (SSH) and trained Rapid Response Teams (RRT). Case management was primarily handled at the nearby Medical College, with patients directly accessing care and no facility-level referrals recorded in Faridkot district and Civil Hospital Jalandhar
- Vector control and community engagement activities for dengue and related vector-borne diseases were ongoing through routine fogging/larviciding, monthly inter-sectoral coordination, and awareness drives.
- System capacity was strengthened through recent trainings for clinicians, Integrated Vector Management (IVM) officials, and ASHAs, along with visible IEC at facilities and timely incentive payments.

IDSP

- IDSP reporting through P, S, and L forms on the IHIP portal was being carried out, with functional District Public Health Laboratories (DPHLs) in both districts planned for integration with IPHL; however, private sector reporting remained low.
- All reported outbreaks in the previous financial year were confirmed and managed. Water quality testing was conducted, with 254 samples tested in Faridkot and 729 in Jalandhar, showing pass rates of 60% and 40% respectively.
- Influenza cases were also reported, including 1 H1N1 case in Faridkot and H3N2 cases (6 in Faridkot and 4 in Jalandhar) during FY 2025–26.

NRCP

- Anti-Rabies Vaccine (ARV) and Rabies Immunoglobulin/serum (RIG/ARS) were available across secondary care facilities in both districts. Medical Officers and staff nurses had been trained in animal bite management under the programme.
- Category III bite cases were being managed with ARV and ARS, with follow-up records maintained at selected sites.
- Dedicated wound wash stations were not available, and wound cleansing was being carried out in toilets or at open taps within facility premises.

PPCL

- Leptospirosis was reported as endemic in Punjab, with cases recorded in both Faridkot and Jalandhar districts.

- Diagnostic facilities (ELISA/rapid tests) were available for leptospirosis diagnosis across districts, supported by availability of Doxycycline as per Essential Medicines List at DH/SDH/CHC levels.

NPPCSE

- Anti-Snake Venom (ASV) was available at secondary-level facilities across both districts, with storage maintained as per guidelines.
- Medical Officers and nurses had been trained under the programme for snakebite management. However, complicated snakebite cases were referred to the Medical College for advanced care.

NP-NCD

- NCD clinics were established at DH/SDH/CHCs and were operational daily in the routine OPD hours, with designated HR; only opportunistic screening was being conducted, by referrals from other department MOs, not for all eligible population above 30 years of age; screening also primarily focused only on HTN & DM; follow-up was observed to be low.
- Faridkot and Jalandhar were the part of the Hub and Spoke models for managing STEMI (heart attack) and Stroke cases. Thrombolytic Drug-Injection Tenecteplase - TNK 40 mg is provided free of cost for the thrombolysis of STEMI patients.
- Routine entry was being done in NP-NCD portal by the data operator. However, multiple registers were used for entering the same cases.
- DCCCs were established in both districts visited, providing chemotherapy, counselling and palliative care services.

PMNDP

- PMNDP was operational in both the districts in PPP mode, with free of cost services for patients; separate machines were available for infectious cases; waiting list at the DH was managed via a mobile application used by dialysis technicians and patients.
- RO plant ensured water safety with biannual bacteriological testing and routine monitoring under this programme.

NPCBVI

- The district hospital in the districts were providing free diagnostic services for eye conditions; Ophthalmologists were available in both the district hospitals cataract surgeries were performed; at CHCs, optometrists were available for screening of refractive errors, distribution of free spectacles, dispersing eye drops and referring patients to higher facility for surgeries; community and school visits through outreach camps and had collaboration with RBSK team.

NPPCD

- Ear care services were available in both the DHs, including medical and surgical care with regular outreach screening camps; audiometric screening remained limited due to unavailability of age appropriate equipment; trained staff and drugs were available at the visited facilities.
- Awareness talks on 'Dos' and DON'Ts for safe hearing were being conducted on World Hearing Day.
- 'SOHUM' (New born hearing screening) and Universal Neonatal Hearing Screening (UNHS) initiatives for early detection and management of hearing loss in neonates in Jalandhar district had been introduced.

NPHCE

- Service delivery under NPHCE remains highly centralized at the DH in both the districts, with limited outreach or decentralization to lower facilities; separate IPD beds for geriatric care were available in DH Jalandhar.
- In Faridkot, Sadiq and Jaito CHCs had initiated geriatric care reporting in 2025.

NPPC

- Palliative care services were not fully available in both the visited districts; separate palliative care OPD was not functional at CHCs or DH; patients were registered into regular OPD, and drugs like tramadol and other analgesics were available.
- Basic procedures like Ryles tube insertion, urinary catheter insertion, wound dressing were being done at the DH and CHCs.

NOHP

- Dental services were available till CHC level in both the districts. Dental chair and equipment were available; basic routine dental procedures were being performed at the CHCs, and at DHs, RCTs were also being done. OPG and dental X-ray was also available at the DH level; Dental laboratory had not been established or empanelled.
- Dental outreach camps were being organized in schools, District Jail Faridkot and at community level.

NTCP

- TCCs were established in both the districts for counselling and treatment (pharmacotherapy), however, it was not functional at the time of the visit in Jalandhar; 'No tobacco' IECs were displayed across health facilities.
- In Jalandhar district total number of challan done for September 2025 was 165 and in Faridkot was 89 as per COTPA, 2003; E-Cigarettes and 'Hooka' bars were banned.
- Total tobacco free villages in Faridkot district was 40.

- There were 26 Outpatient Opioid Assisted Treatment (OOAT) clinics operational in Jalandhar and 13 in Faridkot district.

NPPCF

- Fluorosis remains a major concern for Faridkot district and Jalandhar district due to groundwater contamination.
- The secondary care facility staff were less sensitized or prepared for screening, diagnosing / detecting fluorosis.
- The administration ensured safe drinking water through frequent water sampling but dental and skeletal fluorosis management was found weak under this programme.

NIDDCP

- Under this programme salt and urine samples were being collected and tested for estimation of iodine at DH level; IEC activities displayed during an awareness program on regular consumption of Iodized salt.

NMHP

- Psychiatrists were available at both DHs, routine OPD was functional; CHCs lacked psychiatrist or psychologist and hence the patients were referred to DH in both the districts; psychotropic drugs were available and were secured in separate locker and SOPs followed at all secondary care facilities.
- Tele MANAS service linkages were not available in both the districts; toll free number was also not displayed.

NPCCHH

- The Health Department in the districts had taken significant steps to address Heat-Related Illness and Air-Related Illness under NPCCHH programs.
- State and District Action Plan on Climate change and human health had been developed.
- Activities planned were Climate change Knowledge Centre (Jalandhar), Sustainable agriculture, Sustainable habitat, increasing green cover, renewable energy for health sector- HVAC, LED lighting etc.
- Medical Officers and other healthcare workers had been trained within the last six months.
- Heat illness preparedness was established with dedicated beds/room, core temperature monitoring, cooling facilities, and respiratory support equipment (CPAP/BiPAP/ventilator/nebuliser) and a five bedded heat stroke room operated during summer months.
- Reporting heat related illnesses and deaths was being coordinated by the Civil Surgeon Office.

- A Nanak Bagichi (Green space/Herbal garden) has also been established within District Hospital Faridkot, cultivating useful medicinal plants to support awareness and resilience efforts.

Rajasthan

Maternal Health

- Institutional deliveries were reported to be very high at 97% in Nagaur and 97.1% in Jhunjhunu districts.
- Postnatal care within two days of delivery was reported as 80.8% in Nagaur and 84.6% in Jhunjhunu.
- USG services were being provided free to pregnant women through MAA voucher scheme during PMSMA.
- Some facilities had male nursing staff posted in labour rooms, leading to discomfort among pregnant women.
- Availability of specialists was inconsistent, with absence of anaesthetists affecting service delivery at SDH level.
- There were gaps in infection prevention practices in labour room .

Family Planning

- Contraceptive prevalence rate was reported as 83.4% in Nagaur and 77.8% in Jhunjhunu.
- Use of modern methods was reported at 69.3% in Nagaur and 69.1% in Jhunjhunu.
- Female sterilization was the dominant method at 48.3% in Jhunjhunu.

Universal Immunization Programme (UIP)

- Full immunization coverage among children aged 12–23 months was 80.6% in Nagaur and 88.7% in Jhunjhunu.
- Measles-containing vaccine first dose coverage was 92% in Nagaur and 94.6% in Jhunjhunu.
- DPT/Pentavalent third dose coverage was reported at 96% in Jhunjhunu.

Child Health

- Newborn care services were robust, with a 20-bedded SNCU at the DH equipped with single entry–exit points and full functionality of radiant warmers, phototherapy units and infusion pumps.
- The SNCU reported an 80% successful discharge rate. A 5-bedded NBSU was functional at DH Najafgarh.

- NBCCs were available near labour rooms, equipped with radiant warmers, resuscitation bags (zero and one size), suction machines, and Vitamin K1.

Child Nutrition

- CLMC/LMU with required equipment such as electric/manual breast pumps, deep freezers, and sterile storage bottles available where applicable.
- Lactation counsellors supported early initiation and exclusive breastfeeding, and visiting mothers received structured counselling.
- The NRC was operational with key amenities such as a dedicated kitchen, play area, anthropometric equipment, glucometers, feeding supplies, room heaters, blenders, and separate hygiene facilities.
- MO/Paediatrician, Nutrition Counsellor, and staff nurses were in place and night feeding was ensured.

RBSK

- In Jhunjhunu DEIC was functional with essential equipment and specialist personnel, including an audiologist, psychologist, optometrist, and physiotherapist.
- In Jhunjhunu DEIC recorded a footfall of 60–70 cases, including 13 cases of congenital heart disease and 13 cases of cleft lip/palate.
- Mobile Health Teams were conducting scheduled visits to schools and AWCs, with micro-plans and screening kits in place.
- DEIC was not functional in Nagaur district.

TB Mukht Bharat Abhiyaan (NTEP)

- Extensive active TB case finding was conducted across both districts with involvement of CHOs, ANMs, ASHAs, and Anganwadi workers, supported by IEC activities.
- Vulnerability mapping was completed in Nagaur, and TPT services were being provided. Preventive services were also integrated with community-based screening platforms.
- Sputum microscopy services were functional at PHCs, while CBNAAT and TruNAT facilities were available at CHCs and district hospitals in both districts. However, intermittent shortage of CBNAAT cartridges was noted as a key operational constraint.
- Anti-TB drug supply was adequate and monitored through Nikshay Aushadhi with no stock-outs reported.
- Financial support mechanisms were observed, including increased DBT assistance (₹1000/month since Nov 2024). In Nagaur, 1,696 of 1,818 patients received Nikshay Poshan Yojana benefits. However, bank details were available for only 69% of notified patients, though no payment pendency was observed once validated.

- Strong community and institutional engagement along with CSR support from industries (e.g., JSW Cement, Nuvoco, HCL) contributed to nutritional and patient support, including Poshan kits.
- Private sector participation in TB notification was satisfactory in Jhunjhunu, contributing positively to case detection and reporting.
- Line listing and patient tracking systems were functional. However, gaps in patient awareness regarding treatment regimen were observed during field visits, indicating a need for strengthened counselling and adherence support.

NLEP

- Clinical support for leprosy management was strengthened by the availability of three dermatologists at District Hospital Jhunjhunu, contributing to effective case detection and management.
- Follow-up mechanisms were functional, with ASHAs conducting regular follow-ups and doctors undertaking monthly monitoring; each patient was provided with a treatment card for tracking.
- Drug supply and patient support systems were in place, including provision of a two-month initial drug supply followed by monthly dispensing, along with distribution of blankets, sandals, medicines, and bandages with proper documentation.
- Capacity building activities were conducted, with training provided to Medical Officers and ASHAs on new case detection and contact tracing.
- No Grade II Disability (G2D) cases were reported in Jhunjhunu, indicating timely diagnosis and effective case management.

NACP

- Routine HIV and syphilis screening of all pregnant women was being conducted during antenatal visits at public health facilities, ensuring early detection and timely linkage to care.
- Treatment services were available for diagnosed cases, with well-established linkages between testing and treatment units.

NVHCP

- Routine Hepatitis B screening was being conducted for all pregnant women attending antenatal care services.
- A structured referral mechanism was in place for Hepatitis B positive pregnant women to ensure institutional delivery and appropriate clinical management.

NVBDCP

- NVBDCP implementation was strengthened through digital surveillance systems, including the use of the 'Marudhar App' with geo-tagging by ASHAs for field-level

reporting, along with regular anti-malaria activities, dry day observance, and anti-larval measures.

- In Nagaur district, both ELISA and rapid diagnostic testing for dengue and chikungunya were available at District Hospital, with line listing of cases conducted
- Slide collection performance in Nagaur reached 70.62% of the target, indicating partial achievement of surveillance benchmarks.

IDSP

- IDSP reporting systems showed partial functionality, with 80% of Sub-Centres and 85% of DHs/SDHs/CHCs/PHCs reporting P and L forms; however, gaps in S-form awareness and reporting were observed among frontline staff, particularly CHOs.
- Early warning signals were being generated and investigated promptly, supported by regular feedback mechanisms, weekly disease trend analysis, and field visits by the epidemiologist for surveillance review.
- Capacity building efforts included training of Medical Officers and paramedical staff on IDSP case definitions; however, training of ASHAs and ANMs required strengthening, particularly in Jhunjhunu where reporting compliance and awareness of S-form systems were low.
- Inter-sectoral coordination for vector-borne diseases was functional, with regular review meetings conducted under the chairmanship of the District Magistrate.
- Overall, challenges persisted in data quality and completeness, highlighting the need for refresher training of frontline health workers and improved integration of ANMs into S-form reporting systems.

NRCP

- Anti-Rabies Vaccine (ARV) was available and being administered at all PHCs and higher-level facilities in both the districts, while Rabies Immunoglobulin (RIG) was available at CHC level and above.
- Healthcare staff demonstrated good awareness of first aid and post-exposure prophylaxis for animal bite cases, reflecting effective capacity building and knowledge dissemination under the programme.

NPPCSE

- Under the National Programme for Prevention and Control of Snakebite Envenoming (NPPCSE), Anti-Snake Venom (ASV) was available across all PHCs and higher-level facilities.
- Snakebite cases were initially managed with first aid at peripheral facilities and then referred to District Hospitals for definitive treatment, ensuring a structured referral pathway for timely care and management.

NP-NCD

- The State was observing 75 by 25 Program under which the state had targeted treatment of 29 Lakhs patients of Diabetes and Hypertension by December 2025; Madhuhaari Clinics were implemented by State, offering free insulin, glucometers, strips, logbooks and standard treatment protocols to patients with Type-1 DM.
- NCD clinics were being conducted regularly across all facilities, typically once or twice a week, ensuring ongoing screening and management of patients with hypertension, diabetes, and other chronic diseases; dedicated spaces for NCD clinics were available and functional; however, there were no designated CCU or Stroke Unit beds at the visited facilities, which restricted the capacity to manage acute NCD emergencies.
- The focus remained primarily on DM & HTN, with limited attention to other NCDs such as COPD, CKD, NAFLD and cancers. STEMI and Stroke emergency management services were available at the district hospital level only.
- Critical care equipment such as cardiac monitors, ventilators, and oxygen concentrators were functional at higher-level facilities.
- CT/MRI and chemotherapy were available at district hospitals.
- Protocol-based diagnosis and treatment of NCD patients were being followed in most facilities. Patients diagnosed with hypertension and diabetes were promptly put on treatment, though the proportion of patients under regular follow-up and control remains suboptimal due to inconsistent tracking.

PMNDP

- PMNDP was being implemented at designated health facilities to provide free haemodialysis services to patients with chronic kidney disease in the visited districts. The facilities had adequately trained human resources, including Medical Officers, staff nurses, dialysis technicians and housekeeping personnel, who were managing the dialysis sessions effectively.
- Free drugs and diagnostic services required for dialysis patients were available as per PMNDP provisions. Peritoneal dialysis services were not available in the visited facilities; awareness and utilization of the PMNDP online portal remained limited among facility staff.

NPHCE

- There was provision of medicines for geriatric medical and health problems in Daily Geriatric Clinic under Ramashraya scheme.

NPCBVI

- Cataract surgeries were being conducted carried at the District Hospital.
- A dedicated eye OT was available, equipped with two microscopes and a ramming machine. Procedures conducted include Cataract, Pterygium, Chalazion cases etc.

- Since January 2025, 11 special eye screening camps have been held at toll booths, where approximately 300 truck drivers were examined and about 200 were provided free spectacles.
- School children referred by RBSK teams received eyeglasses regularly, and any shortages were covered with support from Bhamashahs; cataract surgeries were being carried out at the DH.

NOHP

- Dentists were available at the DH and SDH level, but not in the CHCs visited; dental chairs were available in facilities visited, wherever dentists were posted. At SDH Jayal, procedures including RCT, extraction, restorations were being performed.

NTCP

- All required COTPA signage was found in most of the visited health facilities; Tobacco-Free Health Institution guidelines were being followed, with proper marking and “No Smoking” banners displayed; health facility staff aware of the COTPA Act and its guidelines.
- Patient counselling for tobacco users was being handled by existing healthcare staff; no psychologist or counsellor were posted; NRT therapy was provided on the prescription of a psychiatrist, and follow-up was being documented.

NPPCF

- No separate HRH was in position; services were integrated with NOHP.

NIDDCP

- Salt samples for surveillance were collected annually by Food Safety Officers. Testing kits were not regularly available.

