



# Common Review Mission

REPORT 2014





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

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**जगत प्रकाश नड्डा**  
**Jagat Prakash Nadda**



**स्वास्थ्य एवं परिवार कल्याण मंत्री**  
**भारत सरकार**  
**Minister of Health & Family Welfare**  
**Government of India**

### Message

I am happy to learn from the report of the Eighth Common Review Mission (CRM) that the inputs provided by National Health Mission (NHM) to bring health services closer to people has resulted in steady improvement in the status of health and access to health care services even in the remote parts of the Country. Though NHM has led to an increase in OPD, IPD and number of Institutional Deliveries, there is more to be done for increasing both — reach and quality of health care. This report of Eighth Common Review Mission has brought out the improvement as well as gaps in service delivery. I note that flexible financing under the Mission has also fostered several innovations across the Country.

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

3. It is also interesting to note that large number of innovations are taking place across States to improve health care service delivery and are thus helping in improved health status.

4. At this stage of NHM, we look forward to consolidating the efforts made so far and make primary health care a reality for the people. The newer challenges like Non-Communicable Diseases and rapid urbanisation are the new frontiers that need to be focused on and dealt with.

5. This Annual Review of NHM has become a process of comprehensive assessment of our performance and a source of guidance for further improvement in future. I thank all the experts who were part of this exercise for their valuable inputs. I see this as an occasion to rededicate ourselves to the goals of NHM.

(Jagat Prakash Nadda)

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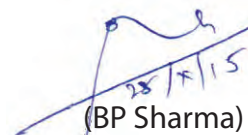
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### Message

The Common Review Mission (CRM) is an important review and monitoring mechanism to assess the progress of NHM. CRM reports provide insights on the progress made as well as critical gaps yet to be plugged and emerging needs. These reports also reflect that people's expectations from the Mission have increased. The Common Review Mission findings also provide an opportunity to the States to adopt appropriate strategies and address critical gaps in governance.

Along with the progress made on the infrastructure, service delivery, increased patient load and institutional deliveries, the findings of the Mission points to various deficiencies that we all need to take note of and work upon. The recommendations from this review mission have emphasized the need for increased availability of human resources, enhancing quality of health care delivery, strengthening community support and accountability mechanisms and increased convergence with the related departments. I am sure that States will incorporate these suggestions into their State Implementation Plans.

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

  
(BP Sharma)

New Delhi  
28th October, 2015





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## **MESSAGE**


The National Rural Health Mission, in its first phase laid the foundation for re-vitalization of primary health care in the nation. The second phase, named National Health Mission - which also included the Urban Health Mission, has seen a renewed commitment to strengthening of public health systems at all levels - from sub-centers to tertiary care facilities. The remarkable increase in utilization of public health care services reassures of the confidence that NHM has given to people across the nation.

The Mission has made a major contribution in strengthening health-care infrastructure at all levels - from the sub-center to district hospital. The other major areas strengthened under NHM have been - community processes and participation to strengthen the demand side, making all health care services for pregnant women and newborns completely free of cost and a push towards governance reforms.

I am happy to read from this report that there is a marked increase in number of out-patients, admissions, institutional deliveries and major surgeries across the country in public health institutions. There has also been considerable increase in the range and quality of services being provided. In particular, district hospitals and block level PHCs have been strengthened and are delivering a wide range of services. Cold chain gaps in immunization are more or less completely attended to and delivery of immunization services has been streamlined. I also note that the CRM has confirmed substantial increase in utilisation of emergency transport services as well as in-facility-based-care for the sick children. Mobile Medical Units are also deployed in most of the difficult-to-reach areas.

However, I also note that there are many areas where the progress has been inadequate- especially in some of the States which face the greatest challenges. Now, we will need to focus attention on these areas - both in the form of providing additional support and monitoring. We also need to develop better and more inclusive strategy for building institutional capacity by leveraging partnerships with medical colleges, schools of public health and civil society.

I wish to thank and assure all stakeholders and participants in this review process, that the Mission takes observations as well as recommendations of CRM very seriously and uses it to draw a meticulous schedule for monitoring follow up actions - particularly for those geographic and thematic areas, where support is most needed. I thank all the participants of the 8th CRM for their time and effort, and invite them to remain partners in the process of follow up and implementation of the recommendations.

  
(CK Mishra)

New Delhi  
28<sup>th</sup> October, 2015









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# Abbreviations ▶

AGCA	Advisory Group on Community Action	DOTS	Direct Observation Therapy - Short-course
AMTSL	Active Management of Third Stage of Labour	DPM	District Programme Manager
ANC	Ante-Natal Care	DPMU	District Programme Manager Unit
ANM	Auxiliary Nurse Midwife	DTC	District Training Centre
ANMTC	Auxiliary Nurse Midwife Training Centre	DWCD	Department Women & Child Development
APHC	Additional Primary Health Centre	EDL	Essential Drug List
API	Annual Parasite Index	EmONC	Emergency Obstetric & Neonatal Care
ARC	ASHA Resource Centre	EMRI	Emergency Management and Research Institute
ART	Anti retroviral Treatment	FMG	Financial Management Group
ASHA	Accredited Social Health Activist	FP	Family Planning
AWC	Anganwadi Centre	FRU	First Referral Unit
AWW	Anganwadi Worker	GNM	General Nursing Midwife
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy	HMIS	Health Management Information System
BCC	Behaviour Change Communication	HMRI	Health Management & Research Institute
BEmONC	Basic Emergency Obstetric & Neonatal Care	HR	Human Resource
BMO	Block Medical Officer	HRD	Human Resource Development
BMWM	Bio-Medical Waste Management	HRIS	Human Resource Information System
BPHC	Block PHC	HSC	Health Sub-centre
BPM	Block Programme Manager	ICDS	Integrated Child Development Scheme
BPMU	Block Programme Management Unit	ICTC	Integrated Counselling and Testing Centre
BPL	Below Poverty Line	IDSP	Integrated Disease Surveillance Project
CBOs	Community Based Organizations	IEC	Information Education Communication
CEmONC	Comprehensive Emergency Obstetric & Neonatal Care	IMNCI	Integrated Management of Neonatal and Childhood Illnesses
CHC	Community Health Centre	IMR	Infant Mortality Rate
CMO	Chief Medical Officer	IPD	In Patient Department
CMOH	Chief Medical Officer Health	IPHS	Indian Public Health Standards
CRM	Common Review Mission	ISO	International Organization for Standardization
CT Scan	Computed Tomography Scan	IUCD	Intra-uterine Contraceptive Device
DH	District Hospital	JE	Japanese Encephalitis
DHAP	District Health Action Plan		
DLHS	District Level Household Survey		

JPHN	Junior Public Health Nurse	OPD	Out Patient Department
JSSK	Janani Shishu Suraksha Karyakram	PCPNDT	Pre-Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex-selection) Act - 1994
JSY	Janani Suraksha Yojana		
LHV	Lady Health Visitor	PHC	Primary Health Centre
LLIN	Long Lasting Insecticide Treated Nets	PHN	Public Health Nurse
LR	Labour Room	PIP	Programme Implementation Plan
LSAS	Life Saving Anaesthesia Skills	PMU	Programme Management Unit
LT	Laboratory Technician	PPP	Public Private Partnership
MB	Multi-bacillary cases	PRI	Panchayati Raj Institutions
MCTS	Mother and Child Tracking System	PWD	Public Works Department
MDR	Multi-drug Resistant (TB)	RCH	Reproductive and Child Health
MIS	Management Information System	RDK	Rapid Diagnostic Kit
MHW	Male Health Worker	RHFWTC	Regional Health & Family Welfare Training Centre
MMR	Maternal Mortality Ratio	RHP	Rural Health Practitioner
MMU	Mobile Medical Unit	RKS	Rogi Kalyan Samiti
MO	Medical Officer	RMP	Rural Medical Practitioner
MoHFW	Ministry of Health & Family Welfare	RMSCL	Rajasthan Medical Services Corporation Limited
MOIC	Medical Officer In-charge		
MoU	Memorandum of Understanding	RNTCP	Revised National Tuberculosis Control Programme
MPW	Multi-purpose Worker	RSBY	Rashtriya Swasthya Bima Yojana
MTP	Medical Termination of Pregnancy	SBA	Skilled Birth Attendant
NFHS	National Family Health Survey	SDH	Sub Divisional Hospital
NGO	Non-Government Organisation	SHC	Sub Health Centre
NHSRC	National Health Systems Resource Centre	SHSRC	State Health Systems Resource Centre
NICU	Neonatal Intensive Care Unit	SIHFW	State Institute of Health and Family Welfare
NIHFW	National Institute of Health & Family Welfare		
NIPi	Norway India Partnership Initiative	SIMS	Softline Intelligent Micro Systems
NPCB	National Programme for Control of Blindness	SNCU	Special Newborn Care Unit
NLEP	National Leprosy Eradication Programme	SPMU	State Programme Management Unit
NRC	Nutritional Rehabilitation Centre	STG	Standard Treatment Guideline
NRHM	National Rural Health Mission	TB	Tuberculosis
NSSK	Navjat Shishu Suraksha Karyakram	TNMSC	Tamil Nadu Medical Services Corporation Limited
NSV	Non-scalpel Vasectomy		
NUHM	National Urban Health Mission	VHND	Village Health and Nutrition Day
NVBDCP	National Vector Borne Disease Control Programme	VHSNC	Village Health and Sanitation and Nutrition Committee









# Executive Summary







## BACKGROUND

The Eighth Common Review Mission (CRM) was held between 07 Nov. and 14 Nov. 2014 in 15 states/UTs. A national briefing with detailed discussion on individual Terms of Reference (TOR) was followed by state and district visits by teams comprised of officials from the Ministry, technical and public health experts, and representatives from civil society, development partners and academic and research agencies. The TORs cover the key components of the National Health Mission, with its two Sub-Missions - the National Rural Health Mission and the National Urban Health Mission. This report provides findings related to each TOR with recommendations and state findings, and state wise reports highlighting strengths and challenges covering all the TORs. The findings and recommendations were shared with the key stakeholders in the states, before being compiled into this report.

## FINDINGS

### TOR 1: Service Delivery

- ▶ All states report an increase in the number of health facilities during the NRHM/NHM period. Most of this increase is in the number of Sub-centres and PHCs, indicating an endeavour to improve access and coverage, and ensure service delivery closer to people. Nonetheless, shortfalls in infrastructure continue to be reported. States which report a major shortfall in number of health facilities are – Uttar Pradesh, Uttarakhand and Bihar.
- ▶ While most states report an adequate number of health facilities as per population norms, this positive outcome is negated by the fact that a number of facilities are non-functional. There are also access barriers to the concept of ‘time to care’ approach across states. Beneficiaries in most hilly states (e.g. Uttarakhand and Mizoram) report unacceptable delays in accessing the appropriate health facility.
- ▶ In terms of infrastructure there has been a significant improvement after the initiation of NRHM in 2005. Most states have reported good progress in completion of infrastructure projects. Provision of quality staff quarters is an incentive for

service providers to reside within the campus of the facilities. In most facilities while staff quarters were available, some require renovation in order to be habitable.

- ▶ Availability of comprehensive secondary care is at the level of the district hospitals in most states, but in Tamil Nadu and Kerala secondary care services at SDH/Taluka level.
- ▶ Immunization and OPD care for basic conditions are the most common services being provided by SHCs across states. In Kerala SHCs conduct NCD clinics, demonstrating a model for the non high focus states to move towards the provision of a more comprehensive primary health care package.
- ▶ Delivery services are provided at the SHC level in some high focus states. In Kerala, Tamil Nadu, Punjab, and Chandigarh, patients tend to prefer higher level facilities, even for OPD care, often due to easier geographical access to these higher level facilities.
- ▶ Almost all states report an increase in number of OPDs, but assured IPD care at sub-district level is still a challenge in most states. Except for Tamil Nadu none of the states have been able to operationalize the desired number of FRUs at sub-district level; District hospitals continue to be overburdened with disproportionate IPD care. Access to OPD care, on the other hand, has improved at PHCs and CHCs in almost all states.



- ◆ While co-location of AYUSH services is a feature in several states, there are three states (Kerala, Madhya Pradesh and Odisha) where AYUSH services and human resources provide significant support to the public health system, including the provision of AYUSH services. In Madhya Pradesh and Odisha, AYUSH human resources are being effectively used to plug HR gaps at PHCs and efforts have been made towards building their competencies and multiskilling. Both states report positive feedback from such multiskilling. In other states an average of 10-14% OPD load is taken care by AYUSH systems and most of the States report adequate availability of AYUSH medicines.
- ▶ While all states have made concerted efforts towards ensuring availability of blood, this still remains a challenge, with the district hospital being the nearest facility for blood availability. Quality of blood available through public hospitals is also a cause of concern in some states. Tamil Nadu is the only exception - where blood storage units are functional at CHC level.
- ▶ In most states laboratory services at sub-district level are available but there are concerns regarding the range of investigations. For instance, while blood and urine examinations are available at sub-district level, availability of radiological investigations is only available at district level facilities in most states. Tamil Nadu has a robust system for diagnostics, whereas Kerala fares poorly on provision of laboratory services at sub-district level. Amongst the high focus states, Uttar Pradesh has a limited range and availability of laboratory services below the district level. Odisha has made efforts to integrate laboratory services across various programmes, enabling the state to improve the coverage of laboratory services at sub-district level.
- ▶ Many states have sub-contracted biomedical waste management, laundry, cleanliness, diet and security services, with overall positive experiences. Fair price medicine shops have had a good response in West Bengal while diagnostics operated in the PPP mode have had a mixed response in states.
- ▶ Uttarakhand and Odisha have sub-contracted UPHCs, PHCs and CHCs, to private agencies, but effective assessment of performance is a challenge. Nutritional Rehabilitation Centres (NRCs) managed by NGOs appear to be working well in Bihar.
- ▶ The utilization of 108 ambulances has picked up over time; however major utilization gaps are reported in Chhattisgarh, Assam, Mizoram and Uttarakhand (facility-based ambulances). Performance of 102 is better as compared to 108 across states. However all states reported low utilization of drop back services. One area of concern is that significant out of pocket expenditure is reported by mothers having to avail private transport to reach the health facility in pockets of Odisha, Mizoram, Telangana, Madhya Pradesh and West Bengal.
- ▶ Despite multiple models of ambulances being implemented in various States, there remains a considerable gap in ensuring assured referral services. For instance in MP both Janani Express and 108 are not yet integrated. In Bihar, multiple ambulance services operate with multiple numbers resulting in ambiguity; even if the call is made to a centralized call centre by the patient, s/he is often asked to contact another service provider.
- ▶ There are adequate numbers of MMUs deployed across states except in Chhattisgarh where this service has been discontinued by the State. Gaps in functioning of MMUs in Telangana, Assam and Rajasthan were noted due to stock-outs of drugs and/or lack of manpower. In Uttarakhand and Bihar, the MMU is not functional due to lack of renewal of contracts with private providers. In MP



the most difficult and inaccessible areas of the districts are not covered by MMUs.

- ▶ The average outpatient numbers seen by MMUs is in the range of 20-70/day across states. In some states, MMUs also serve as treatment points for Non Communicable Diseases (NCDs).
- ▶ A comprehensive evidence based IEC/BCC plan is lacking in most states. Where available such planning of IEC/BCC strategies is done at state level with minimal involvement of districts – and consists of program communication rather than health communication. IEC messages for healthy populations and those pertaining to social determinants of health were found lacking across states.
- ▶ Almost all States show IEC material related to various schemes placed at all levels of health facilities. Maximum visibility of these displays is at the Sub-centres.
- ▶ Shortages in human resources for IEC activity development and delivery were observed across states with little effort to improve IPC skills for existing frontline providers.
- ▶ In most contexts the conceptualization and design of IEC materials are done either by development partners or the national programme divisions at MoHFW, with only limited adaptation to the local context.
- ▶ Poor monitoring of IEC/BCC activities was found across states. The approach currently focuses on the physical presence of IEC materials rather than their utility in helping patients make a more informed decision.
- ▶ Odisha demonstrates best practice in IEC with the development of a comprehensive strategy for health communications at the state level. In Uttarakhand an extensive plan for strengthening the IEC cell has been drawn up. Kerala uses IT as a platform for IEC/BCC.

## TOR 2: RMNCH +A

- ▶ Mapping and prioritizing of health facilities is complete across all states but is largely limited to



provision of delivery care. While a large number of facilities are designated as 24 X 7 PHCs and FRUs, their functionality as delivery points is limited in most high focus states visited, especially in those with a relatively higher proportion of home deliveries. Inequitable distribution of delivery points and FRUs leading to underutilization of some health facilities with overcrowding of others remains a challenge.

- ▶ Emphasis on delivery care provision is seen across all states and limited efforts have been made to increase the availability of services for safe abortion care, comprehensive family planning services, care for RTI/STI and newborn care at block and sub block health facilities. Currently availability of these services is limited to district hospitals in almost all states except Kerala, Odisha and Tamil Nadu.
- ▶ Availability of essential commodities like drugs, vaccines, contraceptives and equipment as per the RMCH +A matrix varied across districts. Shortage or stock-out was seen in several states. Efficient supply chain management with no stock outs was reported from Odisha and Tamil Nadu.
- ▶ Madhya Pradesh has set up Arogya Kendras at AWC in every village with about 16 types of drugs and equipment in an attempt to institutionalize primary care services at village level.



- ▶ There is enhanced thrust on RMNCH+A services and handholding of all the high priority districts by development partners through expanding human resources for management and monitoring, undertaking gap analysis and periodic monitoring in high priority districts.
- ▶ While there has been a steady increase in the uptake of Antenatal Care (ANC) services across all states, the quality of care continues to be a challenge, especially in Assam, Bihar, Chhattisgarh, Kerala, Mizoram and Uttar Pradesh. However, timely identification and follow up of high risk pregnant women continues to be poor across most states.
- ▶ As expected, the rate of institutional deliveries continues to increase across all states. Another promising finding is sustainability of the increased utilization of public health institutions for delivery care. Only in Kerala and Telangana, is the private sector catering to a high proportion (nearly 60%) of institutional deliveries.
- ▶ An effort to improve the services at labour room was evident in all states, though the status varies across facilities i.e. better labour rooms at District level hospitals as compared to CHCs, PHCs and SHCs and across districts - with better facilities in better performing districts.
- ▶ With regard to the quality of clinical care the findings were mixed. Findings from all states note gaps in the capacity of service providers to provide comprehensive services. For instance, most ANMs/ Staff nurses handling delivery cases were not SBA trained in Chhattisgarh, Odisha, Madhya Pradesh and Uttarakhand. Technical protocols and SOPs in local languages were displayed only in a few facilities.
- ▶ Overall the availability of CemONC services have improved across states but the gap between the actual requirement of health facilities according to their designation and their effective functioning is yet to be bridged. States continue to grapple with challenges of setting up blood banks/blood storage units and the availability of specialists to operationalize FRUs/CemONC services. FRU services were not available in two districts – Tehri of UK and Shrawasti of UP; incidentally both these districts are HPDs with poor health indicators with no alternative private sector options.
- ▶ High rate of C section (39.5%) was observed in Kerala where one SDH in Ernakulum recorded caesarean section rates as high as 64%. This was justified with the reason that “doctors do not want to take any risk” while giving a trial of labour to an over-demanding family, which perceives caesarean to be a safer option than a normal delivery. Similar findings are seen in Telangana with over 50% C sections (both in private and public). This high proportion of C sections is alarming and needs a thorough review.
- ▶ A significant increase is seen in the establishment of Facility Based Newborn Care Services throughout the country. However the slow pace of creating SNCUs in states with high IMR rates i.e. Bihar and UP is a cause for concern. SNCUs in Kerala, Odisha, Telangana and MP have good infrastructure and functionality. In MP, 30 SNCUs out of 53 have been accredited by the National Neonatology Forum (NNF) while in Telangana one SNCU at Medak Hospital has been proposed for NNF accreditation. SNCUs at Gandhi Medical College and Niloufer Hospital in Telangana were overcrowded with double/triple occupancy. NBCC and NBSUs need strengthening specifically in states of Assam, Bihar, Chandigarh, Chhattisgarh, Mizoram, Odisha, Uttarakhand, Uttar Pradesh and West Bengal.
- ▶ Referral linkages from the community and follow up of newborns discharged from SNCU need strengthening in most states. The majority of the admissions at SNCU were found to be inborn with fewer outborn admissions in all states except Tamil Nadu.
- ▶ Nutritional Rehabilitation Centres are now in place in most states except in both the districts of UP that were visited. Suboptimal utilization of NRC is reported from all states except Telangana and Tamil Nadu.
- ▶ RBSK has been rolled in most states and is at varying stages of implementation. Majority of the states have nearly completed recruitments and the teams have begun screening of children except in Bihar, Punjab and Telangana while in



West Bengal the program does not cover the entire gamut of services as per guidelines. States of Tamil Nadu and Kerala have their own school health programmes. As the number of screened cases increase, building referral chains with tertiary care centres becomes critical. Kerala has digitalized the school health screening data and established excellent referral systems for addressing the various health problems identified at screening. In Uttarakhand, effective co-operation and support from ICDS and the Education department has led to better coordination between functionaries at the field level for implementation of the programme.

- ▶ Of the four components of RKSK, most states have implemented the WIFS programme and set up AFHCs while peer educator selection is yet to begin. Menstrual Hygiene Scheme programme is implemented in a few districts only. WIFS programme has gained visibility in the community with growing acceptance of the weekly dose of IFA.
- ▶ Home Based Newborn Care (HBNC) through regular home visits by ASHAs is being implemented in majority of the states visited. ASHAs were found to be adequately trained for newborn care and identification of danger signs in newborns and postnatal mothers in Odisha, Punjab, Rajasthan and Uttarakhand. Quality of supportive supervision and mentoring of ASHAs were reported to be poor, affecting the functionality of ASHAs - this was observed in the states of Bihar and Rajasthan.