NMHP

- Appropriate IEC materials, including Tele-MANAS displays, were in place.
- Many awareness sessions were conducted by the department between 10th September (Suicide prevention day) and 10th October (World Mental Health Day). The Mental health team of the district also undertake regular session in the educational institute, Bal Sudhar GRIH, colleges on mental health.
- Gate Keeper Programme is one of the good initiatives which works through 3L chain - Look, Listen, Link. The Gate keeper training has been planned and will be given to the identified gate keepers from the various educational institutions and health institutions. Two to three teachers from the various educational institutions and CHOs/ANMs have been identified in the district for gatekeeper training program. This training will be for one day and will focus on preparing the gate keeper for identifying the person with suicidal risk and establishing the connection with treatment facility (i. e. Psychiatrist/Psychiatric unit/Tele MANAS) etc.

Sikkim

Maternal Health:

- HRP line listing and follow-up monitoring were being conducted at the facility. The high-risk conditions include post-caesarean pregnancies and hypertensive disorders, which require regular follow-up.
- PMSMA was observed on the 9th of every month at the District Hospital. Although PHCs provide routine ANC services, many mothers prefer to seek ANC and delivery services at STNM, Gangtok, leading to increased out-of-pocket expenditure due to travel and service charges at private facilities.
- However, due to the non-availability of an Anaesthetist and Paediatrician, non-functional operation theatre comprehensive emergency obstetric care (C-section) services were not provided at the district hospital.
- The District Hospital had a 24x7 functional laboratory, and all relevant tests were conducted with a report turnaround time of under two hours. However, USG services were limited.
- Partographs and safe birth checklists were used in the labour room; however, the safe surgical checklist cannot be applied due to the non-functional OT and absence of surgical deliveries.
- All essential life-saving drugs were available in the labour room. Respectful maternity care was practiced at the facility. Birth companion provision was allowed, in line with national guidelines. The facility was notified under SUMAN; however, the full range of BEmONC/ CEmONC service guarantees was constrained by the lack of C-section capability.
- Free drugs, diagnostics, and diet were provided at the District Hospital. However, the non-availability of 102/108 ambulance services affected patient transport, particularly for referral cases requiring urgent movement to STNM.
- A Birth Waiting Home was available in the visited district, but no admissions were recorded in the past year, suggesting low awareness and underutilization. No Maternal Death have been reported in last one Year in the District.

Family Planning:

- Family planning clients were not offered a complete basket of contraceptive choices at the facility.
- The Basket of Choice display was not available, and the Sugam Model was not installed in the District Hospital. Family planning services were therefore limited in scope, with clients receiving only a restricted range of methods.
- The ANM and staff nurses demonstrated basic knowledge of short-acting and long-acting reversible methods but the absence of visual displays limits client awareness.

- The facility did not have a Condom Box or a Self-Care Kit (containing condoms/ECP/ pregnancy test kits) placed at any strategic location. As a result, clients do not have easy, confidential access to these commodities, which affects visibility and uptake of self-care options.
- Permanent methods of family planning, including male and female sterilization, were not being provided at District Hospital Mangan. The facility had trained staff in: PPIUCD/PAIUCD/IUCD insertion, Injectable MPA (Antara Programme).
- Sufficient instruments were available for IUCD insertions. Sterilization and disinfection procedures for these instruments were conducted through the functional CSSD at the hospital.
- A structured follow-up mechanism for family planning clients was not observed during the visit. Registers for Injectable MPA (Antara) and IUCD insertions were maintained but follow-up entries were incomplete.
- No dedicated counsellor was posted for FP counselling at the facility. Follow-up and counselling during ANC were conducted by staff nurses, limiting comprehensive postpartum and interval FP follow-up.
- The District Hospital Mangan had a Gynaecologist trained under the MTP Act who provides abortion services as per legal and clinical guidelines. Services were provided in an earmarked area within the Labour Room, ensuring privacy and clinical safety, with post-abortion counselling facilitated by staff nurses.

Universal Immunization Programme

- The Universal Immunization Programme at District Hospital Mangan was characterized by excellent cold-chain maintenance, meticulous documentation, strong digital integration (e-VIN and UWIN), and high adherence to national immunization protocols.
- High compliance with immunization planning and documentation protocols was observed and updated due lists, MCP cards, and counterfoils were systematically maintained and cross-verified.
- AEFI reporting mechanisms were functional; minor AEFI cases were documented and uploaded on SAFEVAC in compliance with national guidelines. No serious AEFI cases were reported in the reference period.
- The electronic Vaccine Intelligence Network (e-VIN) was fully operational. Real-time stock levels recorded in e-VIN were consistent with physical stock verification, indicating strong inventory management and minimal discrepancies across cold-chain points.
- All newborns received Hepatitis B birth dose, OPV-0, and BCG prior to discharge. No newborns born within the last 24 hours were found to have missed their birth dose vaccination during the visit.

- Birth dose vaccinations were administered seven days a week, ensuring timely coverage without dependency on fixed immunization days.
- All ILRs and Deep Freezers were functional, with e-VIN temperature loggers active and transmitting accurately. Temperature monitoring registers were updated twice daily without interruption. No vaccine or AD syringe stockouts were reported during the assessment period.
- UWIN platform was being used for planning, conducting, and closing immunization sessions. Planned versus held sessions were fully aligned, and the staff demonstrated proficiency in digital data entry, beneficiary verification, and real-time reporting.
- Beneficiary verification through MCP cards and UWIN data showed high compliance with the national immunization schedule, with no missed-opportunity cases observed. Routine immunization coverage indicators for the district reflect strong programme performance.

Child Health

- Newborn Care Corner (NBCC) established and functional in labour room (1 NBCC at 4 Labour Tables)
- Designated 4 bedded NBSU unit with Radiant warmers was established near labour room
- No Child Deaths have been reported in DH Mangan.

Child Nutrition

- Comprehensive Lactation Management Canters (CLMC) was not present in District Hospital Mangan.

RBSK

- RBSK screening activities for the 4Ds—Defects at Birth, Diseases, Deficiencies, and Developmental Delays including Disabilities—were being conducted regularly. Follow-up of referred cases from the community was reported to be optimal, ensuring continuity of care for identified children.
- District Early Intervention Centre (DEIC) remains non-functional, limiting access to comprehensive diagnostic and therapeutic services. Additionally, the RBSK team didn't not have a designated vehicle for field screening and was required to hire a vehicle for each outreach activity, which affects the efficiency and timeliness of service delivery.

Adolescent Health

- Adolescent Friendly Health Centres (AFHCs), each with a designated space for adolescent service delivery were available. Essential equipment and commodities including IFA and Albendazole tablets, sanitary napkins, emergency contraceptive pills, and pregnancy testing kits were largely available.

Tamil Nadu

Maternal Health:

- The state follows a policy where all institutional deliveries were conducted at District Hospitals (DH) or designated Comprehensive Emergency Obstetric and Newborn Care (CeMONC) centres.
- Dedicated Maternal and Child Health (MCH) wings were available as separate blocks with clearly demarcated areas for Triage, Obstetrics, HDU, ICU, and Postnatal Care (PNC).
- Identification and follow-up of HRP were systematically managed through the PICME Portal and HMIS 3.0, ensuring real-time tracking from early antenatal care (ANC) to the postnatal period. Essential ANC services were supported by the availability of diagnostic kits (HIV-Syphilis, glucose for OGTT, etc.) and commodities like MCP cards and Safe Motherhood Booklets. In Salem's Tharamangalam CHC, regular yoga sessions were conducted for ANC mothers as part of integrated care.
- The Dr. Muthulakshmi Reddy Maternity Benefit Scheme (MRMBS) was the cornerstone of maternal nutrition, providing ₹18,000 in financial assistance and two nutritional kits worth ₹2,000 each.

Child Health

- Child health services in Tamil Nadu were characterized by high survival rates and advanced neonatal care units.
- Specialized Newborn Care Units (SNCU) were well-established. SNCU reported a survival rate of 96.7% was in Mettur DH in Salem.
- Comprehensive Lactation Management Centres (CLMC) were functional in both districts, providing essential support for neonates who cannot be breastfed directly.

RBSK

- The Rashtriya Bal Swasthya Karyakram (RBSK) teams were active in screening children for the "4 Ds" (Defects at birth, Diseases, Deficiencies, and Developmental delays).
- The District Early Intervention Centres (DEIC) were functional, with Salem showing a robust multidisciplinary team that included paediatricians, physiotherapists, and special educators.
- In Tenkasi, each block had two RBSK teams covering 40 schools per team, screening about 60 students daily, with data managed through the Education MIS and geofenced NALAM portals, and accessible via a web-based dashboard.
- Follow-up was conducted through phone calls, and integration with HMIS 3.0 was expected to further streamline teacher logins and case tracking.

- The average waiting time for operations after RBSK screening was around one month, and dental caries remain the most commonly reported condition, affecting nearly 15–20% of students.

Immunization

- Vaccination services were well-maintained, with staff trained in open-vial policies and cold-chain management.
- Adolescent Health
- Adolescent health services were primarily delivered through Adolescent Friendly Health Clinics (AFHCs).
- AFHCs were functional across DHs and CHCs, providing counseling on mental health, sexual and reproductive health, and nutrition.
- Despite the presence of these clinics, recent literature suggests that awareness remains a significant challenge. A 2025 study found that only 28% of adolescents were aware of AFHC services.
- In Tenkasi and Salem, footfall was often limited to adolescents seeking treatment for minor ailments rather than preventive counseling.
- There was a recognized need to strengthen school-based outreach and Information, Education, and Communication (IEC) activities to improve the visibility of these services.
- The Weekly Iron and Folic Acid Supplementation (WIFS) program was implemented through schools to address adolescent anaemia, though regular reporting from private schools remains a challenge.

Family Planning:

- Family planning (FP) in Tamil Nadu was deeply integrated into the digital health ecosystem, ensuring commodity security and tracking.
- The FPLMIS portal was used for real-time tracking of contraceptives, and both districts reported adequate stocks of condoms, OCPs, and ECPs.
- There was a strong emphasis on Postpartum Intrauterine Contraceptive Devices (PPIUCD) and Sterilization
- All family planning services were linked to the PICME portal, enabling Village Health Nurses (VHNs) to monitor mothers' reproductive choices throughout the postnatal period.

Child Nutrition:

- Nutrition remains a core component of the RMNCHA+N strategy, focusing on both maternal and child interventions.

- A critical gap identified in both Tenkasi and Salem districts was the absence of dedicated Nutrition Rehabilitation Centres (NRCs) within the district hospitals. Children identified with SAM were currently referred to medical college hospitals for therapeutic management.

TB Mukht Bharat Abhiyaan (NTEP)

- Tamil Nadu established a strong TB control framework with widespread diagnostic availability at AAM-PHCs and higher facilities, including IELS at AAM-HSCs; differentiated TB care was routinely followed for all newly diagnosed patients.
- CBNAAT and TrueNAAT machines were available from PHC upwards, but CBNAAT utilization remained low due to interruptions in cartridge supply.
- Direct Benefit Transfers under Nikshay Poshan Yojana were timely until August 2025, after which SNA Sparsh and Aadhaar updation issues caused pendency.
- DR-TB services were limited in Tenkasi and Salem, resulting in referrals to nearby districts in Tenkasi and to the Medical College in Salem.
- Vulnerability mapping was completed, but screening coverage remained low at 29%, X-ray utilization at 10%, and Cy-TB test acceptance among contacts at only 50%.
- Nutritional support through NGOs benefited 20% of patients (360 individuals) via extra rations from 16 Nikshay Mitras but did not meet the “Nutritional care and support for patients with TB in India” guidelines.
- Interdepartmental linkages for screening and referral remained strong across Tamil Nadu.

NLEP

- Leprosy case management functioned well, with a significant proportion of cases detected through active surveillance and LCDC.
- Healthcare Staff training was completed in Salem; all blocks and GHs in Tenkasi had SSS-trained lab technicians.
- Child case detection rates remained high in both the visited districts signalling continued transmission.
- Reconstructive surgeries were being performed (131 in 2024-25 & 68 till October 2025).
- PEP registers lacked critical contact details, hindering follow-up; psychological support linkages with NMHP were not implemented; data regarding follow-up of contacts of index cases and post-treatment follow-up for at least 5 years were lacking.

NVHCP

- Tamil Nadu has integrated Hepatitis B and C screening into primary healthcare from PHC upwards. In Tenkasi, treatment initiation occurred at Govt. Medical College in the nearby district with follow-up at DH; in Salem, cases were referred to Medical Colleges for viral load testing and further management.
- Poor coordination between blood banks, ICTC, laboratories, and ANC units affected seamless screening at DH Tenkasi.
- Viral load reports were delayed by nearly 20 days, and referral linkages from primary to higher centres remained weak.
- Most staff were vaccinated for Hepatitis B.

NVBDCP

- Tamil Nadu has achieved near elimination of malaria, with zero indigenous cases in 33 districts; the program was effectively implemented with no reported deaths from malaria or dengue in Tenkasi.
- Endemic districts completed TAS-III for filariasis and awaited subnational elimination certification.
- Dengue reporting increased due to better IHIP integration; sentinel labs for Dengue and JE were available with required equipment and logistics.
- Surveillance remained strong with entomological teams working across zones; RDTs and microscopy were available at all facilities, IHIP reporting reached 100%, dengue vector control measures with Domestic Breeding Checkers and intersectoral coordination were excellent, and drug supplies remained adequate for malaria and dengue.
- M1-M4 registers were not consistently available in all health facilities; MMDP services at AAM facilities were inadequate, and malaria testing for IP fever cases was not being done at DHQs.

NRCP

- ARV, RIG, and wound-washing stations were available above PHC level; Cat-III cases uniformly received RIG administration and registers, and reporting formats were well maintained.
- Awareness among the population regarding rabies prevention and treatment was good.
- Orientation gaps persisted among MOs at AAM-PHCs regarding Cat-III bites and immunocompromised patient management in DHQ.

NPPCSE

- ASV was available above PHC level, and state-level and district-level training had been conducted for healthcare providers.
- Medical officers were aware of ASV protocols and management guidelines.

NP-NCD

- Tamil Nadu's MTM scheme ensures home delivery of drugs for hypertension and diabetes for two months, with robust screening, drug availability and IEC at all health facilities; follow-up of patients referred for dental or advanced NCD care was poor; VIA and breast cancer screening was available.
- AYUSH Medical Officers contributed significantly to NCD screening and HMIS 3.0 data entry.
- In Tenkasi, cancer screening prioritisation for high-risk groups was lacking, and oral biopsy services were not operational in DHQ despite available pathology staff.
- STEMI and stroke care had critical gaps, with low post-lysis transfer rates and delays in CT reporting.
- Spirometry machines were installed but drug supplies were insufficient.
- In Salem, chemotherapy services were provided through a 10-bedded DCCC at the medical college, catering to around 40 patients daily, but it was yet to be functional at DHQ Tenkasi.

NPCBVI

- PMOA was available in Salem DHQ but was not available at DHQ Tenkasi. However, spectacle distribution was delayed by 2–3 months, and only to a disproportionately lesser number of elderly people in need; ophthalmic blocks in both districts managed cataracts and some glaucoma cases.
- PRP were available but advanced diagnostic tools like OCT and FFA were unavailable at DHQ Tenkasi; ROP screening was being done, but treatment services like lasers and injections required referral to Medical Colleges.

NPHCE

- House visits and weekly sessions at CHC for physiotherapy were being conducted; geriatric OPDs were functional at DHQs, but most elderly patients presented with routine hypertension, diabetes, and orthopaedic issues; Physiotherapy awareness remained poor among the general population despite 'MTM' outreach.

NPPC

- DHQ Tenkasi had a daily OPD and palliative ward, but the HR were not trained in narcotic prescription, limiting effective pain management; basic procedures were also not performed regularly.

- Morphine supply systems were functional with double-locker safeguards; psychological services were not being provided; admission numbers remained low and misaligned with criteria.
- Home-based palliative care was provided with a community palliative staff nurse (visiting 6 days/week) and physiotherapist (visiting 4 days/week) in both Tenkasi and Salem. CAPD bags were also being provided at home.

NOHP

- Dental services were available from CHC level upwards, with dentists and functional dental chairs. Basic procedures were being provided, and UV chamber to maintain sterility of equipment at DHQ Tenkasi were available. Hepatitis-B vaccination for dental staff was incomplete. Additionally, space and HR constraints were observed at district.

NTCP

- Tenkasi lacked a TCC and had no structured referral or record-keeping system. COTPA enforcement measures such as no-smoking signage were visible.
- Salem had an active tobacco control cell conducting outreach screening, counselling, and school-based ToFEI certification. Majority of schools had been certified with ToFEI certification. Tobacco-free villages and health facilities were declared, though documentation of counselling by frontline workers was inadequate.

NIDDCP

- Salt testing was conducted regularly using the salt testing kits, but certain CHC areas reported suboptimal iodine levels below 15 ppm; advanced titration-based testing and UIE assessments at the state lab were not happening due to human resource shortages, resulting in surveillance gaps.

NMHP

- Tamil Nadu's DMHP was active and provides wide outreach through satellite clinics, mobile follow-ups, and integration with jails and institutional homes; Tele MANAS number was displayed in all health facilities, along with district's phone number to provide counselling; ECRC and De-addiction services were available in Salem but missing in Tenkasi.
- The MaNaM programme: Youth mental wellbeing was implemented in schools and colleges but has not significantly reduced suicide attempts among 12–25 year olds as per DHQ Tenkasi data.

Telangana

Maternal Health

- While labour rooms show good practices such as proper case-sheet and partograph maintenance with adequate medicines and NBCC availability, privacy issues in

labour rooms due to inadequate curtains was observed. Absence of ART centres at DHs, hinder quality of care and patient experience within national programme components.

- Anaemia among adolescents remains a major challenge, and FP uptake remains low, indicating need for stronger programme convergence and counselling.
- Data mismatch between U-WIN and the MCH portal reflects weak reporting mechanisms.

TB Mukh Bharat Abhiyan (NTEP)

- CBNAAT testing for TB was conducted at GGH, while admissions occurred at Area Hospital, leading to fragmentation of care.

Non-Communicable Diseases

- Telangana has strengthened its continuum of care by expanding specialized services across government health facilities.
- The state has also operationalized 34 palliative care centres with OPD, IPD (6–10 beds), and home-based care, serving 17,930 OP clients, 2,940 inpatients, and providing home care to 320 beneficiaries.
- Mental health clinics were functional in all 33 district hospitals, enhancing access to psychiatric services.
- 32 elderly physiotherapy clinics support the growing geriatric population with rehabilitation and mobility services, collectively contributing to a more comprehensive, inclusive, and patient-centred health
- Dialysis units, although functioning well, lacked regular monitoring and were not integrated with PMNDP, leading to missed opportunities for comprehensive NCD management.
- A total of 154 dental surgeons were providing services across 114 CHCs/UCHCs, 29 Area Hospitals, and 10 District Hospitals, benefitting 2.40 lakh people in FY 2025.
- Insufficient number of physiotherapists and psychiatrists, along with limited awareness among specialists and medical officers regarding available services under the National Health Programmes was observed.

Uttarakhand

Maternal health

- CEmONC services were available at the district hospital & SDH in Chamoli district but were available only at DH and not at the SDH and CHC level in the US Nagar district.
- Adequate supplies of essential and emergency medicines including inj. Oxytocin, birth doses of vaccines (Hep- b, OPV-0) and antibiotics were available.

- High-risk pregnancies with anaemia, PPH, hypertension and previous history of LSCS were observed in community and mostly referred to the medical college in nearby district.
- Birth waiting homes were available at DH/SDH in Chamoli district but their utilization was low.
- PMSMA sessions were conducted on 9th of every month and 4 additional days for E-PMSMA were also identified. In house USG service for ANC were provided at district hospitals on daily basis and twice a week at Sub district hospitals which were covering the peripheral facilities as well.
- Free entitlements under JSSK were also being provided. However, Out-of-pocket expenditures for ANC and delivery were observed and confirmed by the beneficiaries during community interactions.
- Targets for SUMAN notification of public health facilities were achieved in both the districts. However, SUMAN branding was an area of concern in most of visited facilities in US Nagar.
- Maternal Deaths were being reported in the MPCDSR software, however, few Community based death surveillance was pending for the facility level maternal death in U S Nagar district.
- Most of the Staff Nurses posted in labour rooms were not trained in SBA, Daksh or Dakshta training.
- Register for PMSMA was not maintained separately at any level of facilities. Further, there was no High Risk Pregnancies (HRPs) line listing maintained under E-PMSMA and not updated on the portal.
- Most of the medical officers posted at SDH and CHC level facilities in US Nagar district were not trained in BEmONC and CEmONC curriculum and not able to manage the complicated high-risk cases therefore they have to refer them at higher facilities.

Family Planning

- PPIUCD, IUCD (375m-5 years and 380m-10Y), oral contraceptive pills (OCPs) i.e. Mala-N, Chaya Pills, condoms, were available at DH in both districts. However, Antara Injections were unavailable since last two years in US Nagar district and stock outs of FP Commodities were reported at SDH Karanprayag in Chamoli District.
- PPIUCD was reported as the most popular method while Male sterilisation was negligible.
- Family planning registers were maintained at all facilities, including follow-up registers for PPIUCD. The expulsion or removal details were only maintained for PPIUCD not for IUCD.

- Sterilization services were available in both the districts. Ligation camps were also being held as routine facility-based ligations were minimal. Laparoscopy services were limited and require training of staff to strengthen this component at DH.
- Sugam model (received 6 months back in facilities) was available and functional; however, the light was not functioning in DH. Family planning display kits were used to sensitize women/couple while use of penial model was negligible.
- The Self Care Kit with Nishchay kit and ECPs were well placed at the reception and the supplies were replenished every day in DH.
- FPLMIS was functional and was being used to maintain FP commodity supply chain.
- In CHC, the family planning counselling desk was located along with eye testing (male optometrist), hence, women felt uncomfortable to receive the services.
- A total of 552 health facilities (393 Public & 159 Private) were registered in the state to provide MTP services. There was a lack of trained staff to provide comprehensive abortion services. MTP services were only provided at DH and SDH in the visited districts.

Child health

- Separate Kangaroo Mother Care (KMC) rooms were not available at visited facilities; However, KMC was being practiced.
- Newborn identification tags were used and mothers received counselling on breastfeeding, danger signs, and KMC care.
- Referral of sick newborns was done to Medical College in nearby districts. Two newborn deaths were reported in current financial year due to congenital disorder and extreme prematurity.
- Posted staff nurses were trained in FBNC module and aware of the essential newborn care skills, use of Ambu bag for Neonatal resuscitation and its disinfection protocol.
- Newborn Stabilization Unit (NBSU) was not functional at SDH or below level facilities.

Immunization

- Essential immunization equipment, including Ice Line Refrigerators (ILR) and deep freezers, were available and functional.
- The Electronic Vaccine Intelligence Network (e-VIN) was functional and utilized for stock monitoring, ensuring efficient vaccine management. However, wrong machine numbers reflected in e-VIN, which does not ensure that correct devices were monitored. The updation of e-VIN every one hr needs to be ensured.
- AEFI kits available with ANMs and new AEFI register format (since Sept) with manufacturer details were available. The AEFI register were maintained at the facilities.

- ANMs reported difficulty in entering AEFI details on U-WIN indicating need for capacity building.
- The open vials were stored as per the protocols. Visible vaccine vial monitors (VVMs) and labelling of open vials with date and time were observed. However, placement of the vaccines on icepack was not found as per protocol in one of the visited facilities.

Child Nutrition

- Comprehensive Lactation Management Centre (CLMC) was established in both the district Hospitals and was staffed by paediatricians and staff nurses. While a deep freezer was available, Human Milk Bank was not available in Chamoli district. Nurses were providing lactation support at facilities & Role reinforcement on Breastfeeding at delivery points. Breast feeding corners found at the district hospital with adequate privacy.
- Nutrition Rehabilitation Centre (NRC) were not functional in Chamoli limiting management of severe and moderate acute malnutrition (SAM/MAM) cases.
- In US Nagar district, a 10bedded NRC was established on a 24×7 basis at the District Hospital, but the bed occupancy rate remained below 40%. Admissions were primarily from the District Early Intervention Centre (DEIC) and OPD screening, with limited mobilization of children from the community.
- The average length of stay for children was 8–9 days, with average weight gain of 7–10% before discharge during the current financial year.
- Essential equipment such as infantometer/stadiometer, glucometers, feeding jars, and spoons were not available. Additionally, TV screenings for caregiver education on nutritious food preparation and supportive recovery practices were not displayed.

RBSK

- In Chamoli district, Rashtriya Bal Swasthya Karyakram (RBSK) services were functional across all blocks; however, staffing was suboptimal, with only one Medical Officer per unit in most blocks, limiting the program's capacity to achieve screening targets.
- District Early Intervention Centre (DEIC) has not been established in Chamoli district yet limiting management of developmental delays or congenital defects and requiring referrals to out of the district.
- In US Nagar district, the District Early Intervention Centre (DEIC) provided comprehensive secondary and tertiary care to children aged 0–18 years.

Adolescent Health

- In Chamoli district, the Adolescent Friendly Health centre (AFHC) at the District Hospital (DH) did not have a dedicated functional space and operated within a shared unit without partitions, compromising privacy and confidentiality.

- Although two counsellors were posted, only one could function at a time due to space constraints. Iron and Folic Acid (IFA) tablets, Albendazole, and Emergency Contraceptive Pills were available, but sanitary napkins were not provided since last year. Staff also lacked digital tools such as tablets or laptops for data entry.
- In US Nagar district, AFHCs were operational at Community Health Centres (CHCs) and higherlevel facilities, providing counselling and clinical services to adolescent girls and boys. In addition to facilitybased services, outreach activities were conducted twice weekly in schools and Anganwadi Centres (AWCs).
- Free sanitary napkins were provided to adolescent girls visiting AFHCs, though pregnancy testing kits were not available at the clinics visited. Trained AFHS counsellors were posted at DH, SDH, and CHC facilities. However, BMI charts were not available at the facilities assessed.

TB Mukht Bharat Abhiyan (NTEP)

- Under NTEP, services were effectively decentralized for diagnosis and treatment, with a notification rate of 118% in US Nagar and 73% in Chamoli district. Diagnostic testing was performed using CBNAAT and TruNAAT at the DH.
- Diagnostic services included X-ray imaging, available at a charge of ₹195, with no cost for Below Poverty Line (BPL) patients. Although mobile X-ray units were available, their utility was limited due to the absence of trained technicians. Follow-up was conducted through phone calls and field visits.
- Active Case Finding under TB Mukht Bharat Abhiyan was being conducted with 55% enrolment in US Nagar & 53% in Chamoli of the vulnerable population.
- The turnaround time for Line Probe Assay in drug-resistant TB cases was 2–3 months, leading to delayed diagnosis.
- Senior Treatment Supervisor (STS) and Senior Tuberculosis Laboratory Supervisor (STLS) were available and follow up was also being done by STS to monitor treatment adherence.
- Stock of TB drugs was maintained using the integrated DVDMS-Nikshay Aushadi portal.
- TPT was administered to contacts of pulmonary TB cases and high-risk groups, with both three-month and six-month regimens provided based on medical advice. Acceptance of TB Preventive Therapy (TPT) remained low, and follow-up was also a challenge.
- NPY benefits were disbursed upon notification from the district headquarters, with entries maintained in designated registers. However, Direct Benefit Transfer (DBT) backlog under the Nikshay Poshan Yojana (NPY) was observed due to issues in SNA SPARSH implementation.
- Stigma remained a significant barrier, with patients often requesting confidentiality and asking that their diagnosis not be disclosed even to ASHA workers.

- Records such as the TB notification register and TB laboratory register were available and up to date at the District TB Centre (DTC), and treatment cards were verified and found to be updated.
- IEC materials were prominently displayed at the DTC. ASHA workers were actively involved in ensuring compliance with TB treatment.
- Intermittent interruptions were observed in the Nikshay portal. Co-morbidity screening facilities and fixed X-ray facilities were not available at the DTC in US Nagar district.
- The districts lacked specialists for complicated TB cases, and patients were referred to medical colleges for management.

NLEP

- In Chamoli, confirmatory leprosy testing was conducted at Medical College Srinagar, with staff not familiar with Nikusth 2.0 and records maintained manually, indicating a need for digital reporting training. IEC/BCC activities were ongoing; however, discrepancies in leprosy data were observed between SDH records and NHM office data.
- In US Nagar, the leprosy programme was active with ASHA-led surveillance and community camps for early detection, supported by free MDT, MCR footwear, self-care kits, and contact prophylaxis at DH and SDH; records and treatment cards were up to date, though continued case detection indicated ongoing transmission.
- Key gaps remained, including absence of skin smear testing and reconstructive surgery facilities, along with inconsistencies between Nikusth portal entries and manual records.

NACP

- Routine HIV screening was conducted for pregnant women as part of antenatal care at PHC Chamoli and SDH Karanprayag.
- In US Nagar, a functional ICTC was available at the District Hospital with trained staff, and all ANC cases were screened using dual HIV and syphilis dual kits at DH and SDH, with free drugs and diagnostic services available.
- Patient records were well maintained at DH, and IEC materials were prominently displayed across DH, SDH, and CHC facilities.

NVHCP

- In US Nagar, Hepatitis B and Hepatitis C screening was conducted at DH and SDH, with routine ANC screening, treatment services at DH, and Hepatitis B birth dose administered in labour rooms. However, HBIG was not available, viral load testing was conducted via PPP despite availability of TrueNAT machines, and NVHCP portal reporting was limited to positive cases only.

- Active case search for Hepatitis C was required in high-burden areas of Udham Singh Nagar, with strengthened linkage to care under NVHCP.

NVBDCP

- Disease surveillance was functional under NVBDCP with same-day malaria reporting, ELISA results within three days, and routine IHIP-based data entry supported by equipped District Public Health Laboratories and trained microbiologists.
- Vector-borne disease management systems were strengthened with functional RRTs, dedicated dengue wards, ASHA/DBC-led source reduction, entomologist monitoring, and structured trainings and IEC activities, ensuring no dengue referrals to higher centres.
- JE surveillance showed limited burden but systemic gaps, including one reported case in Rudrapur; while PMR services and fogging activities were available, JE vaccination had not been initiated.
- Institutional strengthening remained partial, with a functional DPHL not yet integrated with IPHL, ongoing VPD surveillance transition gaps, and medical colleges not formally included in RRTs despite supporting diagnostics and reporting.
- Programmatic preparedness varied across districts, with Chamoli progressing towards malaria-free certification, while US Nagar demonstrated functional DH–SDH–CHC implementation but lacked a structured death audit committee and had partial drug availability (ACT limited to DH).

IDSP

- The state maintained a robust IDSP–IHIP surveillance network across 2,726 health facilities, with village health mapping completed in 1,043 villages in Chamoli and 922 in Udham Singh Nagar, strengthening grassroots surveillance.
- Under IDSP, weekly P and L form reporting was conducted through the IHIP platform with participation from both public and private facilities, supported by periodic capacity building of ASHAs and medical officers through state-level trainings
- In US Nagar, S, P, and L forms were routinely filled at facility level, with a functional RRT, District Public Health Laboratory, and regular district task force meetings, although reported measles and diphtheria cases highlighted the need for strengthened surveillance sensitivity.

NRCP

- ARV and ARS were available and included in the Essential Medicines List, with regular training of healthcare workers on animal bite management and rabies PEP, supported by IEC display across facilities. However, reporting discrepancies persisted due to dual entry in digital and manual systems.

- In US Nagar, ARV and ARIG were available at DH, but ARIG was not available at SDH despite a high animal bite burden (6,229 cases till October 2025), with overall ARV supply remaining limited at peripheral levels.

PPCL

- Doxycycline was available at the visited health facilities, ensuring prophylactic treatment capacity for suspected leptospirosis cases. However, no in-house diagnostic facility was available at any of the facilities
- In Chamoli district, confirmatory testing was conducted at the Medical College, Srinagar.

NPPCSE

- ASV was available at both DH and Sub-District Hospital (SDH) in both the visited Districts. Healthcare providers were trained and informed about snake bite management protocols, and informative wall posters were prominently displayed at DH and SDH facilities to support community awareness and patient education.

NP-NCD

- NP-NCD programme was being implemented at DHs & SDHs, though services were limited to management of HTN, DM, oral & breast cancer. Dedicated area for NCDs including oral health, Eye, ENT were available at DH in Chamoli district but was underutilized. Designated NCD clinics were not observed at the SDH level, and follow-up was weak; records well maintained in registers and updated on portal.
- Training of health staff for cancer screening services was underway; IEC interventions promoting risk reduction, such as tobacco cessation were observed; standard protocols for NCD were not being adhered to.
- The infrastructure for a Cancer Care Unit was available at DH but remained non-functional. The existing day care centre under NCD was functional as palliative care ward with suboptimal utilization.
- An ECG machine was available for STEMI screening at DH, but staff were not aware of the programme. Implementation was not observed for stroke, COPD, or NAFLD at DH, SDH, or CHC levels.

PMNDP

- Dialysis Centres in both districts were functional in PPP mode; staff was adequate and trained; machine availability was limited in one district; nephrologist was available on visiting basis; no user charges levied from the patients for the dialysis and drugs; no waiting list observed; no machine was available for the sero-positive cases at the centre.

- RO plant was functional, with regular testing of TDS and cleaning of loop lines; periodic sample was also being sent for testing of chemicals, heavy metals & microbiological parameters.

NPCBVI

- Diagnostic facilities along with cataract surgery and minor eye surgery services were available at the DH; regular eye screening outreach camps were being organized in collaboration with the RBSK at district level; at the sub-district level, the village blind register was maintained; drugs were available at both DH and SDH, and free spectacles were being distributed under the programme.
- Services at SDH and CHCs were limited due to a shortage of specialists; screening services were provided by optometrists at SDH, though equipment availability was limited.
- The districts lacked diagnostic and management services for diabetic retinopathy, and there were no IEC activities or training programmes for glaucoma and other eye conditions at the community level.

NPPCD

- At the DH in US Nagar, an ENT specialist and an audiometric assistant were available and the program was functional in collaboration with Rashtriya Bal Swasthya Karyakram (RBSK); In Chamoli district, at the DH level, infrastructure and equipment were available but due to unavailability of audiologist, desired services could not be provided and patients were referred to higher centres.
- Program was not functional at the SDH and CHC levels due to the absence of specialists and essential diagnostic equipment in these facilities.