- ▶ Family planning service delivery continues to be centered around limiting methods with little focus on spacing methods like IUCD and PPIUCD. Most states have rolled out PPIUCD services but it is yet to gain momentum. PPIUCD services are available only at secondary level due to lack of trained manpower. Fixed day Services (FDS) for sterilization are provided in a few states such as Bihar, Chandigarh, Odisha, Tamil Nadu and Uttar Pradesh. Availability of sterilization services is also limited to District level health facilities and at best at a few CHCs when camps are held. Findings from Bihar highlight gaps in quality protocols being followed during female sterilization camps.
- ▶ Home based distribution of contraceptives has begun in almost all states. Supply of contraceptives for ASHAs was regular in all states except Assam, Bihar, Kerala and Uttar Pradesh. Counselling skills for front line workers like ASHA, ANM and even FP counsellors on contraception is a challenge.
- ▶ Community level awareness among beneficiaries regarding benefits of the JSY was good in almost all states. Payment of JSY incentives has been streamlined through Direct Bank transfers in several states, but delays persist in some districts.
- ▶ While JSSK has made a significant contribution in reducing out of pocket expenditures, OOPE are yet to be eliminated. The findings are variable regarding awareness and utilization of entitlements under the newborn and infant component. Incidence of OOPE was observed in several states, with expenditure being reported on transport, drugs and consumables.
- ▶ Dedicated Grievance Redressal Mechanism for JSSK was not found in any state except UP where a toll free number has been established at state level. However it is likely that community awareness of this was low, as there was no display of the toll-free number at the facilities visited. Assam and Rajasthan use the general 104 toll free number for grievance handling; this was displayed in facilities.
- ▶ All the states visited have systems in place for Maternal Death Review except for Bihar, but a mechanism for Child Death Review exists in only few states viz. Chandigarh, Kerala, Tamil Nadu and

Rajasthan. Most states are yet to begin utilizing the output of the reporting system for taking corrective action.

- Regarding Immunization services, significant improvements have been made in the program. The use of work plans and due lists by field workers have contributed to strengthening of the program. Cold chain maintenance and vaccine logistics systems need strengthening in Bihar, Chhattisgarh, Madhya Pradesh, Mizoram, Punjab and Tamil Nadu.

### TOR 3: Disease Control Programmes

- Malaria has shown a declining trend in Punjab, Kerala, Assam, Chhattisgarh, Uttar Pradesh, Odisha, Rajasthan, and Bihar; however, there appears to be a persistent number of cases in Tamil Nadu, Telangana, Mizoram, Uttarakhand and a rise in cases reported from Madhya Pradesh and West Bengal.
- There is a shortage of human resources at different levels and overburdening of staff - this impedes active surveillance in states such as Madhya Pradesh, Rajasthan and Mizoram. Decreasing ABER is an area of concern in states like Tamil Nadu, Chandigarh, Uttar Pradesh and Bihar.
- The number of cases of Dengue too has declined compared to last year in Punjab, Chandigarh, Rajasthan and West Bengal while increases have been reported in Tamil Nadu, Odisha and Madhya Pradesh. A rising trend in Chikungunya has been observed in Odisha and Madhya Pradesh while Telangana shows a declining trend. AES and JE cases have increased in Assam and Bihar. Kerala continues to report cases of Leptospirosis. West Bengal has shown improvement in morbidity and mortality due to JE. In Bihar, a decline in cases and deaths due to Kala Azar was seen as compared to the same period last year.
- The Lymphatic Filariasis programme appears to be doing well, with Mf prevalence declining in Tamil Nadu, Chhattisgarh, Telangana and Uttarakhand. There are considerable delays in operating and managing cases of Hydrocele and Lymphoedema in Madhya Pradesh and Bihar.

- Regarding tuberculosis, Tamil Nadu, Telangana, Punjab, Chandigarh, Uttar Pradesh, Rajasthan, West Bengal and Assam shows satisfactory performance in achieving targets for diagnosis and cure. However, Madhya Pradesh, Bihar, Odisha, Uttarakhand and Kerala need to strengthen implementation.

- A well-established human resource pool with trained District TB Officers (DTOs) and supervisory staff was available in Punjab, Mizoram and Assam, but vacancies were reported from Uttar Pradesh, Chhattisgarh and Tamil Nadu. Training of the newly recruited staff is pending in Rajasthan, Punjab, West Bengal and Madhya Pradesh.

- Laboratory registers, TB registers and treatment cards were found to be complete, and IEC material was well displayed in health facilities visited in Tamil Nadu, Punjab and Assam.

- PMDT (Program Management of Drug Resistant TB) is well established with suspect identification, sample collection decentralized to DMC level and good linkage with Culture and Drug Sensitivity (C&DST) labs for all the districts for diagnostic and follow-up testing services. Adequate service provisioning was found in Tamil Nadu, Telangana, Rajasthan, Uttarakhand, Uttar Pradesh, Bihar, West Bengal and Assam.

- Effective TB-HIV collaboration with Provider Initiated Testing and Counseling (PITC) of TB suspects for HIV was seen in Telangana, Rajasthan and Chandigarh. Gaps were noticed in Bihar, Chhattisgarh, Mizoram, Uttarakhand, Tamil Nadu, Odisha and Punjab.

- Involvement of private practitioners, laboratories and hospitals for notification of TB cases under Nikshay has been initiated in many states.

- Low paediatric case detection for TB was seen in Uttar Pradesh, Madhya Pradesh, Uttarakhand and Tamil Nadu. This is a cause for concern.

- Surveillance units have been established in all states/districts, with major components including integration and decentralization of surveillance and strengthening of public health laboratories for IDSP being implemented across states. There has been improvement in the reporting status



of all three SPL formats ('Syndromic', 'Probable' and 'Laboratory' confirmed) using standard case definitions.

- ▶ Most outbreaks were reported and responded to by the district/state surveillance units; States also received media alerts from the central surveillance unit to confirm the outbreak and take appropriate action as seen in Kerala, Telangana and Bihar. However, only a few districts/states were using analyzed IDSP data for developing the District Health Action Plan (DHAP).
- ▶ Referral lab network under IDSP has been established by utilizing the existing functional labs in medical colleges and various other major centers in States and linking them with adjoining districts for providing diagnostic services during outbreaks.
- ▶ In Bihar, 18 districts are yet to achieve the target of leprosy eradication. ASHA payments under the program are irregular and an IEC plan for the reduction of stigma and discrimination is not available in both the districts visited in Bihar.
- ▶ In Madhya Pradesh, newly appointed Medical Officers (MOs) are yet to be trained in leprosy. Treatment completion rates are poor in urban areas in comparison with rural areas. In Odisha, 15 districts reported prevalence of more than 1/10,000. AYUSH Medical Officers were trained in leprosy to manage DPMR clinics at block CHCs. In Tamil Nadu, special efforts are made for early detection of leprosy through trained ASHAs and good referral and feedback mechanisms are in place for the early detection and treatment of leprosy cases. In Telangana, involvement of general health staff in NLEP needs improvement. In Uttar Pradesh, 64 districts have achieved the target of leprosy elimination but 10 districts continue to have more than the target prevalence rate of 1 per 10,000 population.
- ▶ Implementation of the National Programme for Control of Blindness is underway across states, with satisfactory progress in cataract surgeries. Bihar, Odisha, Rajasthan and Uttarakhand have inadequate human resource for the blindness control programme. In Kerala, eye bank/eye

collection centers are established in every district, and in eight districts village level blindness registries to facilitate eye care services are in place. Mizoram and Uttarakhand also have one eye bank in the state capital. School based eye screening programme was reported from Kerala, Odisha, Tamil Nadu, Telangana and Uttarakhand. In Tamil Nadu, screening of school children for refractive errors was established at two levels – initially by school teachers and then by ophthalmic assistants.

- ▶ Adequately functioning NCD clinics providing regular OPD services were seen in Tamil Nadu and Kerala. However, the programme is still evolving in the other states visited.
- ▶ With regard to other national programs, progress is varied across states:
  - National Programme for Prevention and Control of Fluorosis is being implemented in Madhya Pradesh, Rajasthan, Telangana and West Bengal. Fluorosis control units have been established in selected districts to carry out regular surveys to assess the prevalence and coordinate with the public health engineering department.
  - Implementation of the National Tobacco Control Programme is reported from selected districts of Bihar, Mizoram, Rajasthan, Tamil Nadu, Telangana, Uttarakhand and Uttar Pradesh.
  - National Programme for Trauma Care reported from Madhya Pradesh
  - National Iodine Deficiency Disorder Control Programme reported from Kerala and Telangana.
  - National Mental Health Programme is being implemented across selected districts in Assam and West Bengal.
  - Implementation of the National Programme for Health Care of Elderly is reported from five districts of Madhya Pradesh only.

#### **TOR 4: Human Resources for Health**

- ▶ Despite efforts, shortage of specialists and doctors still remains an impediment to providing universal access to quality health care. Significant vacancies



for doctors, nurses and paramedical staff were observed in Uttar Pradesh, Odisha, Telangana, Chhattisgarh and Uttarakhand, Bihar and Madhya Pradesh.

- Irrational deployment of available human resources adds to the challenge of ensuring adequate staffing in health facilities with a high caseload and those located in difficult-to-access underserved areas.
- The recruitment process in several states like Kerala, Punjab and Odisha have been streamlined by adopting innovative measures like web-enabled procedures, decentralized recruitments, direct walk-in interviews and the constitution of specially empowered committees for expediting recruitment processes.
- Retention strategies have been adopted by many States including differential salary for postings in difficult areas (Mizoram, Bihar & Madhya Pradesh); Performance Based Incentives (Odisha); credit marks for admission to PG courses (Tamil Nadu); reserved seats in PG programmes (Uttarakhand); Compulsory One Year Rural Posting for MBBS doctors to get admission in PG courses (Assam) and CRMC (Chhattisgarh)
- Competency assessment tests have been recommended to evaluate skill gaps of existing care providers and for the recruitment of competent candidates. States like Tamil Nadu

and Madhya Pradesh have developed skill labs and started baseline skill assessment tests but the overall progress has been slow.

- Performance appraisal systems followed in Chandigarh, Mizoram and Bihar are still in the preliminary phase with minimal linkage with incentives and salary increments for staff. States like Assam and Kerala utilize such systems to identify non-performing staff so that further capacity building or punitive action can be initiated.
- A training calendar was in place in most of states with appropriate details of training sites, trainers and batches but post training deployment plans were not prepared in any state.
- h. Online Human Resource Management Information System (HRMIS) enables states to maintain updated personnel details including their qualifications, training details, posting location and service duration. Inter-state variation in implementation and utilization was observed among states. States like Jharkhand, Bihar, Assam and Odisha have HRMIS in place while other states are in the process of setting it up. However, its application for planning of human resources, trainings and post training deployment is still limited.
- A well-implemented Public Health Cadre in Tamil Nadu is an example of good practice; other states do not have such a system though there is interest in establishing one in some states.

## TOR 5: Community Processes

- PRIs play an active role in VHSNC in many states, with Kerala reflecting the most well defined and institutionalized systems. PRI involvement in the RKS was seen in Odisha, Kerala, Chhattisgarh, Mizoram and Tamil Nadu.
- West Bengal reports 'Convergence Committees' with representation from PRI, Department of Women and Children, and Public Health and Engineering Department and others from block to the State'. Madhya Pradesh, Kerala and Rajasthan also report institutional convergence to improve action on social and environmental determinants.



- In Bihar, UP, Telangana, and West Bengal, VHSNCs are at the level of Gram Panchayat, rather than at revenue village level, with bank accounts being operated by Sarpanch/Panchayat Secretary and ANM. The process of restructuring of VHSNCs is pending in most states.
- For Palliative Care and Mental Health programmes in Kerala, funds and strong community support are enabled by elected representatives and funding sources extend beyond untied funds.
- Well functioning and active VHSNCs are also seen in Odisha and Chhattisgarh. In Odisha, low performing VHSNC (about 45% of total) were identified and provided capacity building inputs. In Madhya Pradesh, VHSNCs are reported to be taking local initiatives around issues of water and sanitation, spray of DDT and Gammaxine.
- Awareness and knowledge levels of the PRI representatives were reported to be weak in most states, except Odisha. Regularity and quality of monthly meetings of VHSNC were weak in most states.
- Kerala has institutionalized decentralization mechanisms and convergent processes, including a nodal officer for convergence measures at state level. Palliative care is now mandatory and a comprehensive Health Plan has been prepared for a period of five years. School children have been involved in Sanitation, and Vector control activities and generating awareness on hazards of alcoholism among students.
- While effective convergence is reported from several states, between ASHA, ANM and AWW, for organizing VHSNC meetings, VHND, convergence between the Health, ICDS and PHE departments appears to be a challenge at the block and district level. In UP an “AAA” (ASHA, ANM and AWW) platform is implemented in 25 high priority districts for effective convergence between frontline workers.
- Across the states, the focus of VHND appears to be on immunization. Where ANC is provided, the quality of services is weak, and the full complement of ANC services, like, Hb test, BP check-up, and

abdominal examination is not being provided in most states. No specific mechanisms for monitoring of VHNDs have been reported from most states. West Bengal reported monitoring mechanisms to be in place, however, major discrepancies were found between the number of VHNDs planned and held and those attended by ANM, AWW and ASHAs.

- While in all other states, immunisation session and VHND are being organised together, Odisha and Tamil Nadu report holding separate sessions for immunization and VHND, allowing for more time to undertake the entire gamut of outreach activities.
- Selection of ASHAs is complete across most states. Gaps are noticed, where targets were revised according to the 2011 census and identification of non functional ASHAs, but pace of recruiting new ASHAs is an issue of concern in UP, Mizoram and Uttarakhand.



- The database of the ASHA programme across states has become more robust with information on selection, training, ASHA drop-out, and incentive payments. Rajasthan, Punjab and Maharashtra, have developed a web-based software for database management and updating for payments.
- Refresher training on the skills taught in Module 6&7 training rounds have been planned across many states. Module 6&7 training is still in its

initial phase in UP, although the momentum has increased. Rajasthan has also only recently stepped up the pace of Module 6&7 training. The pace of training in Module 6&7 training has also slackened in Bihar and MP. Bihar which showed good progress over the last three years has lost momentum due to large delays in fund releases.

- ▶ The pace of Home Based New born Care (HBNC) interventions and related ASHA skills is variable, but steadily improving in most states. Several states report a low level of HBNC skills among ASHAs, particularly where Module 6&7 training rounds have been conducted without giving HBNC kits to ASHAs. In Kerala the knowledge and skills of the ASHA on basic RCH issues were found to be weak. Reports from Assam, Chhattisgarh, Mizoram, Telangana, and UP indicate that ASHA are not able to identify pregnant women with complications. The role of the ASHA in the disease control programmes especially malaria and leprosy was well appreciated in West Bengal, Odisha, and Tamil Nadu. (For leprosy).
- ▶ Across the states, problems in drug kit replenishment were reported. Delays in drug replenishment from sub centre were reported from Chhattisgarh and Bihar.
- ▶ Most state reports the average incentive earned by ASHAs between Rs 1500 to 2000 per month. States are yet to begin paying the routine and monthly recurring incentive of Rs. 1000.
- ▶ Chhattisgarh, Madhya Pradesh and Odisha have a provision in place for reservation of a percentage of seats in the ANM schools for ASHAs. Bihar and Chhattisgarh also support ASHAs for enrollment in education equivalency programmes in National Open School. In several states, selection of ASHAs as ASHA Facilitator is also a mode of career progression.
- ▶ Interventions in Community Action for Health programme were reported from Punjab, Bihar and Madhya Pradesh. In Chhattisgarh Community Based Monitoring is now a part of VHSNC monthly meetings using a public services monitoring tool. Social audit of deaths related to maternal, child, fever, TB etc, and community feedback regarding

services being provided by govt health facilities and block level public hearings are undertaken. No CAH related programme interventions were reported from Odisha, Mizoram, Chandigarh, Uttarakhand, Telangana, West Bengal and Kerala.

## TOR 6: Information and Knowledge

- ▶ In comparison to earlier years the quality and use of HMIS data has improved especially in those states where local HMIS systems are used for flexible and customized data analysis and feedback. All states are reporting facility-wise data into the HMIS web Portal except for Tamil Nadu (due to lack of integration between the local state system and the HMIS Web Portal) and West Bengal (where urban facilities under Municipal Corporation do not report in to HMIS). Performance audit of districts and facilities are being conducted on the basis of HMIS data.
- ▶ A few private institutions (some accredited) also participate in HMIS reporting across some states. Punjab, Kerala, Odisha, Madhya Pradesh and Bihar have issues of duplication of data entry due to the absence of a data exchange interface between the HMIS Web Portal and the local HMIS system. This needs to be addressed.
- ▶ HMIS data quality is still being affected by the use of non-standard registers especially at secondary and tertiary care institutions. Manual compilation of HMIS reports from the register leads to computation errors; this has also been raised in previous CRM reports. An Integrated RCH register is available at sub centers; ANMs expressed a need for relevant training to use these registers effectively.
- ▶ Several functional health information systems were noted across states; the most promising among these are the Human Resource Management Information System (HRMIS) in Bihar, Chhattisgarh, MP, UP, Odisha, Tamil Nadu, Kerala, Assam and the Drug Vaccine Logistics Management Information Systems (DVLMS) in Punjab, Rajasthan, Kerala, Tamil Nadu, and Telangana. However multiplicity of information systems also leads to problems like increasing the burden of data entry and

data duplication; this is compounded by the lack of interoperability among these information systems.

- ▶ States are making an effort to make MCTS functional. Distribution of Closed User Group (CUG) SIM cards to ANMs for real time updation of services delivered via Unstructured Supplementary Service Data (USSD) gateway is in process. ANMs in a few states (Chhattisgarh, Rajasthan, Punjab, Assam, Kerala, Telangana and Odisha) have started reporting via USSD.
- ▶ "Swasthya Seva Sandesh" initiative taken by Rajasthan has shown significant progress by sending almost 30 lakhs SMS to beneficiaries upto Nov'14.
- ▶ Progress on registration of MCTS is fairly good across all states. However, the use of MCTS data by states to address gaps in service delivery are still sub optimal. Effective monitoring and supportive supervision to improve tracking and follow up of identified beneficiaries remains a challenge.
- ▶ The role of SIHFWs is limited to planning, coordinating and conducting training programs across states.
- ▶ SHSRCs are established in Odisha, Chhattisgarh, Punjab, Kerala and West Bengal. Chhattisgarh has an SHSRC with adequate human resource and plays an active role in addressing health system challenges in the state. SHSRCs in other states are grappling with limited resources as well as a lack of role clarity vis-à-vis the state health society.

## TOR 7: Health Care Financing

- ▶ Delays were observed in the transfer of funds from SHS to DHS due to several reasons, such as the absence of standard operating procedures (SOP) for the new arrangement of money passing through the treasury route since 2014-15 (taking between 60-90 days in states); untied funds not being released e.g. in Uttar Pradesh as some vouchers were not certified; delays in receiving the state share e.g. Bihar.
- ▶ Underutilization of funds was found in several states. Reasons noted were - money allocated for

National Urban Health Mission was not utilized as the States have just initiated the scheme; transfers being made without considering the unspent balance already with DHS e.g. in Assam and Odisha; delays in transfers to ASHAs and JSY beneficiaries; and delays in release of untied funds.

- ▶ The transfer of funds from State Health Societies (SHS) to District Health Societies (DHS) is still according to the District Health Action Plan and activity based instead of the budget pool, as seen in Uttarakhand, Kerala and Tamil Nadu.
- ▶ Financial and administrative power from the State Health Society to the District Health Society (DHS) has been delegated in most States. Digitalized office procedures through Digital Document Filing System at DHS has enhanced financial and administrative efficiency e.g. in Kerala.
- ▶ States like Bihar, Rajasthan, Madhya Pradesh and Assam still have vacancies in posts for finance and accounts. The key post of the Director is still vacant in Bihar, Chhattisgarh, Kerala and Uttarakhand. Shortage of staff and inadequately trained staff impact financial management by causing delays in allocation of budgets to facilities; release of funds to ASHAs and beneficiaries; preparing Bank Reconciliation Statements (BRS) etc.
- ▶ Training in financial management under NHM has been provided at state, district and block level, in most states, except in Rajasthan (at block level) and Mizoram for PFMS.
- ▶ In almost all states funds are being transferred from state to the district level via Electronic transfer (e-transfer). Direct beneficiary transfer (DBT) to the last facility and to beneficiaries is being implemented in a few states such as Odisha, Punjab and Kerala.
- ▶ Cheque transfers are still being made in some states from the District Health Society to CHC/PHC and also for ASHAs and JSY beneficiaries. Delays in opening bank accounts have led to delays in transfer of funds. Some states continue to use direct cash payments for ASHAs eg. Kerala, Assam and Mizoram.



- ▶ The new banking guidelines issued by the Government of India have been implemented in all states. All required bank accounts have been opened except in Kerala, Assam and Telangana. Linking of bank accounts has just started in many states.
- ▶ Statutory and concurrent audit is being conducted regularly covering all programs under NHM. However finalization of these reports is pending in most states. Most states have completed the CAG audit up to the FY 2013-14.
- ▶ Most States accounted for and utilized the interest earned on unspent balances as per guidelines of GOI. Interest earned at state and district levels are converted into grants and utilized on PIP approved activities only.
- ▶ Majority of states maintain and prepare accounts through a double entry book keeping system using the software Tally ERP 9. In Madhya Pradesh single entry system is used and in Telangana, Mizoram and at the District level in Tamil Nadu the accounts are still maintained manually. In most states, over 50% of agencies have been registered under the Public Financial Management System (PFMS).
- ▶ In most states, physical progress is not captured in the Financial Monitoring Report (FMR) along with financial progress. Only Chandigarh, Odisha and West Bengal have reported both physical and financial data in the FMR and expenditures are monitored on a monthly basis at all levels from State to Block on the basis of SOE and FMR submitted by them.
- ▶ In Kerala and Assam, consolidated financial reports are not available in FMR and non-compliance of rules was observed at facility level. Single signatory for use of untied funds was observed instead of joint signatories under GOI guidelines and no cash books are maintained for untied funds and the annual maintenance grant funds at facility level.
- ▶ In most states, the cost of care in public facilities (other than minimal registration charges) especially for students and BPL families is low. Most health care services such as drugs and

diagnostics, consultation and counseling are being provided free of cost. However, interviews with patients revealed they had to pay for drugs and diagnostics even though they were BPL inpatients. In Bihar, patients were not aware of availability of free diagnostics. Private transport for beneficiaries accounts for high OOPE in many states. In some states, patients had to pay for services provided through PPP models e.g. West Bengal.