NPHCE

- In US Nagar district, beds were earmarked for elderly patients in the inpatient departments (IPD) of the DH & SDH, but these were not functional; physiotherapy unit was available at the SDH; separate geriatric outpatient services were not established, however, a facility of a separate OPD queue for elderly patients was provided.
- Free health services were available for elderly patients at the DH, SDH, and CHC; no active field-level interventions were being carried out for health assessment of the elderly, and there was no system of regular home visits for the care of homebound or bedridden elderly patients.

NPPC

- Palliative care program was in a nascent stage. Basic procedures such as wound care and catheterization were available at the DH & SDH; however, no separate records for palliative care patients were maintained.

- There was no dedicated palliative care OPD at the DH, SDH, or CHC in US Nagar and healthcare providers have not been oriented on the palliative care program.
- In Chamoli district the existing DCCC at DH was functional as palliative care ward with suboptimal utilization.

NOHP

- Under NOHP, dental services were available at DH & SDH level in Chamoli district. Essential instruments and consumables were available enabling provision of basic procedures.
- At the DH in Udham Singh Nagar, well-equipped and appropriately maintained Dental clinic with dental specialists; trained staff was available providing services including extractions, restorations, scaling, and root canal treatments; in contrast, although dentist was available at the SDH level in US Nagar, service delivery remained limited due to inadequate availability of equipment and consumables.

NTCP

- TCCs were functional in both visited DHs, offering both counselling services and pharmacological (nicotine gums). Implementation of TOFEI was poor as achievement was very low against the targets; “No Smoking” signage, IEC was displayed in the health facilities and community awareness programs on anti-smoking and tobacco control, were being actively conducted; challans were also being issued for violation of COTPA Act.
- The initiative was well integrated with the Rashtriya Kishor Swasthya Karyakram (RKSK), ensuring a holistic approach to youth health and tobacco cessation.

NMHP

- In US Nagar district, a psychiatric OPD and Mental Health Unit were operational at the DH; a dedicated helpline number was also available at the DH; essential psychotropic drugs were stocked at the DH; psychiatrist availability was not observed in Chamoli, and limited number of psychotropic medicines (Diazepam, Alprazolam & Fluoxetine) were available at DH, however, a counsellor was available who was providing counselling services through camps in Jails and other community places.
- Outreach camps were being conducted along with counselling sessions in schools, colleges, and the community, and the program was integrated with the Rashtriya Kishor Swasthya Karyakram (RKSK) in US Nagar district
- Tele-MANAS linkages was not observed at the visited facilities.

NPCCHH

- In US Nagar district, an action plan and LED display were available at the DH; at the SHD, a poster with the helpline number was displayed. However, no task force had been formed, and designated beds for heat-related illness or acute respiratory infections (ARI) had not been identified.

NSCAEM

- District Udham Singh Nagar had screened the population for sickle cell anaemia and the six patients were being treated with hydroxyl urea. HPCL machine was available and diagnosis and treatment is being done in the district.
- Screening for Sickle cell disease had been conducted for the vulnerable and eligible population in Chamoli.

Uttar Pradesh

Maternal Health

- Emergency obstetric care services were available at secondary care facilities; however, functionality was affected due to shortage of specialists and human resource gaps.
- Infrastructure readiness was suboptimal, with several facilities lacking functional sterilization rooms, attached washrooms in PNC wards, and properly installed equipment such as autoclaves and NBCC units.
- Uterotonics were being used for induction without adequate monitoring, and partographs were poorly maintained across facilities.
- Identification and referral of high-risk pregnancies were delayed in several facilities.
- Postpartum haemorrhage was under-reported due to absence of maternity pads and reliance on cloth usage by beneficiaries.
- Laboratory services were not available round-the-clock, and lack of point-of-care tests resulted in out-of-pocket expenditure.
- ANC and PNC wards were not separate in some facilities, compromising privacy and quality of care.
- Documentation gaps were observed including missing registers, ANC reporting, and inconsistent USG tracking.
- ASHA support during labour room admissions was inconsistent and awareness of entitlements such as JSY and JSSK was limited.

Family Planning

- Uptake of permanent family planning services, especially post-partum sterilization and male sterilization, was low.
- Family planning counselling was weak at facility level, affecting service uptake.
- IEC materials were not user-friendly and had language barriers limiting comprehension among beneficiaries.
- Governance compliance for MTP services existed; however, gaps were observed in facility-specific approvals and SOP adherence.

Child Health

- SNCUs were functional; however, utilization was uneven with one facility showing 133% bed occupancy and another around 30%.
- CPAP machine was not available at District Women Hospital, Balrampur.
- HMIS data entry at SNCU level was incomplete, affecting resource allocation.

Child Nutrition

- NRCs were functional; however, gaps were observed in follow-up care post discharge.
- Repeat haemoglobin testing was not done in some cases prior to discharge.
- Linkages with communicable disease screening such as TB were inadequate.

Rashtriya Bal Swasthya Karyakram (RBSK)

- Limited DEIC availability affected service delivery for special children.
- Counselling services for congenital conditions were inadequate.

Adolescent Health

- RSKS services were functional through Saathiya Kendras at DH and CHC levels.

TB Mukh Bharat Abhiyan (NTEP)

- Diagnostic scale-up remained partial, with NAAT coverage reaching 73% of blocks (930 machines), but testing uptake remained below 50% due to continued reliance on sputum microscopy.
- Under TB Mukh Bharat Abhiyan, about 50% of line-listed vulnerable population was enrolled in Ni-kshay, but only 27% were offered X-ray screening.
- Ni-kshay Poshan Yojana DBT payments were on hold due to SNA SPARSH issues, though the state could initiate direct payments via IFMIS and reconcile subsequently in Ni-kshay.

NLEP

- Leprosy burden remained minimal and concentrated in certain pockets, but lack of focused teams at district level across all districts led to gaps in surveillance, early case detection, and follow-up care.
- Child cases and Grade-II disabilities continued to be reported, indicating active community transmission and delayed detection.
- Leprosy Case Detection Campaigns (LCDC) were conducted in only 47 out of 75 districts, with the western zone of Uttar Pradesh excluded due to lack of dedicated human resources, resulting in poor case detection.

NVHCP

- The NVHCP was implemented across the state through 6 Model Treatment Centres, 6 State Reference Laboratories, 105 Treatment Centres, and 95 District Laboratories.
- Hepatitis C positivity exceeded 1%, indicating a generalized epidemic with spread in the general population.
- Need existed to strengthen screening for Hepatitis B and C among vulnerable populations, scale up vaccination, and enhance surveillance among blood bank voluntary donors, pregnant women, and high-risk groups such as sex workers, men having sex with men, injecting drug users, migrants, and truckers, in coordination with UP State AIDS Control Society (UPSACS).

NVBDCP

- Good control and prevention activities were implemented for vector-borne diseases, with AES/JE and other vector-borne disease control as top state priorities.
- Special annual campaigns were organised including a one-month communicable disease control campaign and a 20-day door-to-door campaign conducted in three phases.
- Inter-departmental activities, public awareness campaigns, and publicity efforts resulted in decreased patients and deaths from all vector-borne diseases, especially encephalitis (AES/JE).

IDSP

- The state developed a UDSP portal for reporting IDSP/IHIP-related diseases, but a mismatch was observed (under-reporting in UDSP), with only 20 out of 50 outbreak-prone diseases reported in UDSP compared to IDSP/IHIP requirements.
- The Metropolitan Surveillance Unit was not yet operationalized, with the only gap being posting of human resources by the state to this centre.

NRCP

- Rabies prevention services were integrated with general OPD and emergency services, but dedicated animal bite clinics remained limited, especially at peripheral facilities.
- PostExposure Prophylaxis (PEP) was available at district hospitals and selected CHCs; however, intermittent stockouts of AntiRabies Vaccine (ARV) were reported at PHC level, leading to referrals or delayed initiation of treatment.
- Intradermal (ID) rabies vaccination was not uniformly implemented at lowerlevel facilities and Rabies Immunoglobulin/AntiRabies Serum (RIG/ARS) availability remained inadequate and largely restricted to higherlevel facilities.

- Recording and reporting of animal bite cases under IDSP/IHIP and NRCP showed discrepancies, reflecting data quality issues and duplication of records.
- Intersectoral coordination with Urban Local Bodies, Veterinary Departments, and Municipal Authorities for stray dog management and animal birth control was limited, weakening the One Health dimension of rabies control.
- While ARV was generally available at district hospitals, its availability at CHC/PHC level was inconsistent; drug logistics management systems required strengthening through realtime monitoring, demandbased forecasting, and regular audits.

PPCL

- Leptospirosis surveillance was integrated under UDSP, but underreporting was likely due to low clinical suspicion and limited index of suspicion at primarycare level.
- Laboratory diagnostic capacity for leptospirosis (ELISA and confirmatory tests such as MAT/PCR) remained limited to selected districts or statelevel laboratories, restricting timely confirmation and case ascertainment.
- Seasonal preparedness during the monsoon was variable, with awareness and preventive activities not uniformly implemented in highrisk and endemic areas.
- Coordination between health, animal husbandry, and local administration was weak, limiting the effectiveness of a One Health response to outbreaks and risk periods.

NPPCSE

- Snakebite cases were managed across multiple facilities, but standard treatment protocols were not uniformly displayed or followed at all health facilities.
- AntiSnake Venom (ASV) was available at district hospitals and CHCs; however, quantities at peripheral facilities were often inadequate, and coldchain maintenance and stock monitoring required strengthening.
- Training of medical officers and nursing staff on snakebite case management, early referral, and rational ASV use was inconsistent, contributing to variability in clinical practice. Additionally, delays in referral from the community and peripheral facilities increased morbidity and mortality among snakebite cases.
- Community awareness on correct first aid, early reporting to health facilities, and myths related to traditional practices for snakebite remained limited.
- ASV was available under freedrug initiatives; however, stock forecasting, timely replenishment, and rational use of ASV needed systematic strengthening to avoid shortages and wastage.
- Surveillance of zoonotic diseases remained largely humanhealthcentric, with limited routine data sharing and feedback loops between the human health, veterinary, and wildlife sectors.

NP-NCD

- Balrampur district was planning for establishing a cancer care centre.
- PMNDP, NAFLD & COPD programme activities were implemented in all 75 districts, while STEMI was being implemented in 35 districts & Stroke in 7 districts across the State.

PMNDP

- Dialysis units have been operational since 2018 on a PPP mode; adequate HR and equipment was available; of the active dialysis cases, over one-third of the active cases were found to be aged below 40 years; water testing was being done quarterly – AAMI (Mineral, Heavy Metal) tests and Bacterial Endotoxin tests were conducted monthly.
- Lack of clarity was observed on the criterion of marking patients as inactive. Demand-supply issues were also observed with waiting list of 7-10 cases approximately.

NPCBVI

- State achieved its set targets with more than 17 lakh cataract surgeries conducted and free spectacles were distributed to 1.9 lakh children & 1 lakh elderly persons in 2024-25.
- Cataract service delivery in the district shows active collaboration with multiple providers; however, there remains a higher dependency on private and NGO facilities as compared to government hospitals.
- Although three eye surgeons were posted, only one was routinely performing surgeries.
- Additionally, beneficiary contact details were not captured during spectacle distribution, limiting follow-up and service continuity.

NMHP

- Mental Health programme is implemented across the State. There were 4 Tele Manas Cells functional in Bareilly, Agra, Varanasi and Gorakhpur with more than 60 Counsellors with Mentoring Institute at Department of Psychiatry, KGMU, Lucknow.



REFERRAL TRANSPORT SYSTEM /NATIONAL AMBULANCE SERVICES

17th

REFERRAL TRANSPORT SYSTEM /NATIONAL AMBULANCE SERVICES

NATIONAL OVERVIEW

Emergency Medical Services (EMS) play a crucial role in saving lives by providing time-sensitive care and transportation to healthcare facilities during emergencies. EMS is particularly significant because of the country's expansive geography and large population. Over the years, Indian ambulance services have evolved significantly, starting with the Centralized Accident and Trauma Services (CATS) in 1991 and evolving into the comprehensive National Ambulance Services (NAS) under the National Health Mission (NHM) in 2012. Dial 108 is primarily designed to attend to patients in critical care, trauma, and accident victims. Dial 102 services include basic patient transport that aims to cater to the needs of pregnant women, children, and others.



The NHM provides technical and financial support for emergency medical services in States/UTs to establish referral linkages through a functional National Ambulance Service (NAS). Support for one ALS ambulance per five lakh population and one BLS per one lakh population is provided to the states/UTs.

According to the NHM-MIS June 2025 Report, over 28,321 ambulances under the NHM are operating across 36 states/UTs, providing emergency and patient transport services. It includes 3,129- ALS, 15,251- BLS, 3,926- PTV, 19 boat, 81 bike and 5,915- other ambulances.

KEY OBSERVATIONS AND CHALLENGES

1. Ambulance Availability, Distribution and Functionality

- Referral transport services through 102 and 108 ambulance networks were operational across most states, supported by centralized call centres and operational in public-private partnership models.
- The distribution was uneven and was influenced by geography and population density. Basic Life Support (BLS) ambulances were generally more available than Advanced Life Support (ALS) ambulances.
- Ageing fleets, delayed replacement, and non-functional or poorly maintained vehicles were reported in many states.
- Some states have introduced specialized transport models, such as feeder ambulances, boat ambulances in riverine regions and neonatal transport units.

2. Response Time, Accessibility and Geographic Constraints

- Ambulance response times vary significantly across states and districts and were largely determined by geography, terrain, and fleet placement.
- Urban areas generally experience faster response times than rural, tribal, and mountainous regions which had longer response times.
- Night time response was slower in some areas because of limited vehicle deployment or logistical constraints.

3. Equipment Availability and Clinical Preparedness

- Some ambulances lacked advanced life support features, monitoring devices, neonatal transport equipment, and essential diagnostic tools.
- Routine equipment checks, maintenance, and replenishment were not uniformly practiced.

4. Human Resources and EMT Capacity

- The shortage of trained Emergency Medical Technicians (EMTs) was a recurring challenge across multiple states. In some areas, ambulances operate without adequate clinical support, and drivers transport patients independently.
- Where EMTs were present, skill gaps in trauma management, neonatal transfer, advanced resuscitation, and emergency decision-making were frequently reported. Regular refresher training, competency assessments, and structured skill-upgradation programs were limited or inconsistently implemented.

5. Monitoring Systems, Digital Tracking and Data Use

- GPS tracking and centralized monitoring systems have been implemented in some states, but their coverage and functionality was inconsistent.
- Documentation and record keeping remained weak across several states. Referral slips, trip logs, equipment maintenance records, and follow-up tracking were often incomplete or poorly maintained.

6. Service Utilization and Community Awareness

- Despite the availability of free ambulance services, their utilization remains suboptimal in several areas. Limited awareness, accessibility barriers, and perceived delays lead patients to rely on private transportation.
- Knowledge of emergency helplines and referral transport entitlements varied widely among communities.

7. Maintenance and Infection Prevention Practices

- Maintenance, sanitation, and infection prevention practices were inconsistent. Equipment checks, vehicle servicing, and routine inspections were irregular in certain regions.

- Supervision and monitoring at the district and state levels were often insufficient. Operational challenges were further compounded by difficult terrain, high maintenance costs, weather-related disruptions, and infrastructure limitations.

KEY RECOMMENDATIONS

1. Strengthen Fleet Planning and Infrastructure

- States to ensure the equitable distribution of ALS and BLS ambulances based on geography, population, and travel time and replace aging and non-functional vehicles through systematic procurement and condemnation policies.

2. Improve Response Efficiency and Accessibility

- States to optimize ambulance deployment using geographic mapping, service demand analysis, and response time monitoring and simplify call centre protocols to improve dispatch responsiveness to reduce delays. Ensure adequate fleet deployment during night hours and peak demand periods.

3. Standardize Equipment

- States to ensure the uniform availability of essential equipment and emergency medicines in all ambulance categories and routine equipment inspection, maintenance, and replenishment systems should be implemented.

4. Strengthen EMT Workforce and Capacity Building

- States to ensure that every operational ambulance is staffed by a trained EMT and institutionalize periodic refresher training, certification, and competency assessments. Specialized training in trauma care, neonatal transport, advanced life support, and emergency decision-making should be provided.

5. Expand Digital Monitoring and Data-Driven Management

- States to implement universal GPS-based fleet-tracking and real-time monitoring systems and establish performance-monitoring dashboards to track response times, utilization, and service outcomes.

6. Strengthen Referral Coordination and Continuity of Care

- States to standardize referral documentation across all facilities and strengthen coordination between referring and receiving facilities to ensure seamless patient transfer.

7. Improve Community Awareness and Service Utilization

- Targeted IEC campaigns should be conducted to improve awareness of emergency transport services and helpline numbers to promote the utilization of free ambulance services in remote and underserved communities.

8. Strengthen Governance, Supervision and Quality Assurance

- Establish structured monitoring and supervision mechanisms at the state and district levels and regular audits of vehicle maintenance, sanitation, and service performance should be conducted.

STATE SPECIFIC OBSERVATIONS

Andhra Pradesh

- The State has implemented a unique emergency access model through the Feeder Ambulance, an adapted two-wheeler ambulance designed for transport of patients from remote and inaccessible locations. Equipped with a stretcher-cabin attachment, the Feeder Ambulance provides safe and stable transport to the nearest AAM, PHC or '108' ambulance pickup point, thereby bridging the crucial first-mile gap in emergency response. This model is especially valuable in hilly and tribal areas where terrain and road connectivity limit conventional ambulance movement.



Assam

- The state had a fairly wide ambulance network under '108', which was supplemented by private providers as many private players were also present and provide emergency transportation to patients. Most cases were of snake bites and similar acute emergencies.
- Ambulance services were provided under '108' toll free number. State had a total of 800 ambulances which include 14 ALS, 779 BLS, and 7 boat ambulances. BLS ambulances were saturated as per population norms, but ALS ambulances were still below the required number (72) which limits pre-hospital critical care, especially for obstetric, trauma, and NCD emergencies.
- The average response time reported was approximately 20 minutes which is encouraging but may still be long for time-sensitive conditions.
- Field teams noted that a large share of ambulance use was for emergency conditions, such as snake bites and similar acute events.
- In both districts, ambulance services were visible and generally trusted, but there was a scope for improving integration with facility triage, emergency care protocols, and referral documentation. Private ambulances were also active, but their linkages with the public referral system, standardization of charges, and reporting mechanisms was not clear.
- Assam has invested in a broad referral transport network and is meeting BLS norms. The main gaps were in ALS coverage, integration of '108' with facility-based triage and referral pathways, and systematic use of ambulance data for planning

(hotspots, peak demand, repeated calls). Strengthening these elements will improve emergency response and reduce avoidable delays in reaching the appropriate levels of care.

Bihar

- In Munger district, referral services were being provided through eight ALS/BLS ambulances. In total, 1575 patients in the month of October 2025 were referred from lower facilities to higher facilities for treatment. The average number of trips per day was 1.88.
- In Saran district, ambulance services were available for referral transport from primary and secondary care facilities to the district hospital. '102' was the centralized number for availing ambulance services. All the ambulances ALS/BLS were staffed with a driver and an EMT.
- All Ambulances were GPS enabled. Average trip per day for ALS and BLS was 3.5 and covered distance up to 100 km per day. DH Saran had 3 ALS and 4 BLS ambulances. There was no MMU available for hard-to-reach areas in Saran.
- During community interactions, it was reported that though ambulance services were free of cost, but awareness among the community was low.
- ALS and BLS ambulances were well maintained, services were linked through centralized call centre, but GPS tracking and centralized tracking was not available.

Chhattisgarh

- Both visited districts had emergency and referral ambulance services: '108' Sanjeevani, '102' Mahtari Express, '1099' Muktanjali Seva, departmental ambulances, and MMUs.
- Kanker had 70 ambulances (12 Ambulance in "108", 16 ambulances in "102", 10 ambulances in "1099", 30 departmental and 2 MMUs).
- Mahasamund had 36 ambulances (9 ambulance in "108", 11 ambulances in "102", 7 ambulances in "1099", 7 departmental and 2 MMUs).
- Majority of 108 ambulances were BLS, few were ALS. Average response time was 35–45 minutes; delayed response time in remote areas was generally due to network & connectivity issues.
- Booking was managed through a centralised call centre; however, callbacks and follow-ups remain inconsistent, and community awareness of ambulance services was low.
- Staffing gaps especially shortage of trained EMTs was observed and drivers often transport patients without clinical support.
- Referral slips, call logs, and equipment maintenance records were inadequately maintained, and sanitation practices were found to be irregular.

- Out-of-pocket expenditures were reported in some cases.

Kerala

- Referral transport services were operational through the PPP mode in the state. The district of Kasaragod had 14 BLS Ambulances operational under the '108' services. No ALS ambulance was available under '108' in the district.
- The DH also had facility based BLS Ambulance managed through HMC. Referral transport services were functional across all facilities. GH Pala operated 3 ambulances (1–108 and 2–102), while GH Kottayam had 5 ambulances (3–102 and 2–108).
- GH Pala showed smoother coordination with the EMRI control room and timely dispatch for interfacility transfers. GH Kottayam, being a major referral point, experienced higher demand, leading to occasional delays during peak hours. Documentation of trips, equipment checks, and turn-around time was inconsistent.
- CHC Sachivothamapuram had one ambulance, for routine and emergency use, with partial availability of essential emergency equipment and inconsistent EMT presence at night.
- Ambulance cleanliness was satisfactory in GHs, while consumable stock (like PPE) was irregular at CHC level. Pre-transfer stabilisation and referral slips were generally in place at GH facilities.

Madhya Pradesh

- In Mandsaur ambulance fleet was available as per norms, including 3 ALS, 16 BLS, and 23 Patient Transport Vehicles (PTVs) while in Vidisha fleet size was significantly larger, comprising 32 ALS, 213 BLS, 254 Janani ambulances, and 5 PTVs, reflecting higher district-level demand and deployment.
- Vehicles were observed to be in good condition, with functional GPS, adequate equipment, and up-to-date fitness certification.
- Each ambulance was staffed with an EMT and a pilot; however, EMT knowledge assessment revealed gaps, with only one-third achieving a satisfactory score.
- Response time was reported to be 22 minutes in rural areas and 8 minutes in urban areas in Mandsaur reflecting generally good accessibility while in Vidisha response time was 24.11 minutes (rural) and 16.55 minutes (urban), indicating more variability and longer travel times than in Mandsaur,
- Too many ambulances were stationed at the DH Mandsaur which may be deployed at field to improve the response time.
- There was no clarity on the replacement plan for ageing ambulances, which may affect service continuity in the long term.

Maharashtra

- The State had an ambulance fleet comprising 233 Advanced Life Support (ALS) and 703 Basic Life Support (BLS) ambulances on a PPP Model. Nandurbar district had three ALS and 11 BLS ambulances, whereas Satara had six ALS and 26 BLS ambulances.
- The ambulances observed by the team were clean, well-equipped and staffed by a trained Medical Officer serving as an Emergency Medical Technician (EMT) along with a pilot/driver.
- The district team in Nandurbar reported that the unavailability of medical officer hindered the operationalisation of ambulances and suggested that they could deploy allied and health staff e.g., EMTs instead.
- The ALS operators have adopted several innovative technologies to improve response efficiency, including: “What3Words” (a web application) for precise location and identification of callers, Geotagging of ambulances for real-time fleet monitoring and Good Samaritan App to facilitate immediate assistance from the community.
- The community largely reported positive experiences with the 108 ambulance services. However, a serious operational issue was reported in Satara where the 108-ambulance service refused transport for patients requiring mental health services, indicating a gap in sensitization or protocol adherence.
- In hard-to-reach tribal blocks like Dhadhgaon (Nandurbar), gaps in ambulance availability were noted due to the difficult geographic terrain and the corresponding time taken to complete a trip. Instances were observed where the Taluka Health Officer (THO) had to provide personal funds to ASHAs to hire private vehicles for transporting patients when government ambulances were inaccessible.
- To overcome the geographical barriers to service delivery in the tribal and hilly regions along the Narmada River, State has operationalized boat ambulances covering ~20,000 population in Nandurbar district. The Boat Ambulances also function as floating clinics, carrying medical teams to deliver a range of services, including primary care services, routine immunizations, and antenatal/postnatal check-ups, directly to the remote tribal communities.

Meghalaya

- Critical care services were accessible within 30–60 minutes from major settlement areas in East Khasi Hills, whereas in North Garo Hills, difficult terrain and long travel times (1–2 hours) delayed access.
- ‘108’ and ‘102’ services were functional in both districts. However, North Garo Hills faced significant challenges due to difficult terrain and long distances. Ambulance availability partly mitigates delays, but referral linkages required strengthening.
- Response time was longer during night hours because of limited vehicle deployment. Most ambulances met basic norms but lacked advanced life-support features.

Equipment gaps including defibrillators, suction apparatus, transport incubators and oxygen delivery systems were observed.

- EMT shortages persist across both districts, periodic refresher training in trauma management, neonatal transfers and advanced resuscitation was required.
- Skill gaps contribute to sub optimal prehospital care and inappropriate referral decisions.

Nagaland

- A total of 6 ambulances were available in DH Mon out of which 2 were not in working condition. Only 2 ambulances were functional in DH Zunheboto.
- Emergency medicines and Emergency Medical Technician were not available in ambulances at DH Mon. Oxygen cylinder was available but log book was not maintained.
- Ambulance services were fully chargeable, with user fees of ₹40 per km on Road (A) and ₹70 per km on Road (B).

Odisha

- There were 860 (411 ALS and 449 BLS) ambulances, 500- '108'-RTS (Janani Express) and 6 Boat ambulances operational across the State.
- The ambulance services under Emergency Ambulances (EMAS) (108) and 108 –RTS (Janani Express) were accessible through a single Toll-Free No. "108".
- As per the norms and the approved RFP for Integrated Patient Transport & Health Helpline Services (IPTHHS) Phase II, all emergency ambulance services (ALS and BLS). Ambulances were equipped with the necessary equipment.
- Access to ambulance service (fully equipped with critical equipment and EMTs): As per the approval of Govt. at least one ALS ambulance has been deployed in every Block, equipped with life-saving equipment i.e., Defibrillator, Ventilator and Syringe pump etc. Further, each '108' Ambulance had a trained EMT.
- The concerned helpers of Ambulances were instructed to clean the ambulances upon returning to their base location after dropping a patient at the hospital to ensure infection prevention.
- The operations of Integrated Patient Transport & Health Helpline Services, Phase-II project in the state was being managed by the Service providing Agency (M/s EMRI-GHS). The Agency has been selected for five years (2024 -29) through an open tender process for the Operations & Management of the Ambulance Services in Odisha.
- There was no separate response time for rural and urban areas hence a single average response time (20 Minutes & 12 Seconds) was being considered for the entire fleet and not on the basis of geography.

- Out of the total fleet capacity (860 '108'-EMAS ambulances) of the state, 421 EMAS ambulances were due for replacement for which as per the approval of Govt. the procurement/replacement process was in progress.
- Regarding the age criteria, as per the RFP for the 'IPTHHS Phase-II project, an Ambulance becomes eligible for replacement after completing 2,50,000 kilometres or 5 years of service, whichever is later.

Punjab

- State has implemented referral transport services integrated with a centralized call centre in PPP mode.
- A fleet of 331 ambulances were available under the dial '108' model functional in OPEX mode and operationalized by 'Ziqitza Healthcare Limited'. All vehicles were state owned and staffed by an EMT and a pilot.
- ALS ambulances were making 3–4 trips per day while BLS ambulances were undertaking about one trip daily.
- 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. 80% of the total calls received at the call centre were dispatched an ambulance with an average response time of <30 mins.
- The approximate percentage of BLS services availed for road accidents was 23% for pregnant women, 22% and 55% for other cases.
- Ambulances were GPS-enabled, well-maintained, and staffed with trained EMTs and drivers.
- Most critical equipment was available and functional; however, in Faridkot district essential monitoring equipment such as BP apparatus, pulse oximeters, and glucometers were not available in ALS during assessment.
- Utilization of referral transport in some rural areas and urban slums appeared suboptimal due to low awareness.

Rajasthan

- The Integrated Ambulance Project (IAP) under the National Health Mission (NHM), Rajasthan has integrated 108 Emergency Ambulance, 104 Janani Express, and Mamta Express services under one unified command and control centre.
- It ensured 24x7 emergency medical, referral, and transport support across all 42 districts through toll-free numbers '108' and '104' with 125-seated Integrated Call Centre functional at SIHFW, Jaipur.
- The '108' service handled emergencies, accidents, and fire or police cases; the 104 Janani Express supports pregnant women, sick neonates, and RBSK beneficiaries;

while Mamta Express functions as a hybrid model, operating as a mobile OPD for eight hours and as a Janani Express ambulance for the remaining sixteen hours.

- Nagaur district had 31 ambulances available under the '108' fleet and 14 Janani Express ambulances. Average cases reported per day was 2 to 3 per ambulance. During the visit, a test call was placed from SHC Dhanni, and the ambulance arrived within 30 minutes.
- The 108 BLS ambulance was adequately equipped with oxygen, essential drugs, consumables, and an EMT. The logbook was properly maintained.
- Average response time in Urban areas was 20 min., for rural areas 30 min. and for hilly areas, it was 40 min.
- Community was aware of the toll-free number for referral ambulance helpline. Beneficiaries reported satisfaction with these services and confirmed having availed their benefits when needed
- Each ambulance was making 4-5 trips per day, covering a maximum distance of 60 kms in a day.
- Staff manning the ambulances were well trained and knowledgeable and were able to demonstrate Cardio Pulmonary resuscitation technique.
- The 2 AM test: The test was conducted at 12 AM on 2.11.25 . The 104 helpline was unavailable and 108 was disconnected multiple times. The test was again conducted at 3 PM on 3.11.25 . The 104 helpline was again not available while official from district team could connect on it. The 108 helpline got connected, however a long list of questions lasting 10 minutes were asked before help was offered (like OPD number , tehsil etc). This implies different state people can't connect on 104 and precious time could be lost in answering the standardized questions on 108.
- Poor response Time was recorded during late night hours while response time during day was 30 minutes. State needs to ensure ample number of functional ambulances as per population norms, with trained manpower and all emergency drugs and equipment.
- Supervision /monitoring done at the district level for the referral transport system was inadequate hence a streamlined monitoring and supervision system of ambulances should be developed with facility of random checks.
- Helpline process could be streamlined /simplified so that patients get timely emergency care.

Sikkim

- The State of Sikkim operates referral transport services primarily through the '102' and '108' ambulance networks under the National Health Mission.
- The '108' Emergency Response Service functions as the State's primary mechanism for trauma, emergency and obstetric referrals, while the '102' service caters to

routine patient transport, including pregnant women and sick infants under JSY and JSSK. These services play an essential role in ensuring timely access to higher-level facilities across the State.

- ‘102’ and ‘108’ ambulance services were not available in Mangan district, which significantly limited the ability of facilities there to ensure timely referrals, particularly in emergency maternal, neonatal and trauma cases.
- Given the difficult terrain, marked by steep gradients, narrow roads and frequent weather disruptions, the absence of standardised ambulance services in certain districts, particularly Mangan, was a major constraint for the State’s referral transport network.
- Soreng district had a defined referral mechanism in place for upward referral to higher health facilities. Depending on proximity and service availability, patients were routinely referred to District Hospital Gyalshing or District Hospital Namchi. Critical or specialised cases were directly referred to STNM Hospital, Gangtok.
- Although ambulances were available at PHC level, the patient transport vehicle at Soreng PHC was found to be in poor condition and unable to operate reliably in steep terrain, rendering it effectively non-functional. Ambulances also face delays in reaching AAM–SHCs due to challenging geography, long travel distances and weather constraints.

Tamil Nadu

- The district hospital itself has three designated ambulances (BLS:1, ALS:1, NLS:1), ensuring coverage for diverse medical needs.
- The average response time was 11 minutes, with ambulances running 200–250 kilometers daily and transporting 2–3 cases per day.
- Additionally, the ‘102’ JSSK Drop back Service was operational, and all ambulances were clean, well-maintained, and equipped to provide reliable patient care.

Telangana

- The State had a robust emergency transport network supported by a comprehensive ambulance fleet comprising ALS, BLS, and dedicated neonatal units, ensuring seamless care for maternal, neonatal, trauma, and other medical emergencies.
- The inclusion of neonatal ambulances strengthens the safe transfer of critical newborns from CHCs and PHCs to SNCUs, while the strategic distribution of ambulances across urban, rural, and tribal areas enhanced service availability.
- Integration with the state emergency response system enabled rapid deployment, supported by GIS-based routing and dynamic repositioning to reduce delays. As a result, Telangana sustains efficient response times in urban areas due to optimized placement and navigation systems, and only marginally higher in rural and tribal regions despite geographical challenges—contributing to timely stabilization, effective referrals, and improved emergency outcomes across the state.

Uttar Pradesh

- The state has outsourced the ambulance services which includes 108 and 102 ambulatory services. Adequate ALS & BLS ambulances were available.
- The community feedback on availability of ambulance services when required was found to be positive.
- Capacity building for the key personnel working in the ambulances was required to improve the quality of care provided during transfer, especially for paediatric & trauma cases.
- To further strengthen and build a robust referral system, it is recommended to build a system of pre intimation, in-transit monitoring, robust feedback system and referral audits to identify both unnecessary and delayed referrals.

Uttarakhand

- State has 54 ALS and 218 BLS ambulances operated through a 50-seater call centre which was integrated with 112. All ambulances were GPS enabled. Response time of ambulances in rural areas was 23 minutes and in urban areas was 13 minutes. Avg. km run/day 95 Km. Avg trip per day per ambulance was 1.5. Percentage of calls denied due to unavailability of ambulances or other reasons was 0.5%. Total cases provided services during FY 2025-26 was 1,38,369.
- EMT, emergency medicines and equipment were available in the ambulances visited during the field visits. Hygiene issues were observed in one of the visited ambulances as the spare wheel was kept inside the ambulance.
- In addition, State also has 134 ambulances (Ambulance services-102) also called as 'Khushiyaun ki Savari' for drop back of Pregnant women & sick infants (0-1 year) from the health facilities to their home under JSSK.
- Facility based Ambulances were also available at DH level but services were chargeable for more than 15 Km of referral services.
- Air ambulance /Heli-services: Air ambulance/heli-services were reported to be available in the Chamoli district to transport or evacuate the patients in emergency cases or in disaster situations.
- Given the district's difficult mountainous terrain, remote habitations, frequent road blockages due to landslides, snowfall, and flash floods, heli-services play a crucial role in ensuring timely access to advanced medical care.
- The District health team and district administration coordinates with the provider for immediate transfer of critical patients to higher centres. AIIMS Rishikesh has been designated as the Nodal centre for referral of critical cases through air ambulance for further specialised treatment.
- However, several operational challenges were reported in the effective utilisation of air ambulance services. Inclement weather conditions, including heavy rainfall, fog, snowfall, frequently disrupt flight operations. In addition, non-availability

of helicopters at short notice and logistical constraints delay patient evacuation. Furthermore, heli-services are limited to daylight hours, as flight operations are generally not permitted during evening and night due to safety concerns and limited aviation infrastructure in high-altitude terrain. These constraints underscore the need for strengthening emergency care services in the district, to complement heli-evacuation services in the district.