## TOR 8: Quality Improvement

- ▶ Odisha, Madhya Pradesh, Bihar and Uttar Pradesh have selected facilities for rolling out the National Quality Assurance Programme; others are yet to do so. The reconstitution of District Quality Assurance Committees and Units has not been done in any state except Madhya Pradesh, Uttar Pradesh and Orissa. Initial steps have been taken in Bihar and Chandigarh. It is observed that though some states are reconstituting their committees there are concerns over the pace.
- ▶ Training and capacity building has been identified as a key strategy in the operational quality guidelines. Efforts are underway in Kerala, Assam, Uttar Pradesh and Bihar. States like Punjab, Uttarakhand, Chhattisgarh, Rajasthan, Mizoram, Telangana, Rajasthan, Chandigarh, Madhya Pradesh and West Bengal are yet to streamline capacity building and training for the implementation of the National Quality Assurance Programme.



- Services for Bio Medical Waste (BMW) management have been outsourced in most public health facilities. Concerns related to collection, segregation, transportation were found in the majority of public health facilities during the review.
- Adherence to standards for Bio medical waste segregation were satisfactory only in Kerala and Rajasthan. Biomedical waste management was fairly robust in the district hospitals of Mizoram but proper segregation was lacking at CHC as well as PHC. Outsourcing to third parties for sanitation services is the norm across all the states visited. In UP the staff were well versed with waste management protocols.
- Hygiene and sanitation is another area which needs attention. The status of cleanliness and sanitation is relatively poor in healthcare facilities of all states except Kerala. Upkeep of toilets was found to be unsatisfactory in the state of West Bengal.
- Adherence to Standard Treatment Protocols needs improvement across states.
- The practise of capturing patient satisfaction feedback was observed in Punjab, Kerala and Madhya Pradesh, but is yet to be initiated in Assam, Uttarakhand, Chhattisgarh, Orissa, Mizoram, Telangana, Bihar and Rajasthan.
- Reporting and analyzing key performance indicators has to be strengthened across states. Audits like medical audit, prescription audit and death audit needs better implementation.
- Grievance redressal mechanisms are weak across states. In many states, while systems exist, the mechanism to analyze and address complaints needs strengthening.

## **TOR 9: Drugs, Diagnostics, Procurement & Supply Chain Management**

- Significant progress has been made in institutionalizing a centralized and transparent procurement system across most states. These were operational in states of Bihar, Chhattisgarh, Kerala, Punjab, Mizoram, Rajasthan, Tamil Nadu, Telangana and Uttar Pradesh. States of Assam,

Chandigarh, Madhya Pradesh, Odisha and Punjab are in process of setting up these systems. In Uttarakhand and Mizoram although procurement was through Central Medical Store Depot (CMSD), this was found to be inefficient as delays in procurement were common, leading to over 60% of the procurement being done locally.

- In order to create an efficient inventory/supply chain management system, some states have also invested in development of web based software. These were found functional in Bihar (Aushdharma online); Uttarakhand (ProMIS software); Uttar Pradesh (recently started – Drug Procurement and Inventory Control System) and West Bengal (State Management information system – SMIS). Limited functionality was reported in Chhattisgarh (Drug Procurement & Distribution Management information System) and Odisha (Odisha Drug Inventory Management System) while in Punjab, a software- E- Aushadi is in the process of implementation. Odisha also plans to expand the scope of its ICT enabled logistics system (RHCLMIS) from contraceptives to also include essential drugs/supplies.
- The effectiveness of these mechanisms in terms of fewer episodes of stock outs at the public health facilities especially at the sub district level is yet to be achieved. We reported earlier that stock outs of one or more essential commodities (drugs/ equipment and vaccines) as per RMNCH+A matrix were common across all states except in Odisha and Tamil Nadu.
- Storage facilities such as regional/divisional warehouses were available in most states except in Tinsukia, Assam where the drug ware house was in a dilapidated building and Chandigarh where storage space was insufficient.
- Quality control measures with adequate number of functional laboratories was reported from only few states such as Chhattisgarh, Bihar, Kerala, Rajasthan, Tamil Nadu and West Bengal. Assam and Mizoram are yet to empanel any laboratory for testing the quality of drugs while in Bihar the empanelled labs did not follow standard operating procedures. Chhattisgarh and West Bengal had an

inventory management soft ware and laboratories dedicated to ensure quality of drugs, but expired drugs were observed by CRM teams in few of the visited health facilities. This was also reported in Telangana.

- ▶ Although most states notified the Free Drug Scheme, unavailability of drugs at the peripheral i.e, sub district health facilities undermine the initiative to provide free drugs and eliminate out of pocket expenditures. Of the 380 drugs supplied by CGMSC, only 35 % were available in Rajnandgaon and 53% in the Bilaspur warehouse in Chhattisgarh. Community awareness about Free Drug Schemes was poor in West Bengal and Uttar Pradesh whereas in Chhattisgarh, even staff appeared to be to be unaware of the scheme. Free drugs were available only for JSSK beneficiaries and in case of some emergencies in Chandigarh. Madhya Pradesh launched 'Mamta Abhiyan' and also set up 'Arogayakendars at AWCs where 16 drugs and 5 investigations are provided free at the doorstep.
- ▶ Most states do not have a state or district level Drug and Therapeutic Committee except for Odisha where this has been set up in every district. Prescription audit was reported only from two states of Bihar and Chhattisgarh. In Chhattisgarh, the State Health Resource Centre undertook audits and reported that branded drugs were prescribed in nearly half of the cases. The practice of prescribing branded drugs was also seen at some facilities in Assam, Kerala, and Mizoram. Generic medicine prescriptions were seen in BS Medical College and Onda BPHC in West Bengal. In Mizoram, DH and SDH have rented out pharmacy shops commonly known as "Medical Canteens" which charge drugs at market price without any subsidy for patients.
- ▶ Standard Treatment Guidelines have been developed in Chhattisgarh, Mizoram, Odisha, Madhya Pradesh, Rajasthan, West Bengal and Uttar Pradesh but adherence to these protocols was limited in West Bengal and Mizoram while in Uttar Pradesh staff was unaware about STGs.
- ▶ States with EDL are – Kerala, Chhattisgarh, Odisha, Mizoram, Madhya Pradesh, Bihar, Rajasthan and

Uttar Pradesh. The Essential Drug List is yet to be finalized in some states. Kerala has added 73 anticancer drugs in the EDL; Odisha, Rajasthan and West Bengal have classified EDL as drugs for primary, secondary and tertiary care, while Uttarakhand and Bihar have classified this based on the level of the health facility – DH, CHC, PHC and SHC.

- ▶ In contrast to the free drugs made available to the community, the range of services provided free (or just made available) was not universal as it was limited mostly to beneficiaries for JSSK and BPL beneficiaries, as reported from Assam, Chhattisgarh, Mizoram, Odisha (also for freedom fighters) and Uttarakhand. Bihar has introduced an initiative 'Sankalp', through which Radiology (X-Ray/Ultrasound) & pathology services are made free to public but erroneous contract has allowed subcontracting leading to poor monitoring.

## TOR 10: National Urban Health Mission

- ▶ The NUHM Program is at varying stages of implementation across states. Funding for NUHM in 2014-15 has been provided to most states; most of these are in the preparatory phase. Many states have not been able to utilize funds effectively. The pace of implementation is brisk in the state of Kerala but slower in UP, Chhattisgarh, Bihar and Uttarakhand.
- ▶ Planning and mapping of slums is completed in Kerala and Odisha and is underway in other States.
- ▶ Facilities available under NHM have been mapped in the states of Punjab, Rajasthan, MP, Chandigarh, Uttaranchal, Odisha and is in process in other states such as Mizoram. States such as MP, Punjab and Chandigarh are also planning mapping activities in collaboration with other stakeholders and technical agencies.
- ▶ In many states, service delivery structures such as UPHCs have been created, along with strengthening of existing facilities in cities with more than 50,000 populations. While the up-gradation process is underway in some states, establishing new UPHCs is a challenge due to problems of acquiring land in congested urban spaces.



- ▶ Institutional structures such as the urban health program management cells have been created at the state level in most states except Chhattisgarh. State Mission Directors are in place and the recruitment process for positions at district and city level is underway in Madhya Pradesh, Rajasthan, West Bengal, Rajasthan and Odisha.
- ▶ Staff recruitment to the service delivery facilities is underway in most states. Recruitment of Medical Officers, Staff Nurses and ANMs is underway in most states.
- ▶ Involvement of urban local bodies (ULBs) in the implementation of the program has been initiated across states - to a much greater extent in Kerala and Odisha but slower in states such as Chhattisgarh, Bihar and Telangana.
- ▶ The selection of Urban ASHA is slow in many states. Where the management of the process is entrusted to the state ASHA resource centre and its district support teams the process is facilitated and strengthened by cross learning from the rural ASHA programme. An important factor expediting the process in the cities of Bihar, Odisha, Uttarakhand, and Rajasthan is the presence of NGO led interventions. Kerala, Tamil Nadu and West Bengal plan to leverage community collectives of programmes in other sectors for MAS formation and ASHA selection. States such as Mizoram, Rajasthan, Punjab, Chandigarh and UP are yet to initiate selection. States such as MP and Rajasthan have leveraged on the progress made by Health of the Urban Poor Program (HUP) in MAS formation and outreach services. Most states are yet to open bank accounts for MAS and provide funds for their functioning. Training of urban ASHAs has begun in states such as Assam.
- ▶ Provision for a Public Private Partnership strategy for urban service delivery is underway in some states such as Uttarakhand, Bihar and Telangana.

## **TOR 11: Governance and Management**

- ▶ State and District Health Societies have been established in all states and notification for inclusion of the Urban Health Mission issued. However there are variations in terms of functionality, meeting

regularity and programmatic review. Irregularity of state level meetings were reported from Uttar Pradesh, West Bengal, Assam and Telangana.

- ▶ At the level of the District, there is better functionality and meetings appear to be better organized, across most states. Exceptions appear to be Rajasthan, Madhya Pradesh and Shrivasthi in Uttar Pradesh. In Palakkad, Kerala, an active Executive Committee of the DHS took decisions related to differential financing of its facilities and modifying approved activities based on local context for the Attapady block.
- ▶ Though RKSs have been formed across all states visited, their spread at different levels of facilities, functioning, meeting regularity, quality of minutes and levels of participation varies substantially. RKS are yet to be formed in some CHCs and PHCs, while they were in place in all DH in the districts visited.
- ▶ State reports highlight that members had limited awareness about the mandate of RKS and were not clear about the use of RKS funds. Instances of partial release of untied funds and other grants were also reported. The funds are primarily spent on infrastructural improvements and overall ambience/cleanliness. In Madhya Pradesh, poor performance of the once well functioning RKS was attributed to the decline in revenue generated after the user charges were abolished.
- ▶ While active public participation is reported from Kerala, Chhattisgarh, Mizoram, and Odisha, other states lag behind in involving elected representatives and other community members. In Tamil Nadu, the active role of PRIs is gradually getting weakened and it is the executive committee, comprising largely of staff from the facility who run the affairs of the RKS, with community and patient concerns taking a back seat.
- ▶ To a large extent, ready availability of data and the capacity to analyze and plan at local levels determines the extent to which data is used for identifying gaps and planning. This emerges as a gap in most states except in Tamil Nadu and Odisha where there is ready access to the uploaded data.
- ▶ Programme Management Units (PMU) at state (SPMU), District (DPMU) and Block (BPMU) levels

are in place in all states except Tamil Nadu, where programme managers at each level are the designated officers of the existing public health cadre, indicating strong integration.

- ▶ Integration with the Directorate at state and district level is a concern, except in the states of Tamil Nadu, Odisha, Uttarakhand and Kerala. Another related issue that emerges is the lack of integration between programme divisions seen in Madhya Pradesh and Uttarakhand.
- ▶ Functionality of DPMU and BPMU depends on the human resources allocated, a sound training and orientation programme and regular supervision. In most states, this appears to be a serious gap. A larger concern is that even where there are adequate staff, monitoring is weak as seen in Mizoram.
- ▶ In Odisha, Uttar Pradesh and Bihar, reports make reference to the role played by Development Partners in monitoring and programme support. In Odisha and Uttar Pradesh there are concerns about effectiveness and duplication respectively, and in Bihar it appears that monitoring at the level of ASHA and ANM is being undertaken by staff of development partners.
- ▶ From a few states (Uttar Pradesh, Madhya Pradesh and Assam) reports highlight the lack of guidelines issued by the state for national programmes leading to poor implementation of programmes for which funds are available.
- ▶ Apart from the state of Tamil Nadu which has a public health cadre in place, there were no reports of instituting such a cadre from any of the other states.

- ▶ Overall monitoring and supportive supervision is weak across states, including non high focus states.
- ▶ Supervisory checklists are not being used, nor are community interactions being undertaken to validate data on services. This was seen in Madhya Pradesh and Odisha. In Uttar Pradesh, plans were signed and checklists were being used, but there is little value to the process in the absence of a system for review and feedback.
- ▶ Another issue is a progressive reduction in support to lower levels for implementation – namely from state to district, district to block and then to the village/city/slum. This was noted in reports from Madhya Pradesh, Rajasthan and Punjab.
- ▶ District/City Level Vigilance & Monitoring Committees (D/CLVMCs) have not been constituted in most states. DLVMCs are yet to be established in Ganjam, in 16 of the 38 districts in Bihar, in Shravasti, Uttar Pradesh, and in Sri Ganga Nagar in Rajasthan. Even where they are in place, they are not yet effective.
- ▶ Mizoram and Chandigarh are implementing the CEA. In Orissa, the process has been initiated to include the registration of all private hospitals under the Clinical Establishment Act while in Tamil Nadu the state is awaiting clearance from the Law department to revive the Tamil Nadu Private Clinical Act 1997, with modifications in the Act and Rules. In Rajasthan and Kerala, the CEA is not in place yet, a critical gap, given the high OOE in the private sector.



# RECOMMENDATIONS

## TOR 1: Service Delivery

- ▶ In order to ensure access states must now prioritize the conversion of non functional peripheral health centres, particularly Primary Health Centres and Sub centres into active centres for the delivery of a comprehensive range of primary health care services, including Reproductive and Child Health Services. Since the basic infrastructure is in place, renovation and repair within a short time frame, need to be undertaken.
- ▶ For new construction, proper planning, adequate cost estimation with stringent timelines to avoid cost overruns, and effective monitoring by the State Health Society for adherence to technical specifications and guidelines need to be ensured.
- ▶ Provision of staff quarters particularly for facilities providing 24\*7 care and especially at delivery points must be ensured to enable access to service providers at all times.
- ▶ In order to provide universal accessible and equitable services and meet the assurance of the time to care approach, states must begin to map unreached and inaccessible areas so as to plan for basic health facilities, or devise other mechanisms to reach such populations.
- ▶ Bio-medical waste management especially in sub district facilities needs to be instituted.
- ▶ Multi-skilling AYUSH doctors to manage public health programmes should become an area of focus in all states, since this not only addresses human resource shortages, but also provides communities with access to AYUSH systems of medicine.
- ▶ The consistent findings across all CRM reports of poor availability and quality of blood transfusion facilities at district and sub-district level needs urgent action.
- ▶ The range and availability of laboratory services below district level needs strengthening. Integration of laboratory services across various programs should be prioritized to make optimal

use of skilled technical human resources and expand the coverage of lab services.

- ▶ Terms of Reference for managing Urban PHC, PHC or CHC through Public-Private Partnerships need to be re-visited, with clarity on caseload definitions, human resource norms, effective performance indicators linked to payment mechanisms and adequate systems of monitoring and evaluation by the state should be addressed.
- ▶ Integration of referral services, especially where multiple models are functional is required. Drop back services and compliance with the National Ambulance Code needs attention.
- ▶ Mobile Medical Units are an important adjunct to service delivery for geography and depth of coverage, and need to be deployed rationally so that the most deprived and inaccessible in rural and urban areas are covered. Their performance should be reviewed periodically with mechanisms for mid course correction.
- ▶ A comprehensive IEC/BCC plan with involvement of districts should be formulated, the capacity of IEC/BCC units at state, district and block level should be built to enable the inclusion of local perspectives, and the IPC skills of frontline workers enhanced to undertake effective communication for health prevention and promotion.
- ▶ State and district IEC bureaus need to be staffed and equipped to develop IEC/BCC strategies and material that take in to account local considerations and culture rather than being held accountable solely for the printing and distribution of centrally prepared material.

## TOR 2: RMNCH+A

- ▶ States need to focus on operationalizing facilities with requisite infrastructure, manpower and equipment rather than merely changing the nomenclature or designation of the health facilities. Expansion of service provision from only delivery related services to comprehensive RMNCH+A services including safe abortion care, RTI/STI, family planning and newborn care is required.



- ▶ Efficient logistics with proper inventory management to eliminate stock outs of critical drugs, vaccines and equipment is required, including the use of ICT in this area.
- ▶ With increase in coverage of ANC services, the focus should now be on improving the range and quality of ANC services as well as timely identification and referral of high risk cases.
- ▶ Facility based newborn care services need attention in the context of implementing guidelines and adherence to protocols laid out for quality of care. At the same time strategic and meticulous planning is needed for strengthening primary and secondary level care newborn services (NBCCs & NBSUs).
- ▶ Referral linkages from community and follow up for SNCU as well as NRC discharged children needs to be strengthened with regular capacity building of front line workers – ASHAs, ANMs and AWWs and improved availability of drugs and equipment.
- ▶ Expedite capacity building of service providers (ANMs, Staff nurses and doctors) such that their skills are commensurate with the job/task



undertaken by them especially in the area of SBA, NSSK and PPIUCD training.

- ▶ Setting up forward and backward referral linkages with tertiary care centres as well as operationalizing DEIC is essential for effective implementation of RBSK
- ▶ A paradigm shift at state policy level is required to promote spacing methods over limiting methods.
- ▶ Persistent OOPE in most states despite implementation of JSSK is a cause of concern. States should ensure that JSSK is implemented in its true spirit and builds mechanisms for community monitoring and accountability to address this issue.
- ▶ Grievance Redressal system is almost non-existent except for a couple of states. States should immediately institute such systems, and ensure community awareness through IEC display at facilities.
- ▶ Under reporting of maternal death and poor implementation of Maternal Death Review needs attention. Child Death Review is practiced in only four states and needs to be scaled up.

### TOR 3: Disease Control Programmes

- ▶ For all diseases control programmes, states should fill vacant positions on a priority basis to enable adequate attention to these programmes.
- ▶ Capacity building of all programme officers at state and district level, orientation of doctors, including specialists, quality and effective trainings of ASHAs and other key staff needs to be ensured.
- ▶ Involvement and accountability of the private sector in disease control programmes needs to be strengthened through mixed approaches such as e-mails, SMS, toll free numbers, missed calls, IVRS, direct entry, post cards and data collection in person.
- ▶ For malaria, training of LTs is needed to ensure quality in microscopy services. Supportive supervision is also required at the field level. Efforts must be made to provide the test result and initiate treatment within 24 hours.

- ▶ Quality Mass Drug Administration must be ensured and pending cases of hydrocele must be operated on without delay. Close supervision and monitoring of programme implementation needs focus.
- ▶ States should implement the current policy of using pooled Lab Technicians for General lab, ICTC and TB to strengthen lab services. Focus on early identification and testing of MDR TB suspects needs strengthening. All DRTB centers to be made functional and Medical colleges to be involved in PMDT service delivery as DRTB centers and for seeking expert opinion about admitted patients.
- ▶ All diagnosed TB patients to be offered HIV testing as per policy & guidelines - after appropriate counseling, so that all TB patients are aware of their HIV status.
- ▶ Nikshay entry mechanism to be made a real time entry system by doing it at PHC/CHC/DH level. States to focus on diagnosis of Pediatric TB cases and improve involvement of Pediatricians in the programme with the support of medical colleges and professional bodies like IMA etc.
- ▶ Analysis of IDSP data should be incorporated in the preparation of district health action plan. States need to ensure that district surveillance officers are not saddled with other additional responsibilities and they need to fill all vacant positions under IDSP.
- ▶ Ensure regular feedback to the block and PHC for taking appropriate action as per environmental forecasts with a special focus on seasonal trends. Strengthening recording and reporting processes and feedback mechanisms through ensuring the weekly analysis of reports and provision of feedback is critical.
- ▶ Strengthen urban NLEP activities, treatment and completion rates. Ensure regular payment to ASHAs for suspect referral and maintain district level ASHA incentive data for disease control programmes.
- ▶ Collaborate with the National Health Mission to develop proper IEC plan for early detection of disease and the reduction of stigma and discrimination associated with some of these illnesses.
- ▶ Strengthen planning for disability prevention, organization of disability camps at block level and the medical rehabilitation of people with disabilities.
- ▶ States other than TN and Kerala need to develop a clear plan backed with adequate infrastructure, human resource and logistic support to implement NCD programmes.

#### **TOR 4: Human Resources for Health**

- ▶ States should consider framing an HR policy with an emphasis on recruitment procedures, retention strategies and rational deployment of HR to ensure the health care providers remain in the system.
- ▶ States need to deploy the health work force rationally to ensure their availability in high case load and underserved areas. In addition to a transparent Posting and Transfer policy, there is a need to categorize areas based on the degree of hardship to ensure equitable distribution of staff at these facilities.
- ▶ Tools must be developed and adopted by all states for carrying out baseline skill gap assessment of existing care providers and recruitment of appropriately skilled personnel in the system. Comprehensive job descriptions for staff are required for clarity about their responsibilities.
- ▶ Strengthen existing HR cells under NHM and establish HR cells where these do not exist in order to streamline workforce management procedures in states.
- ▶ Mentoring systems to be institutionalized in states to ensure adequate hand-holding and supportive supervision to perform skill based activities competently and responsibly.
- ▶ Trainings should be rationalized based on a needs assessment of individual staff members. There should be post training follow up and support for all those undergoing training.
- ▶ Nursing teaching institutes need strengthening in terms of faculty and infrastructure to maintain the quality of nursing graduates. Guidelines for clinical and theoretical training should be strictly adhered with.

- ▶ State should establish/strengthen online Human Resource Management Information System (HRMIS), and use it for HR planning, training needs assessment, performance assessment, promotions, postings and transfers of employees.
- ▶ There is a need to create and institutionalize separate cadres for clinical specialists and public health specialists. Most states have a mixed pool of doctors with varied specialties placed at posts not appropriate to their educational backgrounds.

## TOR 5: Community Processes

- ▶ Engaging representatives of Panchayati Raj Institutions in health committees at various levels is an area that requires action not just by the Department of Health but also by the Department of Rural Development/PRI and advocacy in this direction is a priority. Experiences from Punjab, West Bengal and Kerala have demonstrated that this is possible even though they have adopted different methods.
- ▶ The persistent and wide spread finding of varying and limited functionality and limited or mis use of untied funds of VHSNC is partly a result of the lack of effort at systematic capacity building, but also an issue of the human resources required to support the committees and facilitate regular meetings to take action on local issues. The Odisha and Chhattisgarh experience shows that functional VHSNCs are possible with active and sustained facilitation. Building capacity of VHSNCs requires effort and states will need to involve NGOs and other training institutions to undertake training of VHSNC members.
- ▶ A conscious attempt to address the limited efforts in community action for health requires sensitization of not only state level policy makers but also district and sub district implementers on the necessity of such action and how this can be leveraged to improve outcomes on social and environmental determinants and accountability.
- ▶ The “presence and visibility” of the ASHA in the face of widespread systemic gaps related to selection, skill building, supportive supervision, payment and replenishment of kits, is a testimony to the exercise of individual efforts by the ASHA themselves.
- ▶ ASHA selection must be expedited especially in underserved areas. Learning from the past, where time constraints resulted in inappropriate and patronage based selections (and the fact that such ASHAs tended to drop out anyway) the opportunity to use community based selection for the “right fit” ASHA must not be squandered. States must prioritize the selection of ASHAs and their household allocation so as to ensure appropriate population coverage so that no beneficiaries are left-out.
- ▶ The finding of poor performance among some ASHAs relates to the need to improve the quality of training, post training assessments, refresher trainings and ongoing field level mentoring. This requires that urgent attention be paid to training structures and systems and to strengthening the support structures created. States need to use conventional (audiovisual/print) and newer methods of technology to enable refresher training for additional skill building.
- ▶ While on the training front, substantial progress is reported from most states, the need for continuous refresher training even where training is completed is the next step forward. Adhoc training systems will need to be replaced by institutionalized mechanisms for ongoing training. The certification process planned for this year provides an opportunity for states to initiate this process.
- ▶ Progress on recruitment of support staff for the ASHA is notable across all high focus states, but these states will need to sustain efforts to build on the opportunity provided. The support staff at all levels need to be sensitized to their roles, and provided with appropriate support by their district counterparts in NHM to undertake their task of mentoring and supporting the ASHA and VHSNC. In non high focus states, existing staff that are expected to provide the potential outcomes need to be strengthened to undertake this additional task through appropriate training and monetary/non monetary incentives. States need to undertake





an analysis of the existing HR at block and district level, develop appropriate job descriptions and allocate work equitably.

- ▶ A linked recommendation is that states must ensure provision of kits, drugs and communication material to serve as aids to the ASHAs in order to strengthen her role in motivation for behaviour change and to provide community level care. Strengthening her in these roles will enhance her effectiveness as a social mobilizer.
- ▶ A decade after the launch of the ASHA programme, particularly in non high focus states such as Kerala and Tamil Nadu where there is evidence of the ASHA being an underused human resource, states must seriously start thinking of engaging ASHA in areas such as screening, preventive and promotive measures for chronic diseases and palliative care linked to certification in a set of relevant skills. Viewing the ASHA as a frontline worker located in her community and supporting the Primary health care team offers an important avenue to facilitate universal health coverage.

## TOR 6: Information and Knowledge

- ▶ HMIS Web Portal has helped to establish a discipline of monthly facility-wise reporting across states. However a large number of states are also utilizing local HMIS systems for IT. It is an appropriate time for the HMIS Web Portal to be made interoperable with these systems to reduce reporting burden and allow flexible reporting in the HMIS Web Portal. Similar efforts should also be made to make HMIS and MCTS system interoperable so that duplicate reporting can be avoided.
- ▶ Various households surveys needs to be streamlined to reduce overlap and improve information availability on all health system components. Information sources related to non-communicable diseases, communicable diseases and cause of death needs strengthening.
- ▶ States are creating various Health IT systems to accommodate local data requirements. However these systems are created without rationalizing existing processes of data collection and reporting. It is extremely important that IT systems are developed following proper system requirement assessments to reduce duplication and process errors and follow semantic standards (Metadata & Data Standards) to enable data exchange across systems.
- ▶ The data collection and recoding formats are not yet standardized at secondary and tertiary institutions. It is important that facility registers are standardized following basic semantic standards to provide quality input in all reporting systems.
- ▶ Use of data for decision making at local level needs to be strengthened by using data from various sources and summarizing it in the local decision making context. This requires additional capacity building and support at local level.
- ▶ Skype based video conferencing is being set up in Adilabad district of Telangana to follow up service delivery reporting from the facility (PHCs). This method should be scaled up in other districts in and across the states as per feasibility.
- ▶ Despite nearly a decade of implementation of NHM, SHRCs which were visualized as a key technical

support mechanism are yet to be institutionalized in most states. Better understanding of their role vis-a-vis SIHFW and the State Health Society is needed. States are in a better position to articulate their technical assistance needs. They also need to consider the complementary contribution of existing institutions such as state medical colleges and other public health agencies before making plans to strengthen SHSRCs.

## TOR 7: Health Care Financing

- ▶ Shortage of human resources and appropriate training for financial management and accounting at the state and district level needs to be addressed on a priority basis. Training to all finance and accounting staff should be provided at district and block levels according to Tally ERP 9, Operational Guidelines and the Model Accounting Hand Book.
- ▶ State should focus on the PFMS and use it to track availability and underutilization of funds at each level. Release and utilization under selected activities like untied funds, AMG and RKS funds needs to be monitored. GoI guidelines need to be explained to all cadres of staff involved in planning of services and disbursement of funds.
- ▶ State should use PFMS for Direct Benefit Transfer (DBT) for ASHAs and JSY incentives and salaries to project staff. Bank Accounts for JSY beneficiaries and others should be opened on a zero balance basis.
- ▶ Bank accounts should be maintained as per the new guidelines issued by the Ministry of Health and Family Welfare. Allocations of funds from State Health Societies to District Health Societies should be done according to allocated pools.
- ▶ The States should ensure timely submission of the Statutory Audit Report and Selection of Blocks/Facilities for Concurrent Audit should be done on a rational basis.
- ▶ Documentation and maintenance of records/vouchers needs to be meticulous. Journal Entry must be entered in the journal and supporting vouchers should be filed. All records should be filed in chronological order.
- ▶ Bank Reconciliation should be prepared on a monthly basis at PHCs and CHCs. Unspent balance

should be reconciled on a monthly basis between State, DHS and CHCs/PHCs. Income Tax provision for deduction of TDS must be followed as per Income Tax rules and regulations.

- ▶ Health facilities below the district should report physical as well as financial progress on a monthly basis.
- ▶ Supportive supervision should be made on a regular basis to improve fund utilization and availability of services at the facility level. Action taken report should be prepared at DHS level for concurrent auditor observations.
- ▶ As the public health care system is moving towards achieving universal health coverage, the state governments should plan to waive user charges for all those attending public facilities. It is important to make available and raise public awareness about free transport, drugs and diagnostics.

## TOR 8: Quality Improvement

- ▶ The state should prioritize the certification process and identify facilities for successful implementation of the quality assurance programme.
- ▶ A state specific roadmap with a realistic time frame needs to be prepared by taking critical factors like capacity building, number and level of targeted facilities, supportive supervision and quality improvement activities into account.
- ▶ The Reconstitution of state and district quality assurance committees needs to be done on a priority basis.
- ▶ Conducting Patient Satisfaction surveys by the method of random sampling from OPD and IPD should be undertaken to assess the quality of services. Based on the findings, low scores need to be addressed with a specific time bound action plan.
- ▶ Monitoring and analysis of KPI's (key performance indicators) has to be done on a monthly basis and the data generated should be used for the decision making process for allocation of resources based on demand.
- ▶ In order to make the systems more efficient and robust, prescription and medical and death audits should be carried out in the facilities, with corrective

and preventive actions being implemented on the basis of findings.

- ▶ To provide patient centric care at the public health facilities a grievance redressal mechanism needs to be established and implemented.
- ▶ Infection control methods like bio-medical waste management needs to be strengthened, regular reviews need to be taken by the in charge of the facility to ensure compliance.
- ▶ Hand washing facilities and physical standard methods for sterilization should be implemented along with indicator (biological/physical/chemical) checks.
- ▶ Internal Quality Assurance Programmes like regular monitoring, implementation of housekeeping checklists, conducting internal assessment at periodic intervals, mock drills etc. needs to be implemented.
- ▶ External Quality Assurance Programmes like validation of lab tests, calibration of equipment and instruments, monitoring of radiation exposures by the TLD badges needs to be done on a regular basis.
- ▶ To address skill gaps, training needs assessment should be conducted at periodic intervals at the facility level. The training evaluation of participants and trainers should be recorded for introducing improvements.

### **TOR 9: Drugs, Diagnostics, Procurement & Supply Chain Management**

- ▶ While the introduction of centralized procurement and inventory management processes, are an important first step, strengthening of such systems to avoid shortages and stock outs are a critical next step, to ensure free drug supplies.
- ▶ A centralized procurement process was functional in most states and remaining states are formulating such mechanisms, but more focused efforts are required to make the procurement process efficient, transparent and responsive. This needs to be complemented with an efficient inventory management system to ensure that there are no stock outs at any level.
- ▶ Quality control measures also need to be strengthened for ensuring good quality drugs at

affordable (free) price at all public health facilities. A multi pronged approach is required for ensuring quality of the drugs procured. NABL accredited laboratories may be empanelled for quality control.

- ▶ Formulation of Differential Essential Drug List as per the needs and requirements of state is necessary to cater variations in geography, disease burden and health indicators as well as Standard Treatment Guidelines for different levels of care need to be developed and updated regularly.
- ▶ States need to take cognizance of the fact that despite the overall thrust on promotion of generic drugs, branded drugs are commonly prescribed by providers. This is also one of the most common cause of Out of Pocket Expenditure incurred by patients (even under JSSK). Monitoring mechanisms like Drug and Therapeutic committees need to be created and supported for regular monitoring of such practices.
- ▶ In addition to development of EDL and STGs, states should also invest in conducting regular periodic training of service providers (at all levels) with regards to EDLs and STGs to address the issue of irrational drug use.
- ▶ Diagnostics are an essential component of services delivery yet they receive limited attention in terms of ensuring availability of equipment/trained manpower and maintenance of equipment. This affects the range of diagnostic services available at the public health facilities leading to high OOP for community. Mechanisms for procuring equipment and regular maintenance need to be improved across all states.
- ▶ States should ensure a functional inventory of medical equipment on software provided by the service agency to track the down time of machines.

### **TOR 10: National Urban Health Mission**

- ▶ Implementation and roll out of components and activities under NUHM need to be expedited and strengthened in all states. States must leverage the flexibility in NUHM for implementing customized services through innovations, PPPs and collaborations with local stakeholders.
- ▶ States should expedite the mapping of slums and ensure appropriate ASHA selection in all cities



under NUHM. Community processes interventions in NUHM as mandated in the guidelines must be managed by the same support staff that manages the ASHA for the NRHM. Partnerships with existing slum based NGOs would expedite the selection and training process.

- ▶ States should conduct a gap analysis of the existing infrastructure both human and other resources such as physical infrastructure and equipment for need based planning and implementation.
- ▶ In many states service delivery is required to be strengthened for outreach services, which is a key component to reach the vulnerable and marginalized.
- ▶ States are recommended to expedite recruitments. Recruitment of staff to the management units at the state, districts and service delivery facilities including ASHAs on the basis of the situation assessment and gap analysis needs to be completed in many states.
- ▶ States are required to organize capacity building of recruited staff to enable them to carry out program activities and ASHA trainings on different issues pertaining to slum areas.
- ▶ States are recommended to expedite activity on baselines, vulnerability mapping of slums and slum like habitations for effective outreach.
- ▶ States such as Kerala, where the programme has been rolled out are recommended to create Hospital development Committees (HDCs), ensure availability of all drugs (as per EDL in UPHCs) and essential equipment in all UPHCs.
- ▶ Convergence mechanisms with all related departments are required to be in place in all states, except in Kerala. Orientation and involvement of Urban Local Bodies (ULBs) and convergence with other non-health departments is recommended to be undertaken to facilitate comprehensive and participatory planning of urban health services. Institutional mechanism for coordination and convergence between ICDS, Water and sanitation department and urban local bodies needs to be strengthened and structured.

- ▶ States presently employing the PPP mode for service delivery (Bihar, Uttaranchal and Telangana) are recommended to strengthen these models (including aligning the TORs with the GOI guidelines/framework) on the experiences gained till now.

## **TOR 11: Governance and Management**

- ▶ Delays in meetings at state and district levels indicate a plateauing of interest and commitment to the Mission. With several policy and programmed related interventions needed in several areas, the attention of the leadership at these levels is required to both sustain the gains achieved and to address the more complex challenges that lie ahead.
- ▶ There is an urgent need to address the strengthening of the programme management units including creating TORs, filling up vacancies, ensuring orientation to roles and responsibilities and creating systems for performance appraisal.
- ▶ Hurdles to field supervision be they related to mobility, checklists, formats and registers need to be addressed. States must put in place mechanisms for review and feedback to ensure the complete supervisory cycle and improve programme implementation.
- ▶ The planning process at block and district levels needs to be taken seriously by making available high quality data in a timely fashion to enable context specific planning, accompanied by capacity building of staff to undertake such planning.
- ▶ Capacity building of Rogi Kalyan Samiti members needs to be undertaken to equip them to perform their roles with support and monitoring from the state and district levels to district and sub district facilities.
- ▶ States should create a plan to disseminate guidelines at the monthly review meetings with the CMHO/DPM and those at district levels by uploading them on websites and sending reminders and alerts.
- ▶ National and state level advocacy meetings to expedite the process of CEA and the creation of a public health cadre in states is required to progress towards universal health coverage.



# Mandate and Methodology of the 8<sup>th</sup> Common Review Mission







# MANDATE AND METHODOLOGY OF THE 8TH COMMON REVIEW MISSION

The National Rural Health Mission was launched in 2005, to address the health needs of the underserved rural areas. In May, 2013, the National Urban Health Mission was launched as a sub-mission of the overarching National Health Mission (NHM). The eight Common Review Mission was undertaken when NRHM marked nine years of implementation and the NUHM just one year.

## OBJECTIVES OF 8TH COMMON REVIEW MISSION

1. Review the progress of NHM activities:
  - As against set goals and objectives related with IMR, MMR, TFR and goals related with various disease control programs
  - In terms of its impact on accessibility, equity, affordability and quality of health care services
2. Review preparatory activities and roll out of National Urban Health Mission
3. Review the extent of compliance to recommendations made by earlier CRMs
4. Identify constraints faced and issues related to each of the components
5. Document best practices, success stories and institutional innovations
6. Make recommendations to improve program implementation and design

## GEOGRAPHICAL COVERAGE OF 8TH COMMON REVIEW MISSION

Under the 8th CRM, a total of 15 states/UTs were visited (nine high focus states including two North Eastern states, five Non high focus states and one UT). The states were selected with a view to provide

a representative picture of the progress made under National Health Mission.

The states covered under 8th CRM include: Assam, Bihar, Chandigarh, Chhattisgarh, Kerala, Madhya Pradesh, Mizoram, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand and West Bengal.

## COMPOSITION OF TEAMS FOR 8TH CRM

Each state was visited by a 15-17 member team comprising of the following:

1. 4-6 Government Officials
2. 2-3 Public Health Experts
3. 1-2 Representatives of Development Partners
4. 2 Representatives of Civil Society
5. Consultants of various divisions of the Ministry

Teams were provided with a detailed Terms of Reference for the visit, including checklists. The TORs were divided among team members according to area of expertise. Team members were expected to submit observations on these within a specified time frame. Each state report would be a compilation of these findings.

## TIMELINE OF 8TH CRM

The 8th CRM started on 7th November and ended on 14th November, 2014. The first event, as is the practice was a day long briefing at New Delhi followed by briefing at each state capital. Thereafter the teams visited the identified districts. On the last day, there were state debriefings in the respective state capitals.

## COMPONENTS

The components covered by the Terms of Reference (TORs) include:

1. Service Delivery
2. RMNCH+A
3. Disease Control Programs
4. Human resources and training
5. Community processes and convergence
6. Information and knowledge
7. Health care financing
8. Quality assurance

9. Drugs, diagnostics and procurement
10. National Urban Health Mission
11. Governance and management

The final report contains an analytical review and summary of key findings from the respective state reports. It also contains recommendations and state specific findings. An effort has been made to capture the richness of the state reports and include as many observations as possible.



# Term of Reference

1	Service Delivery	33
2.	RMNCH+A	49
3.	Disease Control Programs	70
4.	Human Resources and Training	82
5.	Community Processes and Convergence	91
6	Information and Knowledge	106
7.	Health Care Financing	113
8.	Quality Improvement	125
9.	Drugs, Diagnostics, Procurement & Supply Chain Management	133
10.	National Urban Health Mission	143
11.	Governance and Management	151







# TOR 1

## Service Delivery

### Guiding Principles/Strategies of the NHM

- i. "Build an integrated network of all primary, secondary and a substantial part of tertiary care, providing a continuum from community level to the district hospital, with robust referral linkages to tertiary care and a particular focus on strengthening the Primary Health Care System including outreach services in both rural areas and urban slums"(Para 2.3.1)
- ii. Reduce out of pocket expenditure on health care, eliminate catastrophic health expenditures and provide social protection to the poor against the rising costs of health care, through cashless services delivered by public health care facilities, supplemented by contracted-in private sector facilities wherever necessary"(Para 2.3.5)
- iii. Ensure that all public health care facilities or publicly financed private care facilities provide assured quality of health services (Para 2.3.6)
- iv. Ensure that all public health care facilities or publicly financed private care facilities provide assured quality of health care services"(Para 2.3.6)
- v. Ensure increased access and utilization of quality health services to minimize disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers"(Para 2.3.7)
- vi. Promote partnerships with private, for profit, and not for profit agencies including civil society organizations to achieve health outcomes (Para 2.3.12)
- vii. NHM will encourage the public sector to contract-in or out source those services which improve efficiency and quality of care in the public hospital (Para 5.7.2)

### KEY OBSERVATIONS

#### Adequacy of Facilities

- ▶ All states report an increase in the number of health facilities during the NRHM/NHM period. Most of this increase is in the number of Sub-centres and PHCs, indicating an endeavour to improve access and coverage, and ensure

service delivery closer to people. For instance, Madhya Pradesh has reported an additional 500 SHCs in 2013 alone. In most states, the quantum of increase is proportional to the size of the gap in the state's infrastructure. Nonetheless, shortfalls in infrastructure continue to be reported, with almost all states



report shortfall in the number of facilities in selected districts. States which report a major shortfall in number of health facilities are – Uttar Pradesh, Uttarakhand, and Bihar.

- ▶ While most states report an adequate number of health facilities as per population norms, the positive outcome is negated by the fact that a number of facilities are non-functional.
- ▶ There are also access barriers to the concept of 'time to care' approach across states. Most hilly states (Uttarakhand and Mizoram) report time delays in reaching the appropriate health facility. To address this challenge such states have taken up measures such as operationalizing boat clinics, mobile medical units and establishing health centers through non-health funding (Mizoram). Yet, much needs to be done.

### Infrastructure

- ▶ In terms of infrastructure there has been a significant improvement after the initiation of NRHM in 2005. Most states have reported good progress in completion of infrastructure projects. However in health facilities in Madhya Pradesh, Bihar, West Bengal and Odisha basic amenities for patients such as waiting halls, toilets and drinking water provision were generally found to be either absent or not properly maintained. Even at the level of District Hospitals, there are facilities with no boundary walls in some facilities visited, resulting in the entrance of animals inside the hospital campus raising issues of cleanliness and sanitation.
- ▶ For most facilities visited staff quarters were available, although some require renovation. For example in Bihar and Mizoram staff quarters were present but were inadequate.
- ▶ Most states have reported that construction to setup MCH wings is under process. The pace of construction was found to be satisfactory in some states while in others civil works of approved MCH wings needs to be expedited. For example in CHC Kesinga, Kalhandi district the work for MCH wing approved in 2013-

14 has not started till the date of visit. It was observed that in Punjab, MCH tool kit guideline was not followed during construction of MCH wings, e.g. the labour room did not have an attached toilet.

### Utilization of Facility Based Services

- ▶ Availability of comprehensive secondary care is at the level of the district hospitals in most states. Tamil Nadu and Kerala demonstrate relatively better availability of services at SDH/Taluka level as compared to other states. However, MCH care at sub-district level leaves much to be desired in Kerala.
- ▶ Immunization and OPD care for basic conditions, are the most common services being provided by SHCs across states. In Kerala SHCs conduct NCD clinics. Delivery services are provided at the SHC in some of the high focus states. In relatively Kerala, Tamil Nadu, Punjab, and Chandigarh, patients tend to prefer higher level facilities, even for OPD care.
- ▶ Almost all states report an increase in number of OPDs, but assured IPD care at sub-district level is still a challenge in most states. Except Tamil Nadu none of the states have been able to operationalize the desired number of FRUs at sub-district level; District hospitals continue to be overburdened with disproportionate IPD care. Access to OPD care, on the other hand, has improved at PHCs and CHCs in almost all states.