**PRADHAN MANTRI
JAN AROGYA YOJANA
(PMJAY) SCHEME**

17th

PRADHAN MANTRI JAN AROGYA YOJANA (PMJAY) SCHEME

BACKGROUND

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) is the world's largest publicly funded health assurance scheme, providing cashless coverage of up to Rs. 5 lakh per family per year for secondary and tertiary care hospitalisation. Launched on 23 September 2018, it serves as the cornerstone of India's strategy to enhance financial risk protection and accelerate progress towards Universal Health Coverage (UHC). AB-PMJAY covers over 12 crore poor and vulnerable families, identified based on deprivation and occupational criteria of the Socio-Economic Caste Census 2011 (SECC 2011). Since its inception, the scheme has been progressively expanded to include additional beneficiary groups, such as Accredited Social Health Activists (ASHAs), Anganwadi Workers and Anganwadi Helpers and their families, as well as universal coverage for senior citizens aged 70 years and above, irrespective of socio-economic status.

Pradhan Mantri Jan Arogya Yojana (PM-JAY) is being implemented across multiple states as a key financial protection mechanism. Under the scheme, eligible beneficiaries are entitled to cashless treatment for high-cost conditions at empanelled public and private health facilities. In several states, PM-JAY operates alongside, or in convergence with, state-specific health protection schemes, leading to diverse models of coverage, enrolment, and utilisation.

As of January 2026, a total of 43,25,57,764 Ayushman cards have been generated nationwide, including enrolment of more than 86 lakh senior citizens. The scheme has enabled access to secondary and tertiary care services through an extensive network of empanelled facilities and has played a significant role in reducing out-of-pocket expenditure related to hospitalisation among beneficiary households.

Implemented as a key component of the broader Ayushman Bharat programme, AB-PMJAY complements other interventions across the continuum of care. Currently, 33,136 hospitals are empanelled under the scheme, comprising 17,507 public hospitals and 15,629 private hospitals. Of the empanelled private facilities, 1,259 are located in aspirational districts, supporting improved access to specialised care in geographically and socio-economically underserved areas.

During the 17th Common Review Mission, PM-JAY implementation was assessed from the perspective of secondary care service delivery, with a focus on utilisation of scheme in public healthcare facilities, beneficiary awareness, claim processing, and linkages with tertiary care. The observations underscore the scheme's role in reducing Out of pocket health expenditure among vulnerable households, while also highlighting persistent operational gaps that constrain its full potential as a system-strengthening instrument.

KEY OBSERVATIONS

- PM-JAY benefits were available and actively utilised for high-cost conditions across public health facilities. In several facilities, local support mechanisms were in place to facilitate completion of required investigations prior to PM-JAY package activation.

- PM-JAY has enabled beneficiaries to access secondary and tertiary care services through empanelled facilities, with admissions being recorded across multiple states, reflecting operational implementation within public institutions.

- In Chhattisgarh, hospitals have been empanelled in accordance with national guidelines, with substantial Ayushman card coverage observed in the Mahasamund district. In Kerala, public health facilities across CHCs, Urban CHCs, Sub-District Hospitals, and District Hospitals have been empanelled, and a significant number of beneficiaries have availed services under both central and state components.



- In Maharashtra, PM-JAY is implemented in convergence with Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY), extending financial protection coverage across empanelled facilities. Similarly, in Odisha, PM-JAY is implemented in convergence with Gopabandhu Jana Arogya Yojana (GJAY), with large-scale card distribution and claims processed under the converged framework.
- In Meghalaya, implementation is functional at district hospitals, supported by dedicated kiosks and Ayushman Mitras present at facilities. In Nagaland, both district hospitals were empanelled under PMJAY, with beneficiaries availing services through established referral linkages.
- In Punjab, Ayushman Bharat Mukh Mantri Sehat Bima Yojana was operational across empanelled public and private hospitals, covering eligible families and National Health Mission staff. In Rajasthan, Ayushman Bharat–Mukhya Mantri Ayushman Arogya Yojana (MAA-Yojana) was operational across public and private facilities, with enrolment achieved across districts.
- In Telangana, the Aarogyasri scheme functions as the primary health assurance mechanism through empanelled facilities providing services to eligible beneficiaries. In Uttarakhand, tertiary-care admissions and claims have been recorded under PM-JAY during the CRM visit.
- In Tamil Nadu, PM-JAY and the Chief Minister Comprehensive Health Insurance Scheme supplement NHM to provide cost-free diagnostics, drugs, and services across public facilities, with user charges waived off.

KEY CHALLENGES

- Despite substantial enrolment and expansion of empanelled facilities, several operational and systemic challenges were observed across states.

- Pre-diagnostic out-of-pocket expenditure continues to affect vulnerable households, leading to delayed care or borrowing.
- Awareness of scheme entitlements, eligibility criteria, empanelled hospitals, and procedural requirements remains uneven, particularly among tea-garden workers, informal sector populations, and rural communities.
- IEC materials related to PM-JAY and other schemes were not consistently displayed across facilities.
- At CHC level, gaps were observed in tertiary-care linkage, Golden Card issuance, and documentation required for claim processing.
- Incomplete or insufficient documentation has resulted in claim rejections and missed pre-authorisation opportunities, particularly in remote facilities.
- Slow processing of claims and delayed reimbursements have affected scheme functioning in some states.
- Beneficiary registration processes were observed to be complex in certain contexts, particularly due to domiciliary verification requirements.
- In states implementing state-specific schemes alongside PM-JAY, clarity regarding integration mechanisms and eligible populations was limited.
- Utilisation in government facilities remains comparatively low in certain states, with limited package availability at CHC and Sub-District Hospital levels.
- Significant claim pendency was observed in some empanelled public hospitals under converged or state-integrated schemes.

KEY RECOMMENDATIONS

- States to strengthen PM-JAY visibility and beneficiary support through the prominent display of IEC material at District and Sub-District Hospitals, clearly outlining entitlements, package types, and helpdesk contact details. Functional help-desks should be ensured in high-load hospitals.
- States to minimise pre-diagnostic out-of-pocket expenditure by leveraging hospital funds and social support mechanisms, enabling timely completion of essential investigations for economically vulnerable patients.
- Enhance coverage of vulnerable communities including tea-garden workers and informal sector workers through coordinated efforts with tea-estate management and the Labour Department, including support for enrolment, documentation support, and referral transport.
- States to ensure that claim submission capacity, turnaround time and patient awareness need to be improved, particularly in public health institutions especially in remote CHCs.

- Beneficiary registration processes should be simplified and streamlined to ensure that all eligible populations are effectively covered under the scheme.

STATE-SPECIFIC FINDINGS

Assam

- PM-JAY benefits were being utilised for high-cost conditions in public facilities. The team observed that once a diagnosis (often biopsy-confirmed) is established, PM-JAY covers treatment costs. For patients who were not able to afford initial investigations and consultations, some facilities mobilise donor funds to bridge this gap until PM-JAY is activated.
- However, awareness of scheme entitlements and processes remains uneven, particularly among tea-garden and informal worker populations. The IEC related to PM-JAY and other schemes was not consistently displayed at facilities.
- In practice, PM-JAY is reducing catastrophic expenditure for some families. However, pre-diagnostic costs and information gaps still push vulnerable households to borrow or delay care, especially outside district headquarters towns.

Chhattisgarh

- In Chhattisgarh, PM-JAY has been implemented in line with national guidelines, with hospitals duly empanelled and a state-specific scheme extending financial protection for outpatient services. Substantial progress has been made in Ayushman card coverage and distribution in the Mahasamund district.
- At the CHC level, gaps persist in tertiary care linkages and issuance of Golden Cards; incomplete documentation has also led to claim rejections, highlighting the need to strengthen administrative processes.

Kerala

- Under PM-JAY, a substantial number of public health facilities across CHCs, Urban CHCs, Sub-District Hospitals, and District Hospitals have been empanelled, indicating strong participation of public institutions in delivering secondary and tertiary care services. Significant progress has been achieved in beneficiary identification and enrolment under the converged KASP–PMJAY framework, covering both central and state components.
- Service utilisation has also been notable, with a considerable number of beneficiaries availing care through public facilities, reflecting steady uptake of the scheme.

Maharashtra

- In Maharashtra, comprehensive financial protection coverage has been achieved under PM-JAY and Mahatma Jyotirao Phule Jan Arogya Yojana (MJPAY), with ongoing efforts toward card distribution. However, beneficiary registration processes were found to be complex, particularly due to domiciliary verification requirements linked to ration cards.

- While general awareness of scheme benefits exists within the community, gaps remain regarding knowledge of empanelled hospitals and eligibility criteria, with some beneficiaries assuming that coverage is limited to BPL families.
- A notable good practice was observed at PHC Indoli in Satara, where a prominently displayed banner listing empanelled hospitals facilitated easier access to information for patients.

Meghalaya

- PM-JAY has been implemented across both districts, with moderate utilisation in public hospitals and relatively higher uptake in East Khasi Hills due to better proximity to empanelled facilities.
- However, implementation was constrained due to lack of trained personnel for claims processing and inadequate IEC activities at the PHC level.

Nagaland

- In Nagaland, PM-JAY was implemented in being convergence with the Chief Minister Health Insurance Scheme (CMHIS), creating a complementary framework to expand health coverage across the state. While PM-JAY covers eligible vulnerable populations, CMHIS extends financial protection to government employees, pensioners, and other uncovered groups.
- Both district hospitals were empanelled under PM-JAY, with beneficiaries availing services and established referral linkages for tertiary care, enabling broader and more inclusive access to cashless treatment.

Odisha

- State has signed an MoU with the National Health Authority for implementation of AB PM-JAY in convergence with Gopabandhu Jana Arogya Yojana (GJAY), and the converged scheme along with Ayushman Vay Vandana Yojana (AVVY) has been launched.
- Under AB PMJAY–GJAY, eligible beneficiaries can avail free treatment at around 31,000 government and private empanelled hospitals across the country, including empanelled private hospitals within the state.
- The scheme covers a large number of families and beneficiaries, with co-branded cards being distributed in a phased manner, along with card generation under AVVY.
- A substantial number of claims have been raised and settled under the scheme, reflecting ongoing utilisation and claims processing.

Punjab

- Ayushman Bharat Mukh Mantri Sehat Bima Yojana provides cashless health insurance coverage to residents of Punjab through empanelled public and private hospitals, ensuring access to secondary and tertiary care services. Beneficiaries receive MMSY Cards; Centre-funded cases follow NHA guidelines.

Rajasthan

- High enrolment has been achieved under Ayushman Bharat-Mukhya Mantri Ayushman Arogya Yojana (MAA-Yojana); however, utilisation in government facilities and package availability at CHC and SDH levels remain limited.

Tamil Nadu

- In Tamil Nadu, PM-JAY and the Chief Minister Comprehensive Health Insurance Scheme operate alongside NHM to provide cost-free diagnostics, drugs, and treatment services across public health facilities, with user charges waived, as part of the state's commitment to universal free healthcare.
- In Tenkasi district, PM-JAY and CMCHIS were actively implemented with regular card issuance and utilisation in district hospitals; patients reported no issues in accessing services and facility conditions were found to be adequate, though there is a need to strengthen IEC activities for promoting Ayushman Bharat Health Account enrolment.

Telangana

- During the visit to health facilities in Bhadrachalam (BK) it was observed that empanelled public hospitals have huge pendency of claims under Aarogyasri scheme. For instance the Area Hospital, Bhadrachalam had approximate claim pendency amounting to Rs. 2 crores under the Aarogyashri scheme.
- The state informed that PM-JAY is integrated with Aarogyasri scheme, however, there was no clarity on integration of the two schemes as the eligible beneficiaries under the two schemes were different. Under PMJAY, poor and vulnerable families identified through SECC criteria, offering ₹5 lakh per family per year for secondary and tertiary care.
- However, during discussion it came up that the convergence exists in areas such as hospital empanelment standards, treatment protocols, IT systems, and claims management, which follow similar frameworks. Both schemes aim to reduce out-of-pocket expenditure and improve access to specialised care, though their eligible populations differ.
- Despite non-adoption of PM-JAY, Telangana leverages national guidelines, interoperability norms, and best practices to align Aarogyasri with broader National health insurance objectives.

Uttarakhand

- PM-JAY was being utilised for tertiary-care services, with recorded admissions and claims during the reporting period. PM-JAY was supporting access to tertiary care services, with good coverage among frontline workers such as ASHAs and ASHA facilitators. Tertiary care services were being provided under PMJAY. 11,012 admissions & Rs. 20.55 crore worth claims recorded in FY 2025-26 till October in Chamoli district.



**Pradhan Mantri-
Ayushman Bharat
Health Infrastructure
Mission (PM- ABHIM)
and XV-FC Health Grants**

17th

Pradhan Mantri-Ayushman Bharat Health Infrastructure Mission (PM- ABHIM) and XV-FC Health Grants

OVERVIEW

The COVID-19 pandemic highlighted that the present architecture of the public hospitals is not equipped fully to handle the critical requirement of clinical management of affected patients while maintaining essential services during pandemics. Provisions of segregating a part of the building as an infectious diseases' treatment block is missing. Limited laboratory capacity at all levels meant that functions of testing, case detection, surveillance and outbreak management were challenging. Critical care facilities faced shortage of Intensive Care Units, Isolation Beds, Oxygen supply, and Ventilators. This has demonstrated that India's health systems need to be better equipped to address public health needs across primary, secondary, and tertiary care levels.

India's evolving epidemiological and demographic profile, marked by a rising burden of non- communicable diseases, alongside persistent infectious diseases, and an unfinished agenda of reproductive, maternal new-born and child health services, has created an increasing demand on health care and public health services.

To strengthen the Public Health Infrastructure and build more resilient systems capable of addressing future health challenges, the PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) was announced in the Union Budget 2021-2022. PM-ABHIM, aims to address critical gaps in health infrastructure, disease surveillance, and health research across both urban and rural areas. The Centrally Sponsored Scheme (CSS) components of PM-ABHIM include infrastructure support for building-less subcentres and establishing Urban Ayushman Arogya Mandirs (UAAM). The scheme also supports setting up Block Public Health Units (BPHUs) in 11 high-focus states and UTs, along with Integrated Public Health Laboratories in all districts. Additionally, it provides for the establishment of Critical Care Blocks in districts with populations exceeding five lakh.

Under the scheme, the total financial outlay for the scheme period (2021-22 to 2025-26) is Rs 64,180 Crore, including ME and PMU cost, out of which amount of Rs 54,204.78 Crore is for implementation of Centrally Sponsored Scheme Components and the amount of Rs 9,339.78 Crores for implementation of Central Sector component. In this regard, funds have been allocated to the states and UTs.

The XV-FC, for the first time, recommended health grants through local governments to the tune of Rs 70,051 crores over the five-year period from FY 2021-22 to FY 2025-26 to facilitate the strengthening of the health system at the grassroot level. These health grants were conversion of rural sub-centres and primary healthcare centres (PHCs) to Ayushman Arogya Mandir (AAM), (ii) support for diagnostic infrastructure for primary healthcare activities, and (iii) support for urban AAM, sub-centres, PHCs, and public health units at the block level.

KEY OBSERVATIONS

- State and District-level committees were established in the states to oversee implementation under PM-ABHIM and XV-FC, indicating that governance structures were in place.
- Site identification and gap assessments were largely completed but project execution was delayed due to tendering, land availability, administrative approvals, and procurement issues.
- Progress in civil construction was uneven, with Critical Care Blocks (CCBs) advancing more slowly than SHCs, BPHUs, and IPHLs.
- A significant number of building-less SHCs continue to affect service delivery, staff morale, cold chain maintenance, and availability of diagnostics, despite many being sanctioned for upgradation.
- Fund utilisation varied widely across states. While some states demonstrate steady expenditure, others reported low utilisation, unspent balances, and delays linked to 'SNA-SPARSH' processes and compliance requirements between reported financial progress and actual physical progress on the ground, indicating the need for stronger monitoring mechanisms.
- Functional Integrated Public Health Laboratories (IPHLs) and Block Public Health Units (BPHUs) have strengthened diagnostic capacity, surveillance, and outbreak response in some states; however, several facilities remain under construction or partially operational.
- Operationalisation gaps persist, with infrastructure creation not always accompanied by adequate staffing, equipment provisioning, and digital system integration.
- UAAM were being operationalised gradually, but expansion of the full Comprehensive Primary Health Care (CPHC) service package requires more structured planning and convergence.
- Geographic challenges, particularly in hilly and northeastern regions, along with variations in construction costs and contractor-related delays, were impacting timelines and infrastructure quality.
- Overall, while substantial infrastructure has been sanctioned and momentum was visible, accelerated implementation, improved financial management, and stronger monitoring are required to achieve intended outcomes.