- Several states implement co-location of AYUSH services but there are 3 states (Kerala, Madhya Pradesh and Odisha) where AYUSH services and human resources provide significant support to the public health system, beyond the practice of the individual “pathy”. In Kerala, although co-location of services is yet to be implemented, the traditional support provided to AYUSH services has led to stronger development of these systems. In Madhya Pradesh and Odisha, AYUSH human resources are being effectively used to plug HR gaps at PHCs and efforts have been made towards building their competencies and multiskilling. Both states report positive feedback from such multiskilling. In other states an average of 10-14% OPD load is taken care by AYUSH systems and most of the States report adequate availability of AYUSH medicines.
- While all states have made concerted efforts towards ensuring availability of blood, this still remains a challenge. Quality of blood available through public hospitals is also a cause of concern. For instance, in Bihar the Madhubani District Hospital reported storing (untested and tested samples together without labelling or segregation) of blood units in an ordinary domestic refrigerator (because the three refrigeration units were out of order). In most states blood is available at district level facilities; Tamil Nadu is the only exception - where blood storage units are functional at CHC level.
- In most states laboratory services at sub-district level are available but there are concerns regarding the range of investigations. For instance, while blood and urine examinations are available at sub-district level, availability of radiological investigations is only available at district level facilities in most states. Tamil Nadu has a robust system for diagnostics, whereas Kerala fares poorly on provision of laboratory services at sub-district level. Amongst the high focus states, Uttar Pradesh has a limited range and availability of laboratory services below the district level. Odisha has made efforts to

integrate laboratory services across various programmes, enabling the state to improve the coverage of laboratory services at sub-district level.

## SUB-CONTRACTING OF SERVICES

### Key Findings

- Many states have sub-contracted biomedical waste management, laundry, cleanliness, diet and security services. Overall the experience has been positive. Bio-medical waste management needs closer supervision and training in Madhya Pradesh, West Bengal, Odisha, Bihar and Tamil Nadu. Diet services provided through NGOs need improvement in Odisha. Bihar has adopted a good practice of using seven differently coloured bed sheets for every day of the week.
- Fair price medicine shops have had a good response in West Bengal while diagnostics operated in the PPP mode have had a mixed response in states.
- Uttarakhand and Odisha have sub-contracted UPHCs, PHCs and CHCs. They are providing services but assessment of their performance is not being effectively carried out by the respective state governments
- Nutritional Rehabilitation Centers (NRCs) managed by NGOs appear to be working well in Bihar, but need closer monitoring and evaluation

### Ambulance & Referral Transport

- Most states report a mix of ambulance services (102 & 108 along with state ambulances) with a few states reporting more than two models such as Bihar and Assam. Kerala is yet to operationalize a dedicated free ambulance service for mothers and children.
- The utilization of 108 ambulances has picked up over time; however major utilization gaps are reported in Chhattisgarh, Assam, Mizoram

and Uttarakhand (facility-based ambulances). Performance of 102 is better as compared to 108 across states. However all states reported low utilization of drop back services. There is significant out of pocket expenditure reported by mothers to avail private transport to reach the health facility in pockets of Odisha, Mizoram, Telangana, Madhya Pradesh and West Bengal.

- ▶ Partial compliance with the National Ambulance Code (NAC) was seen in Assam and Bihar but yet to start in Punjab, Chandigarh, MP, West Bengal and Tamil Nadu. Uttarakhand and Chhattisgarh report compliance with NAC. In addition, other technical challenges such as call drops (Assam), call diversion (Bihar), difficulty in connecting to the call centre (UP) and non-functional GPS still exist in states.
- ▶ Despite multiple models of ambulances being implemented in various States, there remains a considerable gap in ensuring assured referral services. For instance in MP both Janani Express and 108 are not yet integrated. In Bihar, multiple ambulance services operate with multiple numbers resulting in ambiguity; even if the call is made to a centralized call centre by the patient, s/he is often asked to contact another service provider.



## Mobile Medical Units (MMUs)

- ▶ There are adequate numbers of MMUs deployed across states except in Chhattisgarh where this service has been discontinued by the State. The MMUs in general visit villages on a pre-decided schedule except in Kerala and Chandigarh where MMUs are found stationed in the sub centre.
- ▶ Each MMU is supported by a Medical Officer, Nurse, Radiographer, Lab Technician, Pharmacist and helpers during village visits in most states. In West Bengal 35 MMUs are operational in LWE districts and 6 specialised boat clinics were functional in the riverside areas of the Sundarbans. However the MMUs in Telangana, Assam and Rajasthan do not function properly due to stock-outs or lack of manpower. In Uttarakhand and Bihar, the MMU is not functional due to lack of renewal of contracts with private providers. In MP the most difficult and inaccessible areas of the districts are not covered by MMUs.
- ▶ The average outpatient numbers seen by MMUs is in the range of 20-70/day. Services provided through MMUs include OPD, basic lab services, ANC/PNC check-ups and radiography services. The MMUs have reported frequent stock-outs across states.
- ▶ In Tamil Nadu an advance tour plan for MMUs is made and these activities are monitored through online reporting.
- ▶ MMUs have started treating more patients for NCDs as demand for these is growing.

## IEC/BCC

- ▶ A comprehensive evidence based IEC/BCC plan is lacking in most states. Where available such planning of IEC/BCC strategies is done at state level with minimal involvement of districts – and consists of program communication rather than health communication.
- ▶ Broadly IEC materials fall into two categories – a) materials meant for service providers (STGs, emergency management protocols etc.) and b)





- ensured so that quality of care at SDPs is an assurance.
- ▶ There is a need to devise a rational policy for identification of areas for locating facilities so as to effectively provide services to the population
  - ▶ Operationalizing secondary care at District Hospitals should also be prioritized.
  - ▶ Proper mechanisms for bio-medical waste management especially at the sub-district level needs to be instituted. More attention needs to be paid to segregation of sharps, contaminated
  - ▶ Multi-skilling AYUSH doctors to manage public health programmes should become an area of focus in all states, since this not only addresses the Human Resource Shortage, it also provides communities with access to the AYUSH systems of medicine.
  - ▶ Efforts must be made to improve the availability and quality of blood for transfusion, both at district and sub-district level.
  - ▶ Range and availability of laboratory services below district level needs improvement. Integration of laboratory services across various programs should be done to leverage the human resources and expand coverage of lab services.
  - ▶ The TORs for running Urban PHC, PHC or CHC on PPP mode need to be re-visited. The caseload definition, penalty clause etc. should be inserted in MoUs and mechanisms for monitoring and evaluation incorporated.
  - ▶ Integration of referral services can improve services where different models are functional. Drop back services need attention and compliance with National Ambulance Code.
  - ▶ MMUs need to be deployed rationally so that the most deprived and inaccessible are covered. Monitoring systems to review their performance needs strengthening.
  - ▶ A comprehensive IEC/BCC plan with involvement of districts should be formulated; IEC/BCC cadre at state, district and block level should be developed as a think tank to add the local perspective for campaigns in the state; IPC skills of sub-district functionaries should be developed, monitoring of activities enhanced and mechanisms for performance management included.
  - ▶ It is important that the State IEC bureaus are staffed and equipped to develop of IEC/BCC strategies that take in to account local considerations and culture rather than them being held accountable solely for the printing and distribution of centrally prepared material.

## FINDINGS FROM STATES

### ASSAM

- ▶ Some facilities were clean and well maintained with waiting areas and signage. However, several health facilities were underutilized due to poor planning (DH, Karimganj and Model Hospital, Dullavcherra; Tinsukia - CHC Digboi, MPHC Lido, SC Alubari). In DH, Karimganj and CHC Margarita (Tinsukia) there were several vacant rooms and yet patients were cramped in wards and on the floor. In spite of a high obstetric load, only one out of four OTs was being used for all surgeries.
- ▶ Overcrowding was common at many facilities - Silchar Medical College and DH, Tinsukia & Karimganj and most of the PNC wards. There were many instances of gender insensitivity - presence of men in female wards, lack of curtains in female wards, lack of separate toilets for women and the absence of attached toilets with the labour room and female wards.
- ▶ The maximum number of OPD visits were observed at the Sub centre level which may be attributed to availability of the full complement of staff including the Rural Health Practitioner. There has been an increase in OPD and IPD admissions compared to earlier years.

- ▶ Institutional delivery rates too show considerable increase as a result of schemes like JSY, JSSK and the state led scheme, 'Majoni'.
- ▶ Laboratory services were available in most of the facilities. An area of concern was the lack of lab services in the evening in the DH and the CHC which was a constraint in service delivery at night.
- ▶ Guidelines and district wise activity plan for all 27 districts for IEC/BCC have been prepared by the state. These plans lay emphasis on districts with poor performing program indicators.

## BIHAR

- ▶ While most of the sanctioned facilities in the state are functional, the infrastructure for these facilities is housed in old buildings which are not fit for purpose.
- ▶ Location of Sub Centres is an issue, which have been set up in areas far from the main village with poor connectivity to all weather roads to most HSCs. There is severe shortage of APHCs and BPHCs.
- ▶ Staff quarters are few and in dire need of renovation.
- ▶ There has been a sharp decline in institutional deliveries reported in 2013-14 as compared to deliveries taking place in 2012-13.
- ▶ The data for year 2013-14 indicates that out of the 18 APHC 9 had less than 10 deliveries per month and if the same trend continues this year there will be a decrease compared to 2012-13. One reason for the low reporting of institutional delivery rates could be the non-receipt of ASHA incentives for several months.
- ▶ Training of ASHAs throughout Bihar is through NGOs/Private Agencies and their effectiveness is varied. The state has blacklisted many NGOs on grounds of poor performance and financial impropriety.
- ▶ The state has outsourced collection of facility data to an agency using innovative software, Sanjeevini, to capture outpatient, inpatient, drugs and diagnostics data. Although a lot of data is being recorded there is no evidence of how this information is being reviewed and used for decision making.
- ▶ The population:ambulance ratio is inadequate; only one ambulance is available in Madhubani district with for population of 48 lakhs. Various ambulance services are not integrated creating a lot of confusion.
- ▶ The MMUs in PPP mode are not functional since April 2014 due to non-renewal of their contracts.
- ▶ Limited IEC display at District Hospitals and peripheral facilities especially at APHCs and HSCs.
- ▶ Outsourced generator services are very helpful at sub-district levels

## CHANDIGARH

- ▶ The available Infrastructure is well built and maintained in the UT
- ▶ Rationalization of space and beds in the facilities is needed. It was observed that there is a dis-proportionate allocation of beds in private wards, vis-à-vis the general male, female wards and MCH beds.
- ▶ The pace of Infrastructure work in Chandigarh is very slow. Proper planning of Infrastructure works with adequate cost estimation to be ensured. There should be a strict timeline for completion of infrastructure works.
- ▶ The case load is concentrated at tertiary centres. Availability of specialized care at tertiary care centres and their proximity to the community has led to congestion of these facilities. The UT needs to strengthen Sub Centres and Civil Dispensaries to ensure adequate distribution of load.

- ▶ The range of services has also increased. Increase in caseloads in terms of OPD, IPD, deliveries and other RCH related services was observed by the team.
- ▶ There is no dedicated helpline for assured referral linkages; a common helpline is used to book ambulances. The UT has not complied with National Ambulance Services (NAS) Guidelines.
- ▶ There is a separate IEC/BCC Cell under SPMU.
- ▶ IEC regarding RNTCP was observed to be adequate across all the facilities. However, IEC for some crucial national initiatives was missing at facilities e.g. information on Janani Shishu Suraksha Karyakram (JSSK) was scanty. IEC regarding NVBDCP was almost nil.

## CHHATTISGARH

- ▶ Health facilities are available as per population norms.
- ▶ Utilization of OPD, IPD and delivery services has shown an increasing trend over the last three years.
- ▶ In the sub centres visited, availability of water is mainly through hand pumps and water quality reports are not available.
- ▶ Separate toilets for OPD patients were not available in most of the facilities. The toilets at CHC Katghora were very dirty and the drinking water cooler was adjacent to toilets in a very unhygienic condition.
- ▶ Cases of dog bite and snake bite were reported in the districts; fortunately anti-rabies vaccine and anti-venom are sufficient at all the facilities.
- ▶ In Jashpur, Caesarean sections were being carried out only at the DH, but only 1-2 C-sections were conducted each month even though an OBGY and EmOC trained MO and an LSAS trained doctor are available.
- ▶ MTP services are limited to the district level.
- ▶ The state has a separate BCC cell in the State Programme Management Unit but it needs to be revamped and revitalized with clear accountability for deliverables.
- ▶ Limited funds have been earmarked for IEC and BCC activities for the state resulting in low visibility for the programme.
- ▶ Although Health Education Officers are in position, they lack a basic understanding of BCC (including a mix of different communication methods, approaches and channels of communication)
- ▶ IEC activities were limited to wall paintings and posters at health facilities, with no focus on inter-personal communication and counselling by ASHAs, ANMs and other staff at health facilities to generate awareness and demand for services in the community.

## KERALA

- ▶ The involvement of PRIs and other stakeholders for construction and maintenance of facilities, availability of five agencies for infrastructure development of health facilities, a dedicated civil engineer at District Program Management Unit level for each district are the key factors responsible for a rapid pace of infrastructure completion.
- ▶ Due to availability of a complete range of primary and secondary care services at the district level, the utilization of district level facilities (District hospitals, General hospitals) is high. Similar pattern of utilization was observed at Taluk hospitals (THQH Hospitals). However a cause of concern is lack of comprehensive healthcare at sub-district level.



- ▶ The team observed major gaps in availability of quality care at PHCs and CHCs. Quality ANC, family planning, new born care services and basic lab services are not adequate at PHCs and CHCs. At SHC level the range of services shrink further, despite them being well staffed in most instances.
- ▶ There is a lack of availability of quality delivery/RCH services within the public health facilities, including at PHCs and CHCs. As of now public hospitals are preferred only for ANC care and immunization services.
- ▶ The situation almost reverses when it comes to provision of NCD care. Almost all SHCs conduct weekly NCD clinic providing basic screening services and referral to higher facilities. At PHC level also fixed day NCD clinics are held along with provisions for referral and follow-up care (including provision for medicines). District level facilities provide specialist services; tertiary level care is made available through government institutions.
- ▶ The AYUSH systems, especially Ayurveda and Homeopathy play an important role in the health care delivery system of Kerala. As of now most of these institutes function as stand-alone facilities and have not been co-located within PHCs, CHCs and district level facilities.
- ▶ Sanitation and laundry services are mostly in-house. Outsourcing of ancillary services has not been taken up by the State. Biomedical waste management has been outsourced in the State to an agency (IMAGE) whose performance is satisfactory.
- ▶ Dedicated transport services for mother & child are yet to commence in the state. A certain amount is reimbursed to mothers for availing private transport to access health services.
- ▶ In addition to MMU vehicles, the state has floating dispensaries in a few districts, these operate 6 days a week and make about 20 trips a month (on an average) to serve coastal and riverine areas.
- ▶ Extensive IEC/BCC material regarding preventive health measures, vector control and information on diseases was observed at all the facilities. Citizen's charter in the local language was displayed prominently at all facilities visited.
- ▶ The IEC/BCC interventions under NHM are focused on a) Mass Media, b) Mid Media (use of folk groups) and c) Interpersonal Communication.
- ▶ Special communication campaigns are launched periodically for immunization, promotion of breast feeding and control of communicable and vector borne diseases. Monthly Ward Health Nutrition days are also used for disseminating information about positive health practices.

## **MADHYA PRADESH**

- ▶ Efforts have been made to address the gap between the existing and required Infrastructure at the state and district level.
- ▶ There has been a considerable increase in inpatient and outpatient admissions in both districts, especially for RCH services.
- ▶ Poor condition of existing infrastructure and under equipped health facilities at levels below the District Hospital has led to an increase in the case load at higher level facilities.
- ▶ In both the districts, it was observed that some wards and toilets were not segregated for male and female.
- ▶ Staff quarters in some facilities in Panna need repair. There is a need for staff quarters to be built at 5 facilities.
- ▶ Construction work is progressing slowly at DH Katni. In addition, the construction at PHC Bilhari (in Katni) was stopped by ASI.

- ▶ Prefabricated construction of SC (in Katni) was found unsatisfactory – the systems for electricity, water and sewage (septic tank) could not be integrated into the setup.
- ▶ The DH and PHC Bilhari facilities in Katni district are very old and need renovation and proper maintenance.
- ▶ The comfort of the client and attention to dignity and privacy are missing at all DPs in Panna (except the DH), including the labor room, with no restriction to entry of attendants accompanying patients in the wards and the labour room.
- ▶ Support services like electricity with power back up, running water supply and bio medical waste management remain a problem in health facilities below DH level in both the districts.
- ▶ At CHCs, minor surgeries were performed. However, major surgeries were being done at DH level only in both the districts - due to the lack of availability of specialists at sub-district levels.
- ▶ At PHC and CHC level, AYUSH doctors are often responsible for their running - in absence of other doctors/ staff.
- ▶ Due to delays in ambulance reaching the beneficiary, most have to bear out of pocket expenses to hire local vehicles to reach the facilities. 40% mothers do not get drop back in Panna District due to the non-availability or delayed response by ambulances.
- ▶ Deployment of MMUs in the remotest areas has not been conducted as identified during district visits. Monitoring systems for MMUs has been put in place in the state.
- ▶ State has developed a plan for IEC/BCC for next three years with the involvement of development partners.

## MIZORAM

- ▶ The number and distribution of health facilities in the state is adequate at most places.
- ▶ The rate of institutional deliveries is very high in the state (90%), and most deliveries take place in public institutions (82%). JSY registration is also good. (71%).
- ▶ The state has introduced innovations to increase the accessibility of health services at 'Sub-Centre Clinics'. These are health facilities funded by the state government, on 'as per need' basis in hard to reach areas or in difficult terrains. Set up with assistance from the Planning Commission, SSC offer the same package of services as sub centres. However, contrary to the principle of geographical establishment of SC clinics, one was co-located near SDH Hnathial in Lunglie district – leading to under-utilization of the HR deployed there.
- ▶ Electricity is inadequate in the state, hence most health facilities receive an intermittent supply only. Electricity back up is poor at the SC, but better at PHCs, CHCs and District Hospitals.
- ▶ The health facilities visited had adequate water supply except in Sub Centers.
- ▶ In all patients' wards across facilities, filtered water dispensers were observed. Separate toilets for men and women were also present, although not always functional. In hospitals at CHC level and above, adequate number of toilets were observed.
- ▶ Residential staff quarters at facilities were present, although inadequate in number and under-utilized. At places, these were also rented out to non-staff residents. This is affecting service delivery on a 24/7 basis particularly at the SCs.
- ▶ The utilization of health facilities varied significantly from one facility to another. The utilization at District Hospitals was good.

- ▶ The rate of institutional deliveries is high in the state and most deliveries take place in public health facilities.
- ▶ Instances of irrational deployment of human resources and equipment leading to adverse implications on utilization were observed.
- ▶ The state has 'Medical Canteens' which are medical stores within the premises of government health facilities sublet to private owners. The rent collected from this is pooled in the RKS funds. However, this results in considerable OOPE as medicines are not sold at subsidized rates
- ▶ Ambulances are primarily utilized for drop back and inter-facility referrals with very little patient pick-up from the community.
- ▶ Significant utilization of services provided by MMUs was observed in the state, but MMU staff are often deployed in the district hospitals affecting MMU services. In addition, the large size of MMU vehicles affects their plying on hilly terrain.
- ▶ Display of IEC/BCC material was poor in the facilities. The limited displays were mainly restricted to JSSK and JSY schemes.

## ODISHA

- ▶ There is adequacy of facilities in terms of physical buildings but the range of services delivered is inadequate.
- ▶ At all the delivery points visited, SBA trained personnel were available. Lab Technicians are trained on all programmes and there is an integrated lab at the facility level.
- ▶ Back-up systems for electricity in most facilities visited were insufficient to handle the load of radiant warmers and cold chain logistics for vaccines.
- ▶ New Constructions of 736 facilities including 07 District Hospitals, 10 CHCs, 02 PHCs, 57 other Hospitals and 660 SCs have been sanctioned; of these only 314 works have been completed.
- ▶ Civil work of approved MCH wings needs to be expedited. In CHC Kesinga, Kalahandi district the work for MCH wing approved in 2013-14 has not started.
- ▶ Analysis of service utilization data from HMIS shows that there has been a decline in OPD, IPD and the number of operations.
- ▶ There has been a decline in the proportion of institutional deliveries conducted at public health facilities from 97% to 92% though the proportion of C-section deliveries at public institutions have increased.
- ▶ It was observed that designated FRUs are not functional as per the range of services to be provided due to a lack of specialists and in a few facilities despite sufficient specialists being posted, performance was below par. For e.g. in SDH Chattarpur 3 OBG specialists were posted but average C-sections were less than 1 per day.
- ▶ As regards rational location of new facilities, it was observed in Kalahandi district that SC Utkela is located just 100 metres away from new PHC Utkela
- ▶ One of the most positive features of the state is the multi skilling of its AYUSH doctors. They are trained in SBA, disease control programmes and they not only conduct AYUSH OPDs but also deliveries. In the facilities visited approximately 40% of the deliveries were being conducted by AYUSH doctors.



- ▶ Another positive feature is the system of integrated laboratory services and the multiskilling of lab technicians – as was observed in Ganjam district.
- ▶ A Tele-medicine Project under PPP mode was initiated in 2001 with support from the Department of Information Technology, Govt. of India and Sanjay Gandhi Post Graduate Institute of Medical Sciences (SGPGIMS), Lucknow. Developed in a phased manner, it now covers all public health facilities. This network is also being utilized for capacity building.
- ▶ For performance monitoring of referral transport systems the state has formed committees at various levels. 102 services face technical glitches such as call drops and unavailability of vehicles.
- ▶ A Centre of Excellence (CoE) for Communication has been set up under SIHFW. The CoE is established in an integrated manner and is involved in IEC/BCC for all health programmes as well as its social determinants (Convergence with WCD, WASH etc.).
- ▶ Health Walls – “Swasthya Kantha” were found in villages displaying details of the GKS/VHSNCs (Gaon Kalyan Sameeti), its members, their roles and key meeting proceedings for improved community participation.
- ▶ In the facilities visited, the various IEC materials were displayed in the local language.

## PUNJAB

- ▶ The state has adequate health facility infrastructure and has made good progress in completing Infrastructure with the support of the Punjab Health Systems Corporation.
- ▶ Most of the facilities were found clean and basic amenities were available in most facilities.
- ▶ The state has good infrastructure at facilities and staff quarters are sufficient in most of them.
- ▶ Basic facilities such as mattresses, clean linen, clean drinking water, toilet facilities were up to the mark on quality standards.
- ▶ It was found that every facility has a waiting area, electricity backup, water drainage system and clean toilets.
- ▶ An MCH wing is under construction in Amritsar. It was observed that the state is not following the guidelines for construction of MCH wing e.g. the labour room doesn't have the facility of an attached toilet.
- ▶ Overall the utilization of services is increasing in the state though variation is seen among facilities at District level.
- ▶ Overall the state shows high OPD utilisation, with maximum bed occupancy in the DHs and SDHs, but very low IPD across other facilities visited.
- ▶ Maternal health services are satisfactory. Institutional deliveries are increasing though the proportion between public and private deliveries is the same.
- ▶ Newborn Stabilization Unit, Sick Newborn Care Unit (SNCU) and Comprehensive Abortion Care (CAC) are either missing or not adequate in the facilities visited.
- ▶ Due to lack of AYUSH drugs, AYUSH services are lagging behind. It appears that mainstreaming of AYUSH is not a priority in the State.
- ▶ Ambulances are available in DH, SDH and CHC for referral but are not available in most of the 24X7 facilities visited by the CRM team.

- ▶ It was observed that user charges are levied for all these services provided including OPD, Lab test, ECG and X-ray.
- ▶ Punjab has a road map for IEC/BCC interventions at the state level; display of IEC material was sporadic across the state.
- ▶ There is a dedicated BCC Cell at the State level. In BCC, extensive media publicity is being carried out through TV/Radio/Print Media etc.
- ▶ None of the facilities visited had toilet services attached with labor rooms.
- ▶ Bio Medical Waste Management protocols were not followed at most of the facilities visited.

## RAJASTHAN

- ▶ The overall quality of civil works is good. To ensure quality of infrastructure, samples of construction material are tested at private accredited labs and PWD labs. Apart from this, independent third party Quality Inspectors are also engaged in inspecting works costing more than 40.00 Lacs.
- ▶ Overall support services like housekeeping, laundry, drinking water, toilets etc are outsourced. These were found to be satisfactory in Rajsamand district.
- ▶ The ambulance services are optimally utilized and reimbursement is done for the hire of private vehicles.
- ▶ In both districts visited, MMUs are not functional. The state has not implemented the National MMU guidelines.
- ▶ IEC materials were prominently displayed at facilities and vantage points in the districts of Rajsamand and Sri Ganganagar.
- ▶ The state has launched 10 special vans (Teeka express) to administer vaccines to children at their doorstep in unreached areas and the difficult districts of Eastern Rajasthan like Karauli and Dholpur; these have been identified for special interventions to provide catch up vaccinations for left out and dropout children.
- ▶ The state has recruited District IEC Coordinators in all 33 districts. The Director, State IEC Bureau has issued orders to districts to intensify IEC/BCC activities at Block level with the additional support of Health Supervisor or ASHA Facilitators with the focus on blocks to promote the RMNCH+A strategic framework.

## TAMIL NADU

- ▶ Over the years, the infrastructure has been strengthened in the State. 254 CHCs, 76 PHCs and 24 Health Sub-centers have been added since inception of NRHM (Now NHM) in 2005.
- ▶ The State has shortfall of CHCs, PHCs and Health Sub-Centers as per the population norms. As per norms, there is a shortage of facilities at HSC and PHC level by 33% and 29% respectively. State has however proposed 50 new PHCs but there is still a gap of 163 CHCs, 893 PHCs (minus proposed PHCs) and 4458 HSCs.
- ▶ Progress of Civil construction works is slow as one-third of the sanctioned projects of upgraded PHCs, Additional PHCs and almost two-third of the HSCs are still underway. The patient load also exceeds the bed strength in secondary and tertiary level facilities
- ▶ Basic amenities such as cleaning, drinking water, drainage system and electricity back-up were available in the facilities visited.
- ▶ OPD and IPD performance in most of the facilities showed positive trends with gradual rise in last three years. Proportion of IPDs of the total through put in PHCs has shot up from 28.2% to 45.8% in the state.

- ▶ The state has established 273 blood storage centres in upgraded PHCs. Blood transfusions are provided for anaemic mothers and emergency/trauma patients at the time of transfer to higher centres.
- ▶ Screening of congenital deformities and other obstetric complications is carried out at all CHCs.
- ▶ Screening of Congenital deformities and other obstetric complications is done in all CHC. Requisite training to the MOs and scanning machine has been provided at all CHC.
- ▶ Ancillary services including laboratory tests, diagnostics and medicines were available in all the facilities.
- ▶ Diet Services are provided through self-help groups in some PHCs in Tamil Nadu.
- ▶ Ambulance services are funded through Tamil Nadu Health Systems Project. Currently, there are 684 ambulances (also includes 50 Neonatal ambulances) in the State out of which 220 are GPS enabled and piloting of GPS enabled services is going on before the effective roll-out in the State.
- ▶ 108 EMRI is functional and linked to centralized call centers located at Chennai. All the calls from districts are made to this centralized call center and EMRI are sent to the respective place.
- ▶ Dial-102 ambulance is also used for bringing medicines from ware houses to facilities and transporting patients to CHC for Family Planning procedures. Drop-back from medical college is yet to start in Madurai Medical College.
- ▶ Annually MMUs are required to conduct a minimum of 40 camps in surrounding villages. Their performance is monitored by an assistant director via random monitoring visits. As no prescription slips were given to patients, this made tracking and follow up of patients difficult in Madurai.
- ▶ IEC at facility level was in the local language and informative. However, IEC on JSSK was found missing at many facilities. IEC and IPC at community level was found missing across the state.
- ▶ Maternity Clinics - Under this initiative, tours for all pregnant women are organized to the local PHC where they undergo all medical investigations and routine check-ups. It is undertaken with the objective to make PHCs people friendly and win the confidence of women and encourage them to deliver at the rural health facilities.

## TELANGANA

- ▶ Compared with many other states, the infrastructure for health facilities in the state is fairly well developed.
- ▶ Out of the total PHCs, 343 (47%) were functioning as 24 x 7 PHCs; 39 (83%) out of total of 47 PHCs in tribal blocks were functioning as 24 x 7 PHCs. Out of the 4905 sub centers 4409 (90%) have two ANMs posted.
- ▶ 144 facilities (CHCs, SDH, and Area Hospitals etc.) have been operationalized as FRUs.
- ▶ In the tribal blocks, 27 facilities are operationalized as FRUs.
- ▶ None of the health sub centres visited in the district had a regular electricity supply, running water supply or attached functional toilets.
- ▶ Residential quarters for ANMs and doctors were not available in the majority of health institutions
- ▶ It has been reported that most pregnant mothers use private transport as they do not receive free transport benefits under JSSK.
- ▶ Only 5% of the MOs attended fixed day health services. The major focus at these events is on NCDs, diagnostics and drug distribution with minimal focus on MCH.



## UTTAR PRADESH

- It was observed that both the districts had good infrastructure but the provisioning and utilization of these services varied across the two districts.
- Primary Health Centres - In Shravasti, none of the PHCs are 24X7 and they provide only OPD services. Lab services are also not provided at this level. In Meerut however, deliveries and limited lab services are being provided at 24X7 PHCs.
- Community Health Centres - In Meerut the three designated FRUs do not meet the essential criteria due to inavailability of Blood Bank/Storage facilities while in Shravasti, the three designated FRUs have become non-functional as there is no Gynecologist and the Blood Storage Unit is non-functional. However, CHCs in Shravasti provide delivery, OPD and IPD services.
- District Hospitals: The district hospital has been recently set up in Shravasti but manpower is grossly inadequate. Also the DH has been set up near a CHC, rendering it non-functional. The blood storage unit at the DH in Shravasti is nonfunctional. In Meerut, the DH is functioning well as is the the SNCU.
- Both Meerut and Shravasti show a marked drop in OPD services during 2012-13.
- There are nine blood banks in the district of Meerut; Shravasti has one blood bank but this was not functional.
- Dial '102' and Dial '108' ambulances have shown encouraging trends in utilization; the average case load was 5 cases/ambulance/day.
- Mobile Medical Units were not available in the districts visited by the CRM team.
- Awareness about ambulance services in the state for emergency care was fairly high; on being questioned by the CRM review team, most beneficiaries were aware of the helpline numbers.
- None of the IEC campaigns implemented used multi media or a 360 degree campaign approach. Mass media use has been random, with no tracking or monitoring. Local media seems to be used very sparingly.
- There was inadequate focus on reaching out of school adolescent girls through SBCC messages. The VHND platform does not target adolescents and the only attempt to reach them seems to be through sporadic meetings with the ASHA.

## UTTARAKHAND

- Service utilization is sub-optimal, especially at DH & SDH level.
- Two 100 bedded separate Maternal and Child Health Wings (MCH wings) at Mahila Hospital, Haridwar and Medical College Srinagar has been sanctioned in FY 2012-13. Construction is under progress but needs to be accelerated.
- The majority of health services in the state are provided by the public sector, especially in the difficult terrains; the concentration of private practitioners is limited to the larger towns.
- User charges at public health facilities range from Rs.13 to Rs.15 for an OPD consultation and Rs. 10 to 70 per day for IPD admission. User charges were also levied for the entire range of diagnostic tests conducted at the health facilities.
- The tertiary care services at Tehri and Almora are limited to antenatal care, normal delivery and post-partum care along with the National Health Programmes. There is no facility for conducting C-sections and there are no FRUs or provisions for ultrasound in any public health facility in Tehri district.

- ▶ Uttarakhand has sub-contracted 21 UPHCs, 16 CHCs, MMUs, ARSH clinics and surgical camps. However, there is either a lack of any penalty clause in the MoU or these are not effectively used by the state government when targets or deliverables are not achieved by the private providers.
- ▶ EMRI and Khushiyon Ki Sawari (KKS) do not ply on kuchha roads due to a clause in their Insurance contract. Due to this pickup and drop facility is limited to motorable roads only.
- ▶ The state should strengthen the MoU with private partners including clear cut deliverables, targets and the provision for punitive action for instances of non-performance by MMUs.
- ▶ The state has developed a communication strategy with clear objectives focused on RMNCH+A goals.
- ▶ The state allocation for IEC/BCC has increased over the last three years from Rs.280 lakhs in 2011-12 to Rs.600 lakhs in 2014-15.

## WEST BENGAL

- ▶ Compared to earlier years, there has been an increase in the utilization of health care services.
- ▶ Accessibility to healthcare services in 23 LWE affected blocks in Paschim Medinipur, Purulia and Bankura are inadequate. These have been complemented by offering Mobile Medical Camps. The islands of Sundarban are also identified as difficult-to-access zones - services are provided through Community Delivery Centres (CDC) and specialised boat clinics. It was observed that in most of the health facilities visited there was no boundary wall for the hospital and there were places where there were stagnant pools of water providing breeding sites for mosquitoes. This also encouraged the free movement of animals in the hospital premises.
- ▶ The overall resources available with the DH for service delivery were found to be limited. However, the number of normal deliveries, C-sections, major and minor surgeries conducted by the DH were commendable. There were allegations of informal payments to facilitate various services for mothers including admissions.
- ▶ The total ANC registration (till Oct. '14) has been satisfactory compared to the estimated pregnancies for the year FY '14-15. It is expected that the state and the districts would be able to achieve 100% estimated pregnancies under ANC if the same trend were to continue.
- ▶ The IPD and OPD services at the state, Bankura and Uttar Dinajpur districts were fully functional and optimally utilized.
- ▶ Subcontracting of services was satisfactory for the Ayushmani scheme, Cooked Diet, Fair Price Medicine Shops and PPP Diagnostics. However it was observed that in SDH Khatara and BPHC Indupur the LTs at public facilities were under utilized due to the PPP scheme for diagnostics being in place.
- ▶ Nishchay Yaan/Maatri Yaan is a state initiated referral transport system under JSSK exclusively for mother & child. However, due to lack of awareness, utilization by mothers is not adequate. Moreover, many women reported non-availability of drop-back services from facilities.
- ▶ Web-based reporting and monitoring for MMUs was in place, complemented by NGOs participating in the monitoring of MMU outreach services. Average trips/MMU/month - 25-27; Avg. operational cost/MMU/month - 2.94 lakhs.
- ▶ The IEC is delivered piece meal in the absence of a State IEC plan; activities are carried out as and when orders are received from the state for specific health days or activities. However, IEC/BCC activities related to disease control programmes such as RNTCP, NPCB, NLEP and NVBDCP were found to be satisfactory.



# TOR 2

## RMNCH+A

### REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD, ADOLESCENT HEALTH (RMNCH+A)

#### Guiding Principles/Strategies of the NHM

- i. Ensure coordinated inter-sectoral action to address issues of food security and nutrition, access to safe drinking water and sanitation, education particularly girls' education, occupational and environmental health determinants, women's rights and empowerment and different forms of marginalization and vulnerability (Para 2.3.2)
- ii. Expand focus beyond maternal and child survival to ensuring quality of life for women, children and adolescents (2.3.17)
- iii. Converge with Ministry of Women and Child Development and other related Ministries for effective prevention and reduction of under-nutrition in children aged 0-3 years and anaemia among children, adolescents and women (Para 2.4.2.13)

### KEY FINDINGS

#### Planning

- ▶ Mapping and prioritizing of health facilities is complete across all states but is largely limited to provision of delivery care. While a large number of facilities are designated as 24 X 7 PHCs and FRUs, their functionality as delivery points is limited in most high focus states visited. This emerges as a major concern in Assam, Bihar, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, Uttar Pradesh and West Bengal with relatively higher proportion of home deliveries.
- ▶ Inequitable distribution of delivery points and FRUs leading to underutilization of some health facilities and overcrowding of others still remains a challenge. This was highlighted in findings from Assam, Chandigarh and Telangana.
- ▶ Emphasis on delivery care provision is seen across all states and limited efforts have been made to increase the availability of services for safe abortion care, comprehensive family planning services, care for RTI/STI and newborn care at block and sub block health facilities.



Currently availability of these services is limited to district hospitals in almost all states except Kerala, Odisha and Tamil Nadu.

- Availability of essential commodities like drugs, vaccines, contraceptives and equipment as per the RMCH +A matrix varied across districts. Shortage or stock-out were seen in most states i.e, Assam, Bihar, Chandigarh, Chhattisgarh, Kerala (at PHC and SHC level), Mizoram, Rajasthan, Telangana, Uttarakhand and Uttar Pradesh. Efficient supply chain management with no stock outs was reported from Odisha and Tamil Nadu. Madhya Pradesh has set up Arogya Kendras at AWC in every village with about 16 types of drugs and equipment in an attempt to institutionalize primary care services at village level.
- There is enhanced thrust on RMNCH+A services and handholding of all the high priority districts by development partners through expanding human resources for management and monitoring, undertaking gap analysis and periodic monitoring in high priority districts. A time bound action plan to address gaps was reported only in Madhya Pradesh, Punjab and Rajasthan. Tamil Nadu has allocated additional 30% funds for Madurai (a High Priority District (HPD) but there is no strategic plan to strengthen the system.

### Care of the Mother and Child

- While there has been a steady increase in the uptake of Antenatal Care (ANC) services across all states, the quality of care continues to be a challenge, especially in Assam, Bihar, Chhattisgarh, Kerala, Mizoram and Uttar Pradesh.
- Despite an increase in ANC care, timely identification and follow up of high risk pregnant women continues to be poor across most states. In Madhya Pradesh, a two pronged approach is used to track high risk pregnancies - at community level ASHAs conduct household surveys identify and at facility level a weekly monitoring of MCTS report is undertaken.



Reminder calls to pregnant women (based on EDD) are made by 108 staff to motivate them for institutional delivery in Kancheepuram, Tamil Nadu known as "Phone to Heart Touch Approach" and in tribal areas of Telangana.

- As expected, the rate of institutional deliveries continues to increase across all states. Another promising finding is the sustainability of high utilization of public health institutions for delivery care. Only in Kerala and Telangana, is the private sector catering to a high proportion (nearly 60%) of institutional deliveries. This may be attributed to lack of diagnostic and clinical services at health facilities as per RMNCH+A matrix below district level.
- With the increasing number of women coming to public health institutions for delivery it is imperative that quality of services meets this fast pace and is sustained at all levels. However this is yet to become a reality in most states especially for health facilities below district level. The reasons for poor quality of services vary across and within states, from poor procurement and inventory management, inadequate or underutilized infrastructure and non-availability of skilled human resources. Odisha has introduced **Delivery point mentoring initiative** in high priority districts which has led to significant improvement in quality of services.

- ▶ An effort to improve the services at labour room was evident in all states, though the status varies across facilities i.e, better labour rooms at District level hospitals as compared to CHCs, PHCs and SHCs and across districts - with better facilities in better performing districts. This was true for all states except in Sri Ganganagar district in Rajasthan and Bankura district in West Bengal where lack of physical infrastructure (number of labour tables and PNC ward beds) of labour room at District hospital affects the quality of care. While the functionality of labour rooms was reported to be better in Chandigarh, Odisha, Rajasthan and Tamil Nadu, there are still gaps in quality standards related to ensuring privacy, safety and basic facilities like functional toilets in all levels of facilities.
- ▶ With regard to the quality of clinical care the findings were mixed. Findings from all states note gaps in the capacity of service providers to provide comprehensive services. For instance, most ANMs/Staff nurses handling delivery cases were not SBA trained in Chhattisgarh, Odisha, Madhya Pradesh and Uttarakhand. Technical protocols and SOPs in local languages were displayed in a few facilities.
- ▶ Overall the availability of CemONC services have improved across states but the gap between actual requirement of health facilities, designation and being functional is yet to be bridged. States continue to grapple with challenges of setting up blood banks/ blood storage units and posting of specialists in order to operationalizing FRUs/CemONC services. FRU services were not available in two districts- Tehri of UK and Shravasti of UP, incidentally both these districts are HPDs with poor health indicators with no alternative private sector options.
- ▶ High rate of C section (39.5%) was observed in Kerala where one SDH in Ernakulum recorded caesarean section rate to the tune of 64%. This was justified with the reason that “doctors do not want to take any risk” while giving a trial of labour to an over-demanding family, which

perceives caesarean to be a safer option than a normal delivery. Similar findings are seen in Telangana with over 50% C sections (both in private and public). Such high proportion of C sections is alarming and need to be reviewed.

- ▶ Availability as well as awareness about PPTCT diagnostic services need to be strengthened, among the service providers, frontline workers and community. Functional PPTCT/ICTC/ ART centres were observed in Chhattisgarh, Chandigarh, Madhya Pradesh and Tamil Nadu.
- ▶ Safe abortion services and STI/RTI services are currently available only at district level hospitals or in one or two CHCs in districts due to shortfall of trained HR and equipment. Limited availability of safe abortion services was reported in Assam, Mizoram, Punjab, Tamil Nadu and West Bengal. In SBS Nagar, Punjab, safe abortion services were not available at all in any public health facility. In Tamil Nadu a reported lack of confidence among trained doctors led to denial of abortion services while in West Bengal use of outdated methods for abortion was reported. A large number of providers were reported to have been trained by IPAS in Bihar, but protocols of MA and MVA were combined in a non standard manner while medical abortion was not available in the district at any level. Shortage of Misoprostol and Mifepristone was reported from Chhattisgarh, Odisha and Rajasthan
- ▶ A significant increase is seen in the establishment of Facility Based Newborn Care Services throughout the country. However the slow pace of creating SNCUs in states with higher IMR rates such as Bihar and UP, which have SNCUs in nearly 50% of districts, is a major concern. It is important to note that in Shravasti, the SNCU is yet to be operationalized *despite being a HPD with the highest IMR of 103 in the country (AHS)*. The design of SNCU in Meerut, UP was not in accordance with SNCU protocols. None of visited districts of UK (Tehri and Almora) had a functional SNCU. In West Bengal, SNCU at Raiganj DH, infrastructure was

under equipped, with no centralized oxygen facility and non-functional Radiant Warmers.

- ▶ SNCUs in Kerala, Odisha, Telangana and MP have good infrastructure and functionality. In MP, 30 SNCUs out of 53 SNCUs have been accredited by National Neonatology Forum (NNF) while in Telangana one SNCU at Medak Hospital has been proposed for NNF accreditation but SNCUs in Gandhi Medical College and Niloufer Hospital in Telangana was overcrowded with double/triple occupancy.
- ▶ Newborn care services at the primary and secondary levels, as NBCC and NBSUs need strengthening specifically in states of Assam, Bihar, Chandigarh, Chhattisgarh, Mizoram, Odisha, Uttarakhand, Uttar Pradesh and West Bengal. In Rajasthan NBSUs were reported to be underutilized while in UP and Chhattisgarh they were not functional as per protocols.
- ▶ Referral linkages from community and follow up of newborns discharged from SNCU needs strengthening. Majority of the admissions at SNCU were found to be inborn with fewer outborn admissions in all states except Tamil Nadu. In states of MP and Odisha analysis shows that the main cause of SNCU admission was asphyxia (over 40%) raising concerns about quality of intrapartum care. Also tracking and follow up of a SNCU discharged new born is done through phone only in Tamil Nadu
- ▶ Nutritional Rehabilitation Centers are now in place in most states except in both the districts of UP that were visited. In Bihar, the NRCs are run on a PPP model where NGO/ Agencies have been provided ward, kitchen and office space by the government. This model appears encouraging but needs to be closely monitored and studied further. In Odisha, the NRCs provide wage loss payments to the mothers/care-givers was being given at time of 2nd Follow up, this appeared to be an effective local solution to enforce mothers to stay till recovery and attend at least 2 follow ups. Mothers were also provided food over and above the wage loss, from an out-sourced nearby hotel.