KEY CHALLENGES

- Delays in tendering, land availability, administrative approvals, and procurement were slowing project execution despite governance structures being in place.
- Wide variation in fund utilization, including low expenditure, unspent balances, and procedural delays linked to SNA-SPARSH and compliance requirements.

- Mismatch between reported financial progress and actual physical progress, indicating weak monitoring and tracking systems.
- Several IPHLs and BPHUs remain under construction or partially operational, limiting expected gains in diagnostics and surveillance.
- Infrastructure creation not consistently supported by adequate staffing, equipment supply, and digital system integration.
- Slow pace of operationalization of UAAM with gaps in structured expansion of the full CPHC service package.
- Geographic constraints, higher construction costs, and contractor-related delays affecting timelines and infrastructure quality.

RECOMMENDATIONS

- States to conduct orientation and sensitization programmes for district health officials on PM-ABHIM and XV-FC provisions, guidelines, and compliance requirements.
- States to organize joint orientation sessions for programme staff, architects, engineers, and medical officers to ensure coordinated planning and effective implementation of infrastructure components.
- State to conduct regular state and district-level review meetings to monitor progress of PM-ABHIM and XV-FC works and address bottlenecks in a timely manner.
- States to ensure timely and accurate updates of physical and financial progress on the PMS portal to enable real-time monitoring and informed decision-making.
- States to initiate sanctioned activities promptly and report fund utilization regularly to facilitate timely release of subsequent instalments from the Ministry.
- During site selection for IPHLs, CCBs, and BPHUs within existing facilities, prioritize integration with current structures and explore vertical expansion over horizontal expansion, wherever feasible.
- Incorporate adequate provisions for open spaces, greenery, and parking areas while designing layout plans for new constructions and renovations.
- Ensure that layout plans include all critical functional components with adequate space allocation as per GoI norms and prescribed standards.
- Develop a clear roadmap for strengthening Urban AAM to operationalize all twelve Comprehensive Primary Health Care (CPHC) service packages in a phased and time-bound manner.

STATE SPECIFIC OBSERVATIONS

Andhra Pradesh

- PM – ABHIM scheme was being implemented under SNA SPARSH since Financial Year 2024-25 only at the State level.
- Civil modifications supported by PM-ABHIM, XV FC and State Government allocations were underway in several secondary care facilities but found to be delayed due to protracted administrative approvals and procurement timelines.

Assam

- As per PM-ABHIM, out of 768 building-less SHCs, 756 (98%) have been mapped; of these, 471 (62%) were under construction, while 162 (21%) were completed
- For Block Public Health Units (BPHUs), all 207 have been mapped; of these, 65 (31%) have not been started, 95 (46%) were under construction, and 47 (23%) have been completed.
- For District IPHLs, out of 33 total, 18 (55%) have not been started, 8 (24%) were in progress, and 7 (21%) were completed
- CCBs have been sanctioned at Government Medical Colleges (GMCs) and district hospitals; however, many remain in early stages of implementation.
- Fund utilisation stands at approximately 51% of available funds, corresponding to 34% of the total resource envelope and 24% of the approved Routine Operational Plan (RoP).
- State faces a “building-less facilities” crisis as significant proportion of Sub-Centres (around 28.3% as per HDI 2022–23) do not have permanent buildings. This affects service delivery, staff morale, and the ability to house point-of-care diagnostics and equipment. Charaideo and Udalguri show a similar pattern, indicating that this was a statewide challenge rather than a district-specific problem.
- For districts like Charaideo and Udalguri, this means that the same IPHS data now need to be translated into simple facility-wise and block-wise improvement plans, linked with NHM and PM-ABHIM resources and supportive supervision

Bihar

- In Munger district, as of October 2025, 52% funds were utilised under PM-ABHIM with eight BPHUs and 55 AAM-SHCs scheduled to start soon. CCB was yet to be constructed at SDH Tarapur .Under XV-FC: work was initiated at 36 AAM-SHC, 12 APHCs (3 completed, 9 under construction) and construction of 1 CHC was ongoing.
- In Saran district, tender was floated for construction of 50 sanctioned SHCs and work order was issued for 16 SHC under PM-ABHIM. While under XV-FC; work was completed for 3 APHCs and was ongoing for 6 against 16 sanctioned APHCs. Work

for 1 CHC was completed and was ongoing for another one. Tender was floated for 95 SHCs against which 32 were under construction and 14 were completed.

Chhattisgarh

- SNA SPARSH system was implemented in the State.
- Under PM-ABHIM, CCB, 4 approved IPHLs were under construction in Mahasamund district. Under XV-FC; 14 Building-less SHCs were approved; however, 11 remained incomplete due to fund constraints, and 3 were still under the tendering process. 1 BPHU at CHC Saraipali has been completed and handed over. Out of 9 approved Urban AAM, 4 have been completed, while work on 5 was ongoing.
- In Kanker district under PM-ABHIM; 1 CCB and 4 BPHU were approved. Land was identified for construction of CCB. Work was near completion for 1 BPHU, ongoing for 2 BPHUs and land had been identified for construction of 1 BPHU. Under XV-FC; total 8 works were approved (6 Urban AAM and 2 AAM-SHC). Work was completed for 1 UAAM, ongoing for 3 UAAM. Work on 2 UAAM & 2 SHC-AAM could not be initiated due to land issue.

Madhya Pradesh

- Under the Pradhan Mantri–Ayushman Bharat Health Infrastructure Mission, critical infrastructure, including IPHL, CCB, and BPHU, has been initiated in Mandsaur, though actual execution lags behind reported progress. Vidisha had a functional Critical Care Block with dedicated ICU and coronary care beds, enhancing emergency preparedness. The district had established infrastructure under the scheme, including 1 IPHL, 1 Critical Care Block, and 1 Block Public Health Unit.
- In Mandsaur, a total 38 projects were sanctioned under the XV-FC, which included 4 BPHU, 5 Building-less PHC and 29 Building-less SHCs. Work was completed for 4 BPHUs and 19 SHCs and ongoing for 10 SHCs & 5 PHCs.
- In Vidisha, a total 67 projects were sanctioned under the XV-FC, which includes 2 BPHU and 65 Building-less SHCs. Work was completed only for 1 SHC and was in progress for 64 SHCs & 2 BPHUs.

Maharashtra

- IPHL and BPHU were in varying stages of operationalisation across both districts. While both units were currently being operationalised in Nandurbar, the IPHL in Satara was not yet functional.
- A notable divergence was observed between the reported financial progress and the actual physical progress of projects on the ground, indicating gaps in monitoring or reporting accuracy.
- There was a significant unspent balance (approx. ₹69.36 Cr) under the PM-ABHIM programme lying in the SNA account, which was not available for utilisation and was not refunded to the central treasury.

- There was a declining trend in cumulative expenditure percentage under PM-ABHIM, dropping from 83.58% in FY 2021-22 to 21.62% in FY 2025-26 (up to Sept), highlighting a slowdown in fund utilisation.

Meghalaya

- Under PM-ABHIM, civil works in North Garo Hills were delayed due to contractor issues and weather constraints. XV-FC grants have been utilized for renovation, equipment procurement. Financial documentation was largely up to date.
- 1 IPHL had been established against a target of 10, and 4 BPHUs have been made functional against a target of 39.
- PM-ABHIM and XV-FC projects require expedited execution, especially in hilly terrains, and digital connectivity needs to be provided to all CHCs.
- The operational and financial jurisdiction of the SNA SPARSH system in Meghalaya had been extended up to the Block level.

Nagaland

- Funds for PM-ABHIM were being effectively utilized for civil works and procurement through executing agencies, with established processes for billing and financial settlement.
- Key financial positions at the State and district levels were filled, with steadily improving fund utilization under NHM and PM-ABHIM.
- The IPHL Laboratory was functional with adequate lab capacity and functional linkages with upward and downward referrals. Staff were trained under IPHL, and the lab had data integration with the IHIP portal. Surveillance activities were also conducted by the lab with the district IDSP cell.

Odisha

- The IPHL at DH was well-equipped and operated as a BSL-II laboratory.
- IPHL and BPHU were functioning well, with diagnostic services being delivered in alignment with Indian Public Health Standards (IPHS), thereby strengthening early detection and disease surveillance.
- Odisha targeted the establishment of 30 IPHLs across districts during FY 2021–26. Out of these, 11 have been sanctioned, 10 completed, and 9 were currently functional, marking a steady progress toward achieving state-wide laboratory coverage.
- District IPHLs such as those in Khurda, Ganjam, Cuttack, and Sambalpur have emerged as models for early operationalisation. These laboratories were providing a wide range of diagnostic and surveillance services including microbiology, biochemistry, haematology, and molecular testing.

- During recent dengue and diarrheal outbreaks, the functional IPHLs played a crucial role by enabling rapid sample testing, confirmation, and reporting at the district level. This helped the State Surveillance Unit to implement timely containment measures and prevent further spread.
- The launch of CCBs under PM-ABHIM has strengthened Odisha's district-level healthcare. By 2025–26, 4 units have been completed, while 18 were in progress across the state. These blocks provide advanced emergency and intensive care closer to patients, reducing dependence on big city hospitals.
- A total of 604 Sub-Centres were sanctioned for construction across various districts. Of these, 590 Sub-Centres have received administrative approval, 543 construction works have been initiated, and 177 Sub-Centres have been completed and made functional.

Punjab

- IPHL and CCBs were under construction in Faridkot and Jalandhar districts
- Construction of BPHU was completed in Jalandhar
- Construction of building-less SHCs in Jalandhar was underway, with 6 out of 24 facilities completed.
- In Faridkot, 3 SHCs have been completed, and 26 were in progress; 2 UAAM have been completed and 7 were under construction; 1 BPHU was completed while 1 was under progress.
- The DPHLs functional under IDSP, were being planned to be merged with the Integrated Public Health Laboratory (IPHL) in both districts.

Rajasthan

- In Nagaur District work for 5 BPHUs was completed and was under progress for 3 BPHUs. Completed BPHUs were yet to be operationalised. IPHL was under construction at DH Nagaur while 8 UAAM were functional.

Tamil Nadu

- The IPHL model was functional on a hub-and-spoke system, where the central lab served multiple PHCs. In some instances, lab reports were sent directly to beneficiaries via WhatsApp, reducing the need for repeat visits to the facility.
- Tamil Nadu was the only State in the Country, which has received all the approved grants from GoI under XV-FC.
- Infrastructure strengthening under NHM includes about 105 ongoing projects; under PM-ABHIM, 30 (50-bedded) and 5 (100-bedded) Critical Care Blocks, along with 38 Integrated Public Health Laboratories, have been taken up.

Telangana

- The state adhered to the DoE guidelines on fund flows and managed to secure releases for all the three years 2021-22 to 2023-24. In the first two years of the grant, the state could utilize around 95 per cent of the released grants and stood next only to Tamil Nadu in terms of the overall absorption of funds in the three-year period.
- The rural-urban distribution of allocation by the XV-FC was broadly in accordance with the degree of urbanization in the state. About 66 per cent of the total grant amount for the first three years was allocated to the rural components; the remaining towards urban
- Telangana Diagnostic Hub was functional as IPHL
- Due to the ongoing process of onboarding onto SNA-SPARSH, NHM scheme-related funds were not released to the district health facilities visited.
- At Bhadradri Kothadugudum district, the Critical Care Block was constructed but yet to be made operational.

Uttar Pradesh

- The state has been sanctioned 1670 Building less Sub Health Centre, 515 Block Public Health Units, 75 Integrated Public Health Labs, and 74 Critical Care Block Units for which Government construction agencies have been finalised for all sanctioned units, and about 80% progress has been achieved. However, progress in CCB Units was less than 10% and needs to be expedited.
- Under XV-FC, the State has been sanctioned 6439 Building less Sub Health Centres of which 570 (9%) have been completed & handed over, while out of 310 BPHUs, 86 (28%) have been handed over. Of the 1160 Urban Health & Wellness Centres sanctioned, the State has been able to operationalise 977 (84%). There has been no progress on the sanctioned 70 Urban Polyclinics under XV FC, which the State may expedite.

Uttarakhand

- Under PM-ABHIM & XV-FC health sector grants; in Udham Singh Nagar district, construction of IPHL and BPHUs was completed, while the CCB was under progress. In Chamoli district, construction of CCB and IPHL was ongoing; 3 BPHUs were completed, 3 were under construction, and work orders for 4 BPHUs were issued with all ongoing works expected to be completed by March 2026.
- Under XV-FC, a total of Rs. 609.38 crores had been approved, out of which Rs 215.09 crore was released, and Rs 62.7 crore was spent at the time of visit. Tender for operationalisation of UAAM was under process at Urban Directorate level, and procurement of Diagnostic equipment and consumables was also under process at Health Directorate level.



**ROGI KALYAN SAMITI
(RKS)**

17th

ROGI KALYAN SAMITI (RKS)

National Overview

Rogi Kalyan Samitis (RKS), also known as Hospital Management Committees, were introduced in 2005 as an institutional mechanism to strengthen governance, service delivery, and accountability in public health facilities. The initiative aims to promote decentralised decision-making and enable community participation in the management of health institutions, with a focus on improving patient care and welfare. The RKS functions as a consultative and participatory platform comprising representatives from civil society, eminent citizens, facility leadership, and government officials. To support its mandate, RKS is provided with an annual corpus grant and empowered to undertake patient welfare and social responsibility functions at the facility level.

A central objective of RKS is to reduce financial barriers to essential health services. It is mandated to ensure that no user charges are levied for services related to maternal and child health, national disease control programmes, and other government-funded assured services. Where applicable, RKS is responsible for determining a transparent and minimal user fee structure for outpatient and inpatient services, displayed prominently within the facility to avoid deterring access to care. RKS also plays a critical role in safeguarding the interests of Below Poverty Line households and other vulnerable groups by ensuring that inability to pay does not result in denial of care. This includes facilitating support for costs related to transport, diet, and attendant stay where required.

Beyond financial protection, the scope of RKS extends to ensuring essential non-clinical services and patient-facing processes such as safe drinking water, sanitation, clean premises, dietary services, help desks, signage, security, and display of the Citizens' Charter and Charter of Patient Rights. RKS supports availability of essential drugs and diagnostics, adherence to standard treatment protocols, patient safety measures, maintenance of records, and periodic review of clinical care. Additionally, RKS is responsible for overseeing facility maintenance in line with Indian Public Health Standards (IPHS), supporting rational use and expansion of hospital infrastructure, facilitating implementation of national and state health programmes, and mobilising community and philanthropic participation to strengthen facility functioning.

The RKS guidelines were revised in 2015 to mandate the constitution of RKS in all public health facilities at the level of Primary Health Centre and above, with a renewed emphasis on participation, transparency, and accountability, highlighting its role as a key governance mechanism within the public health system.

KEY OBSERVATIONS

- RKS have been constituted across secondary care facilities, including District Hospitals, Sub-District Hospitals and Community Health Centres. In all visited states, formal committee structures were present, with defined membership and designated office bearers.
- RKS continues to function as a facility-level institutional platform supporting operational requirements such as maintenance of premises, minor civil works,

procurement of consumables, patient amenities, and other day-to-day administrative needs.

- RKS funds were being utilised at facilities for activities including maintenance of water supply systems, sanitation facilities, minor repairs, procurement of equipment, and support to patient welfare-related services.
- In states such as Kerala, Meghalaya, Uttarakhand, and Rajasthan, meetings were being conducted and minutes were maintained, particularly at the District Hospital level. Documentation of proceedings was available for review in these facilities.
- In Tamil Nadu and Kerala, RKS or equivalent Hospital Management Committees were integrated into routine hospital administration processes, with decisions recorded through formal meeting structures.
- In Madhya Pradesh, visible grievance redressal mechanisms such as complaint boxes and display of contact details of Civil Surgeons and RMOs were observed at District Hospitals.
- In Chhattisgarh, RKS functions under the name Jeevan Deep Samiti (JDS), and committee structures were observed at the facility level. In certain districts, administrative transitions had resulted in modified governance arrangements.
- At CHC level facilities in several states, RKS committees were constituted and records of meetings and expenditure were available, though frequency varied across facilities.
- RKS accounts were maintained at the facility level, and expenditure records were available for review during field visits. Overall, RKS structures were in place across states and were functioning as institutional mechanisms for facility-level management and operational support.

KEY CHALLENGES

- Utilisation of RKS funds remains largely reactive and confined to routine operational expenditure, with limited linkage to strategic service quality improvement.
- Meetings at lower-level facilities, particularly CHCs, were irregular and often need-based rather than periodic. In some facilities, expenditures were incurred without consistent documentation of approvals by the Executive Committee.
- Separate financial audits of RKS accounts were irregular or not conducted in certain states.
- Limited clarity regarding permissible expenditure heads and financial procedures was observed among facility managers and committee members.
- Capacity constraints, including a lack of formal training and orientation of RKS members, affected effective governance and planning.

- In some districts, committee functioning was disrupted due to the transition of facilities to medical college governance structures.
- Linkages between RKS planning and facility-level service delivery priorities, such as infection control, infrastructure gaps, and patient safety, were weak.
- Delays in the availability and utilisation of untied funds limited the timely implementation of patient-centric and maintenance activities.
- Community participation and structured grievance redressal mechanisms were limited in several facilities.

KEY RECOMMENDATIONS

- States and districts should strengthen the financial governance framework of Rogi Kalyan Samitis by ensuring that all expenditures are routed through duly constituted Executive Committees, with clearly documented approvals, meeting minutes, and financial records. Adherence to prescribed governance and decision-making processes should be uniformly enforced across facilities.
- Regular and independent financial audits of RKS accounts should be institutionalised to enhance transparency and accountability. Audit findings should be systematically reviewed at the district and state levels, and corrective actions should be monitored to ensure compliance with financial norms.
- Targeted capacity-building initiatives should be undertaken for Medical Superintendents, facility managers, RKS members, and accounts personnel to enhance understanding of RKS guidelines, permissible expenditure heads, financial procedures, reporting requirements, and their broader governance role. Periodic orientation and refresher training may be institutionalised, particularly following reconstitution of committees.
- Facilities should be encouraged to move beyond routine expenditure and align RKS planning with service delivery priorities. Greater emphasis should be placed on leveraging RKS funds for secondary care enhancement, patient amenities, infection prevention and control, minor infrastructure gaps, and improving patient experience.
- District and state-level monitoring mechanisms should be strengthened to ensure timely fund utilisation, regular meetings, proper documentation, and outcome-oriented use of RKS resources. Monitoring frameworks may include periodic reviews, supportive supervision, and performance-linked feedback to facilities.
- States may also promote greater community participation and representation within RKS to enhance accountability, responsiveness, and local ownership, in line with the original objectives of the RKS framework.

STATE-SPECIFIC FINDINGS

Chhattisgarh

- RKS function under the name Jeevan Deep Samiti (JDS). At district hospitals, JDS were discontinued after the facilities were handed over to medical colleges, with local committees formed in their place.
- Although ₹10 lakh in untied funds is allocated annually, committee members have not received formal training, and meetings were conducted only on a need-based basis.
- Coordination with other departments and a structured grievance redressal mechanism remain limited. The committees primarily focus on financial management, with minimal involvement in planning, service quality improvement, or monitoring of facility performance.

Kerala

- Hospital Management Committees were constituted and registered, with regular meetings and documented decision-making.
- RKS/HMC played an active role in hospital administration, though utilisation remained focused on routine management functions.

Madhya Pradesh

- RKS was well established at district hospitals, with a visible grievance redressal mechanism in place.
- Each ward had a complaint box placed outside, along with clearly displayed contact numbers of the Civil Surgeon and RMO.
- RKS expenditures at the district hospital were being incurred with the approval of the Civil Surgeon, whereas these should be approved through the RKS Executive Committee (EC) meetings. Additionally, a separate audit of RKS at the district hospital was not being conducted

Meghalaya

- RKS committees were functional at district hospitals with regular meetings and documentation. At the CHC level, meetings were irregular, and fund utilisation was suboptimal, indicating the need for capacity building and structured planning.

Nagaland

- RKS committees were constituted at both District Hospitals.
- The committees comprise members, including the Deputy Commissioner (DC), Chief Medical Officer (CMO), Medical Superintendent (MS), and representatives from civil society organisations. An untied fund of ₹40,000 was disbursed to each facility annually, and committee meetings were conducted on a quarterly basis.

Punjab

- RKS existed across secondary care facilities; however, meetings were inconsistent and untied funds were not received by most committees, limiting their functional effectiveness.

Rajasthan

- In Rajasthan, 'RKS' functions as the Medicare Relief Society, a registered body responsible for improving hospital management, resource utilisation, and patient care, while supporting autonomous decision-making to strengthen service delivery at health facilities.
- Its roles include implementing government health schemes at the facility level, ensuring transparent and efficient utilisation of hospital funds, supporting infrastructure maintenance and service improvement, monitoring hospital performance and addressing operational gaps, and strengthening patient welfare and grievance redressal mechanisms.
- Lack of structured and periodic capacity-building for RKS members was identified as a prevalent issue affecting effective decision-making.

TELANGANA

- In Telangana, Rogi Kalyan Samitis (RKS) have been duly constituted across facilities and were maintaining meeting minutes regularly, reflecting active participation in hospital management processes.
- Several facilities were experiencing delays in the availability and utilisation of RKS funds, resulting in pendency of essential upkeep and patient-centric activities.
- To enhance the effectiveness of RKS, it is important to streamline fund flow mechanisms and ensure timely financial approvals, enabling committees to address day-to-day operational needs and improve the overall quality of patient care.

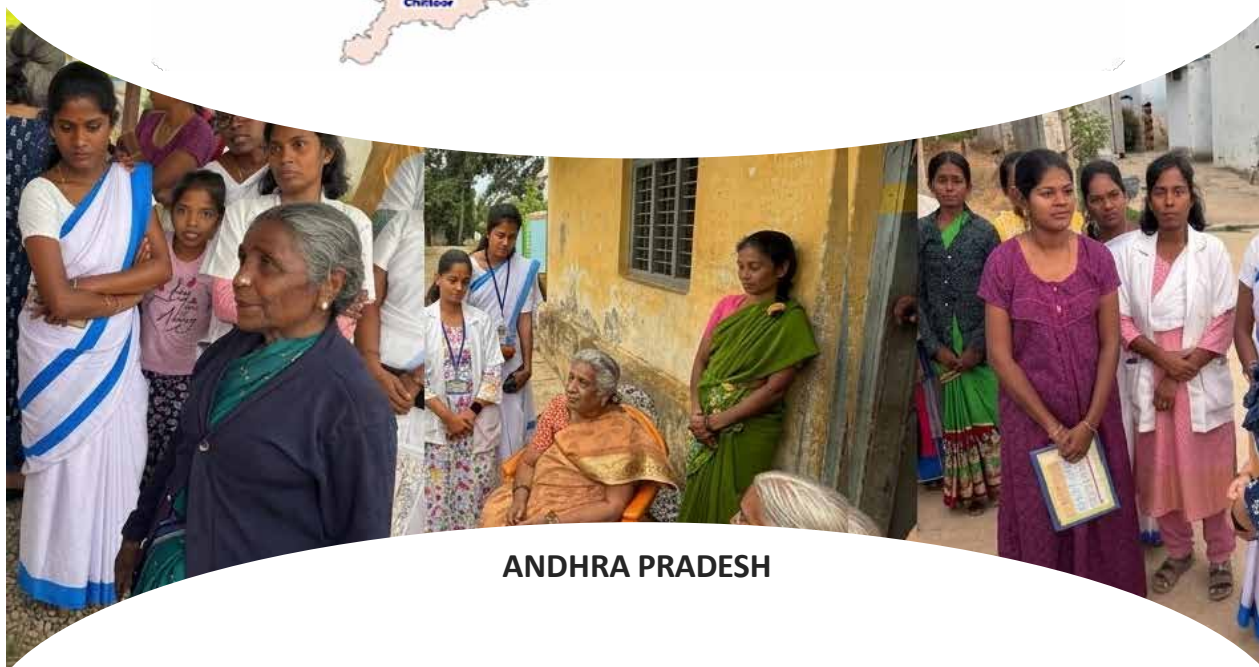
UTTAR PRADESH

- RKS was re-registered in 2022; however, no payments could be made since August 2025 due to delays in 'SNA-SPARSH' integration.

UTTARAKHAND

- RKS/Chikitsa Prabandhan Samitis were operational across DHs, SDHs, and CHCs, with proper record-keeping and the utilisation of funds for maintenance, minor repairs, and procurement. The meeting frequency was higher at the CHC level compared to district hospitals.

CRM STATE TEAMS



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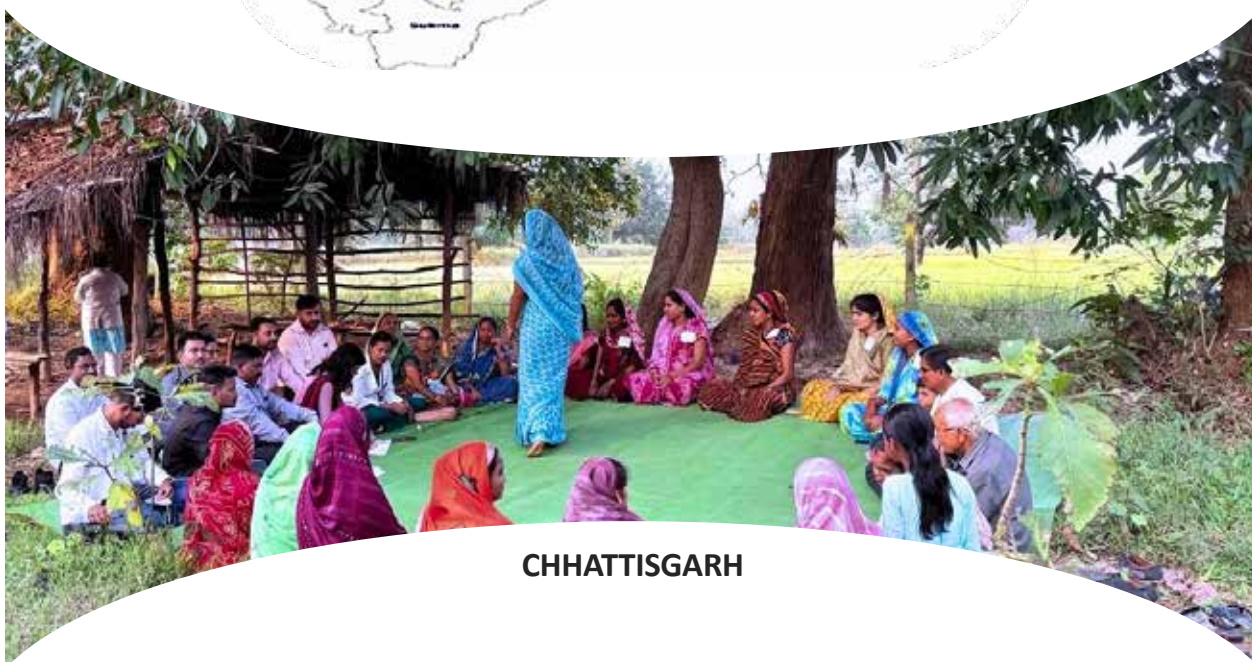


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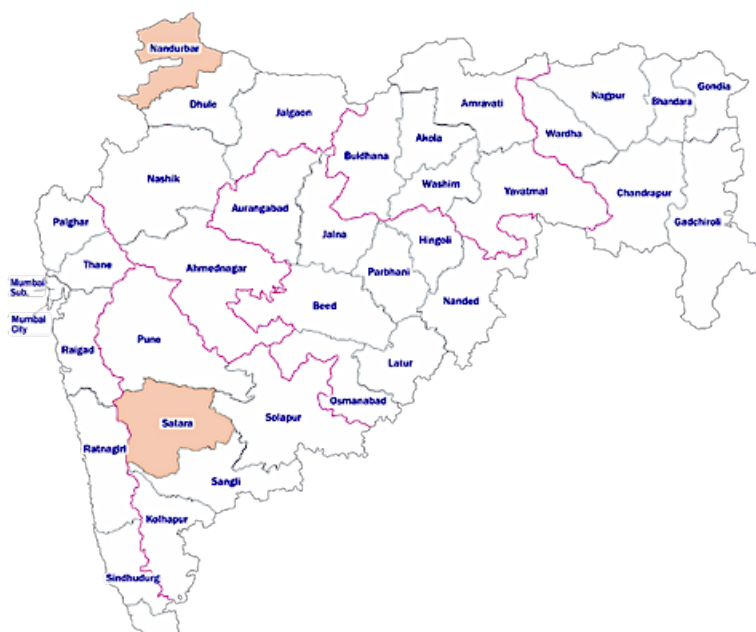


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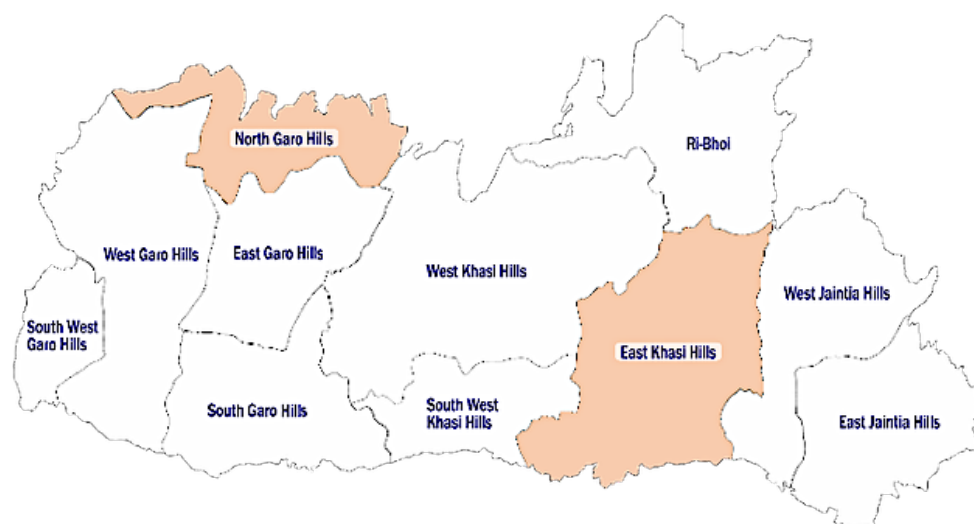


MAHARASHTRA

Team Members

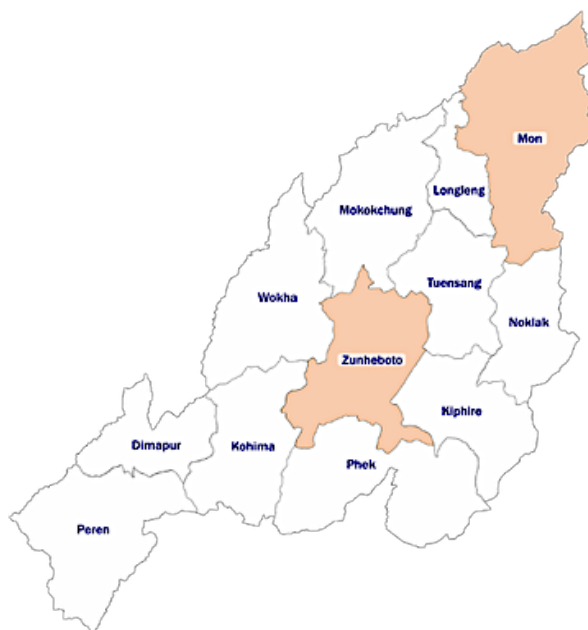
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Ms Nikita Mishra, NHSRC	Mr Aakash Tyagi, MoHFW



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ODISHA

Team Members

Team Members	
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	Dr Sandip Baheti, CARI
	Mr Shazi Iqbal, MoHFW
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RAJASTHAN

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Dr. Kalpana Pawalia, NHSRC

Dr. Anar Singh Dhakar, MoHFW

Sangareddy District

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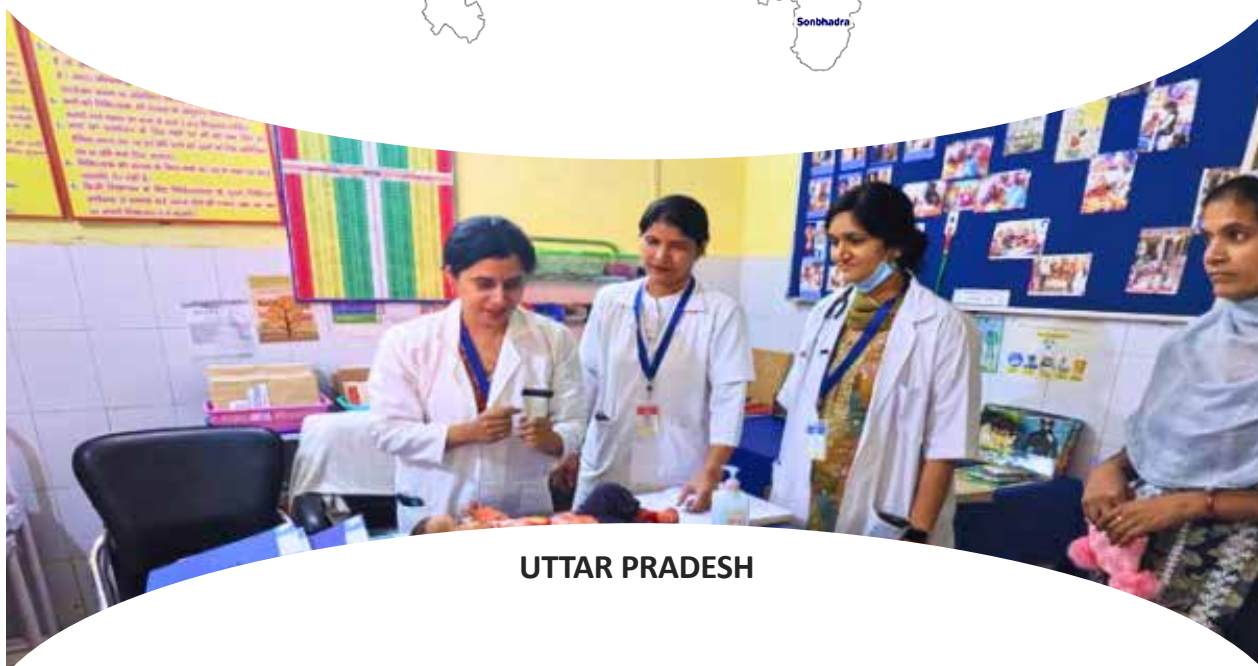
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Dr. Biswo Ranjan Das, MoAYUSH

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Dr. Kavita Chaudhuri, MoHFW

Mr. Arun Sharma, MoHFW



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Dr Vini Sivanandan, PRC Pune

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