- ▶ Suboptimal utilization of NRC is reported from all states except Telangana and Tamil Nadu. Better community linkages to improve the referrals and follow up of SAM children is required to improve the utilization levels.

### Progress under RBSK

- ▶ RBSK has been rolled in most states and is at varying stages of implementation. Majority of the states have nearly completed recruitments and the teams have begun screening of children except in Bihar, Punjab and Telangana while in West Bengal the program does not cover the entire gamut of services as per guidelines. States of Tamil Nadu and Kerala have their own school health programmes covering the 4 Ds- Defects, Delays, Deficiencies and Disabilities.
- ▶ Subsequent to completion of training, screening of children has shown progress across states. As the number of screened cases increase, there is a requirement of building referral chains with tertiary care centers. This has already begun in few states, e.g. - Chandigarh refers cases to PGI, Chandigarh; a Mukhyamantri Bal Shraavan Yojana has been launched in MP for cochlear implantation; Mizoram has identified an NGO "Cure Club Food" to provide free treatment and rehabilitation services; Odisha has initiated tertiary level care and Uttarakhand has setup referral linkages with Himalayan Hospital, Jolly grant, and Fortis and Max hospitals in Dehradun.





- ▶ Lack of transport facilities also affects compliance of referral cases. To address this Uttarakhand has started using the transport vehicle *Khushiyan ki sawari* (used for drop back under JSSK) to enable referral.
- ▶ Kerala has digitalized the school health screening data and established excellent referral systems for addressing the various health problems identified during the screening.
- ▶ In Uttarakhand, effective co-operation and support from ICDS and Education department has led to coordination among functionaries at the field level for implementation of the programme.

### Implementation of RKSK

- ▶ Of the four components of RKSK, most states have implemented the WIFS programme and set up AFHCs while peer educator selection is yet to begin. Menstrual Hygiene Scheme programme is implemented only in few districts.
- ▶ A majority of the states have established the Adolescent Friendly Health Clinics (AFHCs) but the uptake of services by the target population was found to be low in all states except in West Bengal and Telangana. The probable reason for a higher service uptake is the effective community linkages for outreach services. Nilofer Child Hospital (Part of Osmania Medical College), Hyderabad has established a state of art – YUVA (AFHC) clinic staffed by Adolescent Physicians, Gynaecologist, Psychiatrists, Psychologists and Counsellors.

Location of AFHC along with ICTC centers or RTI/STI clinics in Assam, Odisha and Madhya Pradesh dilutes the concept of privacy. Dedicated Counsellors have been recruited and posted only in Chandigarh, Madhya Pradesh, Uttar Pradesh and West-Bengal. Uttarakhand has set up a separate toll free number for adolescents. The skills of counselors need to be built up to gain confidence of adolescents and generate interest in the community.



- ▶ WIFS programme has gained visibility in the community and shows growing acceptance of the weekly dose of Blue IFA. Overall the supply of blue IFA was found to be good except in few states like Assam, Uttarakhand and Chhattisgarh. In Assam, blue tablets were available in the field but were given to pregnant women on priority due to unavailability of the regular IFA (large).

In addition to WIFS for adolescents, Odisha has also implemented WIFS Junior programme, while Chhattisgarh has implemented WIFS only for school going children.

- ▶ The Menstrual hygiene scheme is not a universal scheme. It was found operational in a few districts. However field interactions indicate poor quality of sanitary napkins in the

states of Kerala, Odisha and Rajasthan affecting community demand for these napkins. In Tamil Nadu, the scheme is funded and implemented by state government through AWC and school teachers.

- ▶ Peer Educator programme is in its nascent stages as selection of peer educators has not begun in any state except in Uttarakhand where selection of 4189 peer educators has been done with NGO support.

### **Community level care arrangements**

- ▶ Home Based Newborn Care (HBNC) through regular home visits by ASHAs is being implemented in majority of the states visited. ASHAs were found to be well trained for newborn care and identification of danger signs in newborns and postnatal mothers in Odisha, Punjab, Rajasthan, Tamil Nadu and Uttarakhand.

ASHAs in Karimganj, Assam and Meerut and Shravasti district of Uttar Pradesh are yet to be trained in Round 1 of Module 6&7, hence HBNC has not been implemented in these districts. HBNC in Bihar is slowly picking up but skills of ASHAs pertaining to HBNC were found to be poor and could be attributed to unavailability of HBNC kit with ASHAs (even during training). As Mitani in Chhattisgarh have received training Modules up to 15 (which includes the curriculum for HBNC) they do conduct HBNC visits but there is variation in filling of HBNC forms than the HBNC guidelines.

Quality of supportive supervision and mentoring of ASHA was reported to be poor, affecting the functionality of ASHAs, this was observed in states of Bihar and Rajasthan.

- ▶ Madhya Pradesh has set up Gram Arogya Kendra (GAK) at AWC in all villages equipped with 16 types of medicines and 5 types of diagnostic services as one stop arrangement for availability of all supplies, services. State has issued guidelines specifying that ASHA should be present at GAK from 10 am to 1 pm, but in practice ASHAs stayed at till 4 pm.

Initial findings indicate that GAK has helped in bringing basic primary care community's door step but mandating ASHAs to be present at GAK has adversely affected her household visits. GAK model needs to be studied further to assess its effectiveness.

- ▶ Engagement of local government bodies like Panchayats, Members of Parliament and Legislative Assembly through contribution of resources, planning and monitoring of health services, emerges as a best practice from Kerala. In addition to ASHAs, Kutumbhasree (self-help group) volunteers also contribute in community mobilization, health screening, source reduction activities, and in provision of health services at village level.

### **Reach of Family Planning Services**

- ▶ Family planning services delivery continues to be centered around limiting methods with little focus on spacing methods like IUCD and PPIUCD. Fixed day Services (FDS) for sterilization are provided in few states of Bihar, Chandigarh, Chhattisgarh, Odisha, Tamil Nadu, and Uttar Pradesh. Availability of sterilization services is also limited to District level health facilities and at best at few CHC level in cases of camps. Findings from Bihar highlight gaps in quality protocols followed during female sterilization camps.
- ▶ Most states have rolled out PPIUCD services but it is yet to gain momentum. PPIUCD services are available only at secondary level due to lack of trained manpower. States of Assam, Punjab, Telangana and West Bengal have not started PPIUCD services because of failure to complete TOTs and training of staff. High rate of IUCD removals were reported in Bihar, Madhya Pradesh and Mizoram, indicating poor case selection and weak counseling. Madhya Pradesh has introduced a "Score Card" displayed in labor room for tracking the progress of PPIUCD.
- ▶ Home based distribution of contraceptives has begun in almost all states. Supply of

contraceptives for ASHAs was regular in all states except Assam, Bihar, Kerala and Uttar Pradesh. Availability of Pregnancy Testing Kits was also good in all states except Telangana and Bihar.

- ▶ One new initiative observed in Odisha is “Reproductive Health Commodities Logistics Management Information System (RHCLMIS)” - an innovative ICT enabled contraceptive logistics and supply chain management system.
- ▶ In Rajasmand district of Rajasthan, injectable contraceptive “Khushi DEPOT (Depot Medroxi-Progesterone Acetate)” has been introduced through the initiative of CMOH.
- ▶ Counselling skills of front line workers like ASHA, ANM and even FP counselors etc on contraception is a challenge.

### JSY and JSSK

- ▶ Community level awareness among beneficiaries regarding benefits of the JSY was good in all states, except in Punjab, where there was greater awareness of a state specific scheme – *Mata Kaushalya Yojana* under which beneficiaries are paid Rs. 1000 for delivery.
- ▶ Payment of JSY incentives has been streamlined though Direct Bank transfers. Delay was noted in Tinsukia, Assam (up to one month), Madhubani, Bihar (pending since July 2014), Korba, Chhattisgarh (15-30 days), Mizoram (since May 2014), Punjab (for Gramin Bank accounts), Uttar Pradesh (44-46% payments made) and West Bengal (especially in case of <18 years). Denials of payment were reported from Madhya Pradesh because of inability of beneficiaries to open a bank account. Cash payment of JSY incentives is done in Mizoram because of poor banking services in hilly areas and through bearer cheques in Tamil Nadu and Medak, Telangana.
- ▶ While JSSK has made a significant contribution in reducing out of pocket expenditures, OOPE are yet to be eliminated. The findings are variable regarding awareness and utilization

of entitlements under newborn and infant component. Incidence of OOPE was observed in several states, with expenditure being reported on transport, drugs and consumables.

- Bihar – Transport ( drop back providers found unaware of this entitlement) and cleaning (Rs. 25 to sweeper for cleaning labour room in SHC of Jhanjharpura block)
- Chandigarh - Transportation, diagnostics and drugs
- Korba, Chhattisgarh – Pregnant women charges user fee
- Madhya Pradesh – Transport, drugs, consumables and informal payment
- Mizoram - Transport and drugs.
- Odisha - Diet, diagnostics and transport
- Tamil Nadu – transport (drop back due to social taboos)
- Shravasti, UP – Drugs, Consumables and informal payments
- Uttarakhand – USG and transport
- ▶ In Mizoram instead of providing free entitlements under JSSK to pregnant women, the free services are being provided by utilization of benefits under RSBY. The RSBY amount consumed to avail the delivery service is utilized by the family in other cases of





hospitalization. Thus awareness in community was more on RSBY than JSSK.

- ▶ Most States are providing free diet except in Mani Majra CH of Chandigarh. In few facilities of Korba district of Chhattisgarh cash is given to pregnant women for purchasing food due to non-availability of kitchen. In Assam JSSK diet fund is used to purchase and supply Horlicks up to SC level.
- ▶ Awareness of JSSK entitlements has improved substantially from the previous CRM reports. However in UP and UK community as well as some providers appeared unaware about JSSK entitlements for infant up to 1 year.
- ▶ Dedicated Grievance Redressal Mechanism for JSSK was not found in any state except UP where a toll free number has been established at state level. However it is likely that community awareness of this was low, as there was no display of the toll-free number in facilities visited. Assam and Rajasthan use general 104 toll free number for grievance handling which was displayed in facilities.

## MDR

- ▶ All the states visited have systems in place for Maternal Death Review except for Bihar; the mechanism for Child Death Review exists in only few states viz. Chandigarh, Kerala, Tamil Nadu and Rajasthan.
- ▶ Most the states are not utilizing the output of the reporting system for taking corrective action. Training and MDR workshops were done in initial phases and observations of poor documentation and reporting from most of the states reflects the need of conducting refresher trainings and orientations. E.g.- most deaths in Tinsukia district of Assam were reported from tea plantation area but no strategy was planned to address it.
- ▶ Most of the high focus states are under-reporting maternal Deaths e.g. Uttarakhand, Assam, Chhattisgarh and Mizoram. Community based Maternal Death Reviews are still either not practiced or are inadequate in Assam,

Chhattisgarh and Odisha; whereas Facility based review is not found in Punjab.

- ▶ In Kerala, *Confidential MDR* is being done wherein gynaecologists can send information anonymously (regarding maternal deaths). This is a good practice as it focuses on improving the programme.

## Immunization

- ▶ Regarding Immunization services, significant improvements have been made in the program. The use of work plans and due lists by field workers have contributed to strengthening of the program. But at the same time, there are gaps which need to be bridged. This was seen in Assam, Bihar, Chhattisgarh, and Mizoram in particular. ANMs were not utilizing work plans, due lists were incomplete and the MCP cards were also not duly filled or were missing. Records of zero doses were missing at many facilities visited in different States.
- ▶ Cold chain maintenance and vaccine logistics systems need focus for strengthening in Bihar Chhattisgarh, Madhya Pradesh, Mizoram, Punjab and Tamil Nadu. Stock outs of birth doses were seen in Assam, Bihar, Mizoram and Tamil Nadu due to flawed indenting and supply chain management.
- ▶ Odisha, Chandigarh, Kerala and Tamil Nadu have good VHND session planning and implementation for Immunization services.



- Some good practices were seen such as the Birth Dose Clinic in City Hospital, Ganjam in Odisha where zero dose vaccination was being provided properly through a dedicated deputed staff there. Odisha also had another innovative strategy to maintain vaccine logistics: a 'Passbook for Vaccines and Immunization Logistics for Sub-centers' for maintaining indent and stock of vaccines.

## RECOMMENDATIONS

- States need to focus on operationalizing facilities with requisite infrastructure, manpower and equipment rather than merely changing the nomenclature or designation of the health facilities. Careful mapping of facilities in accordance to caseloads and actual requirement in lieu of time to care concept needs to be prioritized. Expansion of available service components from only delivery related services to comprehensive RMNCH+A services – safe abortion care, RTI/STI, family planning and newborn care is required.
- Efficient logistics system with proper inventory management is the need of the hour to eliminate stockouts of critical drugs, vaccines and equipment. States can explore the use of ICT in this area.
- With increase in coverage of ANC services focus should now be on improving the range and quality of ANC services as well as timely identification and referral of high risk cases.
- Facility based newborn care services need attention in the context of implementing guidelines and adherence to protocols laid out for quality of care. At the same time strategic and meticulous planning is needed for strengthening primary and secondary level care newborn services (NBCCs & NBSUs).
- Referral linkages from community and follow up for SNCU as well as NRC discharged children needs to be strengthened with regular capacity building of Front line workers – ASHAs, ANMs, and AWWs and improved availability of drugs and equipment.
- Expedite capacity building of services providers (ANMs, Staff nurses and doctors) such that their skills commensurate with the job/task undertaken by them especially in the area of SBA, NSSK and PPIUCD training.
- Setting up forward and backward referral linkages with tertiary care centres as well as operationalizing DEIC is essential for effective implementation of RBSK
- Paradigm shift at state policy level is required to promote spacing methods over limiting methods.
- Persistent OOP in most states despite implementation of JSSK is a cause of concern. States should ensure that JSSK is implemented in its true spirit and build mechanisms of community monitoring and accountability to address this issue.
- Grievance Redressal system is almost non-existent except for two states. States should establish the same and ensure communication of the same to community through IEC display in facilities.
- Under reporting of maternal death and poor implementation and use of MDR needs to be resolved with proper training and follow up. Child Death Review is practiced in only four states and need to be scaled up.

## FINDINGS FROM STATES

### ASSAM

- Operationalization of all FRUs and DH for providing CEmNOC care is yet to be completed, e.g.- 24 out of 29 designated CHC and 21 out of 25 DH provide FRU services. None of the secondary level facilities visited were prepared for admitting high risk pregnancies for delivery.
- Stock outs for OCPs, CuT 375, IFA, ORS and Vitamin K, Birth doses of OPV, DPT and BCG at most of the visited facilities were reported.

- ▶ Well functional labour rooms were found at most places but inadequacy of labor tables was noted in few high caseload facilities. Skills of SBA trained GNMs in AMSTL were also found to be poor.
- ▶ Quality of ANC services needs to be improved. Line listing and follow up of high risk pregnancies is yet to begin.
- ▶ OOP expense on informal payments and diagnostics & transport r were reported. Lab services were not available even in civil hospital in spite of 5 Lab technicians being in position.
- ▶ Fixed day services were not available in the districts visited and camps were being organized for sterilization. PPIUCD is at a nascent stage in the state because of delay in training. Home Delivery of Contraceptives through ASHA is operational but contraceptives stock outs were reported
- ▶ Newborn care services need strengthening at the primary and secondary levels, as NBCC were non-functional in some of the facilities visited. At SNCU, inborn admissions were much higher than the out born admissions indicating poor community linkages.
- ▶ Tinsukia has no NRC but has a Nutrition Counseling cum Management Centre at DH which was found to be sub optimally used while in Karimganj, the 10 bedded NRC was non functional
- ▶ The cold chain and vaccine storage system at all facility levels is satisfactory but poor indenting system and erratic supply of vaccines has led to stock out of BCG and OPV at many facilities. Unavailability of micro plans and due lists with ANMs at the SC level is a major concern
- ▶ Abortion care services are nearly missing in both the districts. In both the districts most of the staff was not trained in MTP/MVA, overall only 87 MOs are trained in MTP in the whole State.
- ▶ Under RKSK - AFHCs were grossly underutilized. Convergence between the Education, Health and ICDS Department as observed to be poor for WIFS, which is nonexistent at AWCs. Blue tablets under WIFS programme were being given to pregnant women due to unavailability of IFA large
- ▶ Maternal death review, both community based and facility based need strengthening as findings indicate under reporting of maternal deaths. Most deaths in Tinsukia were reported from tea plantation area but no strategy was planned to address it.

## BIHAR

- ▶ Number of functional delivery points and FRUs was insufficient. In Madhubani, out of 7 designated FRUs only DH was fully functional. SDH, Jhajarpur was functional as FRU but currently BSU is non functional since 6months because of staff being on long leave.
- ▶ Labor rooms at DH and SDH were as per guidelines but at peripheral facilities like BPHC, CHC, and MCH center, poor maintenance and lack of basic hygiene was found. Shortage of beds in the maternity ward led to sharing of beds when case load is high.
- ▶ ANC services need to be strengthened in a big way. Tests for Hb, Blood Sugar, urine are neither available nor ANMs were skilled to perform these tests. IFA tablets and Nischay kits were not available since many months.
- ▶ Irrational use of drugs such as Misoprostol and Oxytocin to induce labour was noted at facilities,
- ▶ Shortage of Oral pills, condoms, emergency pills and Nischay pregnancy testing kits was reported as these have not been available since 4 to 6 months.
- ▶ Female sterilization are conducted at all health facilities either through camp, daily operation or as a fixed day service. About 10% of women delivering at DH received PPIUD. Several ANMs posted in labour rooms



were not trained to insert IUDs while in few facilities PPIUCD services were not provided despite the presence of trained service provider.

- ▶ A large number of doctors were trained in first trimester MTP through an IPAS supported programme but Medical and surgical abortion have been combined in a nonstandard way. Medical abortion was not available in both the district.
- ▶ SNCUs have been established in 18 out of 36 District Hospitals. Sub optimal utilization of equipment at SNCU at Madhubani DH was noted. Phototherapy units in SNCUs/NBSUs are not being used. Quality of reporting at these facilities also needs to be reviewed.
- ▶ State has reported 496 functional NBCCs at Delivery Points, yet many more delivery points need to be covered.
- ▶ Issues of absence of HBNC kits with ASHAs and irregular supply of equipment/drugs was seen. The supervisory and handholding support by ASHA facilitators was found to be very weak.
- ▶ NRCs are run on a PPP model throughout the State. NGO/Agencies have been provided ward, kitchen and office space and a budget provision Rs 3,60,000 of which fifty percent is paid upfront and balance payment is based on admissions. NRC Model appears encouraging but its effectiveness depends on close monitoring and needs to be evaluated.
- ▶ JSY payments were done before discharge through account payee cheque but due to lack of funds, payments have not been done since July'2014. OOP on transport was common as obstetric and pediatric staff was found to be unaware about their responsibility in arranging transport.
- ▶ Huge mismatch in demand and supply of vaccines led to shortage of measles vaccine was observed at almost all facility levels. VHND Sessions were being organized in very cramped spaces, due lists were available only at some places with ASHAs.
- ▶ Maternal Death and child death review are not being conducted in both districts.
- ▶ RBSK scheme is yet to be launched in the state. State is planning to constitute 1068 teams in 534 blocks and DEIC have been planned at nine Divisional Head Quarters.
- ▶ State has 123 operational AFHC clinics but menstrual hygiene scheme and WIFS are non-existent.

## ■ CHANDIGARH

- ▶ Availability of fixed-day services (FDS) for sterilization and IUCD observed, however lack of privacy for women undergoing procedure was an issue.
- ▶ Under JSSK, out of 3 DPs diagnostic (USG) facility is available only at DH 16 leading to huge OOP expenditure by beneficiaries.
- ▶ SNCU was functional with 10 beds in Inborn Unit and 10 beds in outborn unit. In Inborn Unit, 4.5% mortality in 2014 and 2.64% in 2013 while in outborn unit, 1.34 % mortality in 2014 and 1.19% in 2013. Good record keeping observed.
- ▶ Step down unit from SNCU lacking as there were no functional NBSUs
- ▶ Number of second Trimester abortion is significantly high indicating towards possible cases of sex determination, which needs to be further reviewed.
- ▶ No specific designated space for Nutrition Rehabilitation Center in DH 16 and it was running on an OPD basis. Children are admitted in available beds in pediatric ward and followed up.

- ▶ Lab Based Measles Surveillance Reporting Started from October 1st Week onwards along with AFP Surveillance Record.
- ▶ RBSK is still continuing in School Health Program mode. Of the 14 teams constituted out of 16 teams approved. Adolescent Friendly Health Clinics are not functioning across all facilities.

## CHHATTISGARH

- ▶ Technical protocols in labor rooms and NBCCs of some facilities were not adhered to. Though AMTSL, PPH management, Essential Newborn care and resuscitation are being done, but nursing staff providing these services are neither trained nor are being supported for technical skills. Most of them were not trained in SBA, NSSK, etc.
- ▶ Medical Termination of Pregnancy (MTP) services were limited to District Hospital in both the districts as very few doctors having been trained in MTP.
- ▶ No line listing of severely anaemic women and identification of high-risk pregnancies being done
- ▶ Fixed day services for FP are not provided. PPIUCD and IUCD services are available at DH and few PHCs. Emergency contraceptive pills were not available at any facility.
- ▶ NBCCS are available at all delivery points but in Jashpur there is no functional NBSU. Good infrastructure was seen at SNCU of Korba DH but there was no Pediatrician posted in the district.
- ▶ Free entitlements under JSSK being provided to pregnant women and sick infants but entitlements for infants require strengthening. At some facilities in Korba, user fees is being charged from everyone including pregnant women and at few PHCs cash was given to pregnant women for purchasing food due to non availability of kitchen. OOP was also reported on diagnostics due to lack of availability and on transport due to lack of awareness.
- ▶ JSY payments being made timely through crossed cheques in the health facilities visited in Jashpur and Korba district at the time of discharge, while bearer cheques are given at DH in Korba.
- ▶ Three NRCs were functional in Jashpur and one in Korba, however admission through outreach referrals was only 14% in Korba indicating poor referral linkages.
- ▶ Cold Chain was maintained at District Hospitals but not at few sub-district facilities in Minora block in Jashpur and many facilities in Korba. 80% of ILRs in Korba district were not functional. Also Drop out and left out children were not followed up.
- ▶ RBSK teams had been formed in both districts. Improvement is needed for treatment, referral and follow-up of identified cases.
- ▶ ARSH clinics available at the district level in Jashpur and Korba. The WIFS program has been implemented by ICDS and education department, very little role of health department. It is being implemented only for school-going children and yet to be extended for out-of-school children.
- ▶ Community based reporting for MDR was inadequate. Maternal deaths are under reported and lacked programmatic focus for corrective measures. CDR is yet to be initiated in districts visited.

## KERALA

- ▶ Local government bodies like Panchayats, and Members of Parliament and Legislative Assembly allocate substantial resources towards strengthening of public health services. They also actively engaged in the planning and monitoring of health services.

- ▶ State has been able to achieve and maintain this high quality at the district level and (select) sub-divisional hospitals due to successful implementation of NABH & KASH accreditation process. Hospital management, sanitation and quality improvement committees have also helped in improving overall quality of care
- ▶ Only 73 (1.1%) of 6506(15District Hospitals, 65 FRUs, 17 Taluk Hospitals, 233 CHCs, 173 PHCs which are 24x7, 682 non 24X7 PHCs and 5387 SHCs)public health facilities conduct delivery in the state. Existing delivery points below district level do not offer comprehensive and quality RMNCH+A services due to poor infrastructure, unavailability of gynecologists and other specialists and lack of resources.
- ▶ High Cesarean rate of 60-70% at some facilities in Ernakulam district and 30-35% in Palakkad were reported. Field findings indicate high demand for cesarean among pregnant women
- ▶ State is yet to establish free referral transport system for pregnant women, but women are reimbursed for their travel expenses.
- ▶ Ultrasound machines are available at district and Taluka hospital, where ultra-sonologist is hired on per case basis while basic investigations such as hemoglobin and blood glucose are not available at many facilities below district level.
- ▶ Uptake of services at these facilities is low and majorities (80-90%) of the cases are in-born admissions at SNCUs available at the district hospitals (and in one tribal Taluka Hospital).
- ▶ Full immunization coverage is around 81.5% but vaccination coverage of Hepatitis B and Japanese Encephalitis continue to be low in the State.
- ▶ About 66 adolescent health clinics have been set up but ICTC counselors provide counseling services in 13 of these facilities. Poor quality of sanitary napkins supplied under Menstrual Hygiene Scheme has affected the uptake by beneficiaries.
- ▶ Supply of Oral Pills and ECs was observed to be erratic. Most of the cases of PPS are done in private facilities because of low number of deliveries in public health facilities and lack of services. At public health institutions the services are mostly being provided in camp mode or clients are referred to nearby facilities. Uptake of the PPIUCD services is quite low (0 to 5% in both districts) and very few service nurses have been trained on PPIUCD.
- ▶ Death reviews are confined to identifying the medical causes of the death, identifying social determinants and other systemic issues needs strengthening.

## MADHYA PRADESH

- ▶ State has 1412 functional delivery points, of which 419 L1 level, 663 BEmONC and 91 CEmONC facilities are functional. Out of total 152 identified CEmONC facilities, 42 have Blood Bank and 75 have Blood Storage Unit established at L3 facilities. Remaining 35 institutions do not have this facility. These are inadequate and also not equitably distributed with concentration in certain areas.
- ▶ Facilities below DH lack infrastructure, and trained human resources. Intrapartum and newborn care protocols and practices are not followed below DH level.
- ▶ Under reporting of still births was observed eg- two cases of fresh still births and early neonatal death were reported as Macerated still births as verified by CRM teams
- ▶ State is upgrading Labour room into Model Maternity Wing (MMW) with technical support of MPTAST. State has launched Mamta Abhiyaan in 2 phases to strengthen supply side and to ensure quality of care for maternal and child care service



- ▶ State needs to revisit the protocols being followed for Anaemia management including Iron Sucrose Therapy for pregnant women as these are not in concurrence with GOI guidelines.
- ▶ State has developed 15 CAC Training Centres and 76 Master Trainers (Clinical Mentors & 35 Master trainer Staff Nurses). 145 out of the 152 identified Level 3, and 297 out of the 728 identified Level 2 DPs are providing comprehensive abortion care but abortion services were not available at sub district level in both the districts visited.
- ▶ Weekly analysis of MCTS reports and Door to door survey by ASHA worker for identification and follow up of High risk pregnancies is done
- ▶ 55 SNCU sanctioned out of which 53 are functional. Among these 30 SNCUs have been accredited by National Neonatology Forum (NNF). Out of 1412 sanctioned NBCCs, 1236 (88%) are functional, and out of 105 sanctioned NBSUs, 96 (91%) are functional
- ▶ NRCs at the district hospitals are functioning well and maintain records and protocols but sub-district NRCs at CHCs were found sub-optimally functional with wrong admission criteria being used, mothers and children not staying at the facility, diet protocols being ad hoc, staff shortages, weight discrepancy and poor weight or no weight gain.
- ▶ RBSK is being implemented in all districts but field level implementation was found poor as district authorities did not have clarity of the program or the referral linkages. State has launched Mukhyamantri Bal Shravan Yojana for Cochlear Implantation,
- ▶ Adolescent Friendly Health Clinics have been established in all 50 District Hospitals. Signage, IEC display, Referral linkages and capacity of the staff to deal with adolescent services was found to be weak.
- ▶ State has constituted Gram Arogya Kendra (GAK) in all villages as one stop arrangement for availability of all supplies, services and care. These are either made at AWC or at ASHAs residence if there is no AWC. GAK has 16 types of medicines and 5 types of diagnostic services provided at the door step. As per guidelines, the ASHA is asked to sit at GAK from 10 am to 1 p, however the ASHA informed that they have been asked to stay at the GAK from 10 am to 4 pm
- ▶ ASHA has been made accountable for a number of services under the Swasthya Guarantee Yojana in the state. However, the mechanism to support ASHA for providing these services including handholding support are very weak, with poor monitoring and supportive supervision.
- ▶ JSY payments by DBT is well implemented in both the districts but problems were reported in payment to women who did not have bank account.
- ▶ JSSK entitlements were found in place with all service provision being available to the beneficiaries yet OOP was reported on drugs, vehicle and informal payment.
- ▶ Under-reporting of maternal deaths is noted - less than 10% reported till date. Community based maternal death review records could not be found. Districts were found to be using MDR data only for record submission but not using for local action.
- ▶ State has over reliance on Laparoscopic sterilisation but their quality especially during camps is of concern. PPIUCD services have picked up in the state and PPIUCD Score Card was found displayed in LR to track the progress. Removal rate of IUCD was found quite high in the districts - as per HMIS it is almost 50%.
- ▶ All District & focal point cold chain handlers & refrigerator technicians, all District & block Data handlers are trained. But several vaccine carriers, 4 ILRs, and 7 DFs were non-functional in DH Panna – repair was pending for past few months and some needed to be condemned

## MIZORAM

- ▶ The rate of institutional delivery in the state is commendable - 82% of all registered deliveries were conducted in public health institutions. SBA trained staffs were also present at all levels.
- ▶ Though there is no insufficiency of health facilities in terms of numbers, there are inadequacies in terms of range of services. There is a lack of comprehensiveness in availability of services for adolescent health, safe abortion services, NBCCs, NBSUs and NRCs.
- ▶ Availability of Drugs and essential commodities like IFA, Mag. Sulf, misoprotol, oxytocin, zinc tablets was found to be poor. Reports about poor quality of CuT were shared.
- ▶ Under the RBSK Program, teams have been constituted as per the norm. State has made arrangements with an NGO "Cure Club Food" to provide free treatment and rehabilitation.
- ▶ Partial implementation of RKSK Program is seen in the state. While WIFS (Weekly Iron Folic Supplementation) Program has been rolled out, AFHC program is still in its infancy, while MHS has not yet been implemented. State has 27 AFHC but during the facility visits, no adolescent health services could be seen. With high incidence of drug abuse and lack of counselling and support services for adolescents is a concern.
- ▶ For Family Planning services, no fixed day services were found to be available below DH level. Although IUCD insertion services are being rendered, PPIUCD services are not prioritized. Cu-T (Only 380 A) was available at the facilities but owing to its poor quality and reports of breakage adoption rates have declined. High rate of removals of IUCD was reported and needs to be reviewed.
- ▶ Registration under JSY scheme is very good but JSY payments are through Cash transfers instead of cheques owing to poor banking services in hilly and difficult terrains. Payment of JSY incentives to ASHAs and beneficiaries have not been done since May 2014 due to lack of funds.
- ▶ Instead of providing free entitlements under JSSK to pregnant women, the free services are being provided by utilization of benefits under RSBY. The RSBY amount consumed to avail the delivery service can be utilized by the family in other cases of hospitalization. Community is more aware about the entitlements under RSBY Scheme than JSSK.
- ▶ District and sub-district level facilities have rented out facility premises to private pharmacy shops known 'Medical Canteens' dispense drugs at markets rates. High out of pocket expenditure on transport and purchase of drugs was reported
- ▶ Maternal death reporting is poor. Only 16 Maternal Deaths reported for the year 2013-14 in monthly format out of which 11 were reviewed
- ▶ Vaccination at birth (OPV & Hepatitis birth dose, and BCG) was not being provided at any health facility. At the time of CRM visit immunization services were at a standstill on the instructions of state authorities in response to certain adverse events following vaccination.

## ODISHA

- ▶ Out of 8429 Health facilities 600 (7.1%) are functioning as Delivery Points. Out of 64 FRUs (CHCs and other FRUs excluding DHs) only 33 FRUs are conducting C-section. Improvements is observed in designation of L2/L3 facilities but in practice service delivery did not match the designation of the facility.
- ▶ Rational deployment of trained and skilled staff needs to be ensured. In CHC Khallikote and Girisola LSAS trained doctors were unable to utilise their skills due to unavailability of Gynaecologist.

- ▶ State has initiated Delivery Point Mentoring Initiative which has yielded positive results. In both the districts visited, labour rooms maintained trays as per MHN tool kit but infection prevention and Bio medical waste management protocols were being poorly followed.
- ▶ Functional Maternity Waiting Rooms (MAA Gruha) were found. Pregnant Women were found to be motivated by ASHAs to stay in MAA Gruha especially from hard to reach areas.
- ▶ Quality of ANC care needs to be improved as only HB estimation and weight was taken up in an ANC check-up at field level.
- ▶ OOP on diet, drugs, diagnostics and transport in JSSK in some facilities were observed
- ▶ Abortion Care offered is up-to first trimester till SDH level and MMA drugs have been included in the EDL
- ▶ Mixed scenario was found in terms of administering zero/birth dose of Hepatitis B and OPV and Vitamin K injection as few facilities were found to be given while few facilities staff was not adhering to the protocol. Zero dose vaccination was being provided properly in the City hospital, Ganjam where they have established a "Birth dose clinic" and deputed 1 staff there.
- ▶ State has introduced 'Passbook for Vaccines and Immunization Logistics for Sub-centers'.
- ▶ Functional NBCC and NBSU found in both Kalahandi and Ganjam. However, referral linkages need to be strengthened and monitored closely for follow up actions. Lack of NSSK trained staff was found to be one of the major concerns and reasons for poor newborn resuscitation practices
- ▶ Good practices in terms of community growth chart being plotted and maintained at the Anganwadi center, properly documented VHND micro-plans for every ASHA, ANM and AWW were observed.
- ▶ Two NRCs (Nutrition Rehabilitation Center) one each in Ganjam and Kalahandi districts were visited. NRC was providing wage loss payments to the mothers/care-givers as per the GoI guidelines. However, wage loss, payments was being given at time of 2nd Follow – up which appears to be an effective local solution to promote mothers to stay till recovery and attend at-least 2 follow ups. There is need for strengthening the referral linkage between the facility (NRCs & NBSUs) and community.
- ▶ Fixed day FP services are provided on Monday but family planning services are largely focused on terminal methods. The scheme of Home Delivery of Contraceptives by ASHAs has taken off well in Ganjam district however, IUCD and PPIUCD services are offered only at facilities above PCH level. An ICT enabled innovation to ensure contraceptive security for eligible couples known as Reproductive Health Commodities Logistics Management Information System (RHCLMIS) has been introduced.
- ▶ State has separated the VHND from the Immunization Day. This de-linking has shown effective delivery of services. It was encouraging to find Line listing of severe anaemic pregnant women at the VHND sites in Ganjam District.
- ▶ Odisha is the only state to initiate 'WIFS junior' – Weekly IFA tablets to primary school children.

## PUNJAB

- ▶ Health facilities were sufficient in terms of number but there was inadequacy in terms of range of services. None of the visited CHCs was equipped with NBSUs.
- ▶ Safe abortion services are a major area of concern in the State. In District SBS Nagar, safe abortion service is not available at District level.
- ▶ RKSK programme is in initial stage and at present there are 99 Adolescent Friendly Health Clinics



- ▶ Fixed Day services for family planning services were not available. PPIUCDs services were provided only at DH level. Contraceptives are being distributed by ASHAs but supplies of Pregnancy testing kits and ECP were available at selected SHCs only
- ▶ State Government has initiated 'Mata Kaushalya Yojana' under which beneficiaries were provided Rs.1000 for deliveries hence awareness of JSY scheme was poor among beneficiaries.
- ▶ JSSK executed well for pregnant mothers. All beneficiaries we met incurred no OOPs during pregnancy but state is lagging behind in terms of utilization of infant and referral services.
- ▶ MDR are being conducted at facility level as well as community level but records maintenance was poor.
- ▶ Availability of vaccines was observed at all the Sub Centers and VHSND visited. Most immunization were reported in public facilities even for deliveries taking place in private facilities. Poor cold chain management was observed at SDH level in SBS Nagar District

## RAJASTHAN

- ▶ Designated First Referral Units (FRUs) were found to be non functional as per norms due to unavailability of required trained HR and blood storage units in both districts.
- ▶ About 400 essential medicines are supplied by the Rajasthan Medical Services Corporation (RMSC) in all public health facilities. It has assured adequate and timely supply of generic medicines. However, in Sri Ganganagar, supply of important medicines like Magnesium Sulphate, Misoprostol and Mefipristone was found erratic in a few centers.
- ▶ In Sri Ganganagar, the district hospital is only referral centre and receives complicated cases from neighboring districts (none of the CHCs are functional FRUs) yet the labour room at this district hospital has only 7 delivery tables.
- ▶ Functional newborn corners are available in all delivery points; however, they were under-utilized in Rajsamand. NBSUs are available at the level of district hospital.
- ▶ Malnutrition treatment centres (MTCs) were well furnished in Rajsamand district, however, in Reimga, the MTC was shut down due to limited uptake. No MTCs in the facilities visited in Sri Ganganagar.
- ▶ State has constituted 64 Mobile Health teams of RBSK at Zonal Headquarters by utilizing the existing staff. Field level implementation is planned and mapping of schools and AWC is in process.
- ▶ Adolescent friendly health clinics are functional in Rajsamand with dedicated counsellors but they were not functional in Sri Ganganagar. WIFS and School Health Program have been rolled out across the two districts with good coverage. No demand of sanitary napkin from community was reported because of poor quality, though they are available at the warehouse.
- ▶ All PHCs and CHCs are providing fixed day services for sterilization., PPIUCD services are mostly limited to the district hospital because of availability of trained manpower in Sri Ganganagar
- ▶ In Rajsamand District through the initiative of CMHO, injectable contraceptive Khushi DEPOT (Depot Medroxy-progesterone acetate) is introduced in Public Health Facilities by utilizing untied funds. Injectables are procured through an open-tender mechanism at Rs. 28/dose and Rs. 2 as administrative expenses and are made available at Rs. 30/dose.
- ▶ Facility level MDR review has been operationalized but community level MDR is yet to be operationalized. Regular Infant death review through community based verbal autopsy is being done in Rajsamand district.

- ▶ Adequate number of VHNDs/vaccination sessions are being planned throughout the two districts. Micro-plan for immunization of drop-outs and missing children from unreached areas were available.

## TAMIL NADU

- ▶ National and state maternity benefit schemes are implemented through PHCs the ANC mothers are discouraged to deliver at the SDH and DH. Birth doses of Hep-B BCG and OPV are not given at the SDH and DH level.
- ▶ State has allocated additional 30% budget for HPDs like Madurai but separate road map or planning for the high priority districts in line with RMNCH+A guidelines was not found.
- ▶ Separate High Risk Pregnancy Chart is being updated regularly in the 6 categories. In Kancheepuram EDD Chart of all Pregnant women is being maintained to monitor and follow up of each mother to invite her for delivery in PH facility through "Phone to Heart Touch Approach" wherein the 108 staff calls the mother from 1 week before EDD to 1 week after EDD to motivate her for institutional delivery.
- ▶ SHCs were well equipped with diagnostic facilities such as haemoglobinometer, BP apparatus etc. Separate high-risk pregnancy charts are regularly updated and ultrasound facilities are available at the PHC level.
- ▶ All labour rooms are equipped with functional New Born Care Corner, emergency drug trays, sterilized instruments etc. However infection prevention practices need to be improved especially in Madurai where dirty new born resuscitation equipment and unclean toilets were observed.
- ▶ Irrational use of drugs in case of postnatal mothers was noted as - Antibiotics Amoxicillin, Paracetamol and Metrogyl were given in routine to all delivered mothers for prevention of sepsis
- ▶ In addition to JSY, the Dr. Muthulakshmi Reddy maternity benefit scheme is also operational under which Rs. 12000/- are given to mothers in three installments. Payments under JSY are regular and paid through bearer cheque. No out of pocket expenses incurred by the beneficiary but private or own vehicles are being used by the beneficiaries after delivery because of cultural beliefs.
- ▶ Family Planning is limited to sterilization with minimal counseling on spacing methods. PPIUCD & IUCD services are available on daily basis at DH & Sub-district level facilities but the uptake is poor.
- ▶ Modified School Health Programme is operational and recruitment for RBSK teams is under way. Menstrual hygiene scheme is being funded and run by the State government.

## TELANGANA

- ▶ Rate of institutional deliveries is more than 80%, with one-third of them conducted at government institutions. Rate of C-section is more than 40% in both private and public health facilities..
- ▶ An integrated project on tracking of each pregnancy in the remote areas in coordination with the tribal department is being implemented. Based on the expected date of delivery (EDD), pregnant women are tracked and motivated for institutional deliveries through call centers and 108/104 Ambulances
- ▶ With regards to family planning, the focus is still towards permanent methods of sterilization. Though interval IUD services are provided but fixed day services are not available. Home Delivery of Contraceptives through ASHAs has started but is yet to become fully operational. PPIUCD services are yet to be implemented
- ▶ NBCC, NBSU and SNCUs are established with trained staff were available in Medak district. SNCUs were available but lack of power back up mechanisms affect its proper functioning.

- ▶ Routine immunization micro plans were available along with vaccines and cold chain maintenance. Alternate vaccine delivery mechanism is being piloted in Medak.
- ▶ ARSH clinics are operationalized in selected health facilities. The Nilofer Child Hospital (Part of Usmania Medical College), Hyderabad has established a state of art – YUVA (AFHC) clinic manned by adolescent physicians, gynecologist, psychiatrists, psychologists and counsellors
- ▶ NRC in Gandhi Hospital is well maintained with adequate HR but was sub optimally used whereas NRC at RIMS Hospital, Adilabad has bed occupancy rate of 100 percent. State has manned the centre with one medical officer, two Nutrition assistant and two cooks to meet the high case load.

## UTTRAKHAND

- ▶ State has 149 functional delivery points out of 281 delivery points. There 27 FRUs in the state and out of these, 5 FRUs are in Almora while Tehri has no functional FRU. Of the total PHCs, 38% are designated 24x7 facilities and of these 34% facilities are functional as 24x7 facilities
- ▶ Total number of home deliveries in the visited districts has decreased over the years yet it remains higher than the state average, mainly due to poor road infrastructure and cultural preference for home delivery.
- ▶ C-section rate at the state and Almora are same at 11% while it is abysmally low at 0.4% in Tehri. In Tehri, the SDH Narendranagar has a gynecologist, but lacks Blood Storage Unit, while DH has gynecologist but C-sections are not being done in absence of a pediatrician. High-risk pregnant women are referred to the private hospitals like Jolly Grant Hospital and medical college hospitals in the neighboring districts. In Almora at SDH Ranikhet, due to shortage of staff, most C-section deliveries were referred to another facility, which is 90 kms away
- ▶ RBSK is operational in the state since April 2013 and has 148 fully functional mobile health teams and 4 functional DEIC. Developmental delay cases are referred to the Gubbara Centre until the DEICs are opened at all the districts. Children are referred for tertiary care to Himalayan hospital Jolly grant, Fortis or Max hospitals.
- ▶ Availability and acceptability of services under RKSK like Adolescent Health clinics, WIFS and Menstrual Hygiene scheme are low. About 4189 peer educators have been selected in PPP mode through NGO 'Gramin Utthan Samiti'.
- ▶ Poor availability of PPIUCD services was observed. Of the visited facilities in Tehri only 2 staff nurses were trained in PPIUD and 1 was trained in Interval IUD while no HR was trained in Almora in PPIUCD.
- ▶ Majority of the beneficiaries and staff were unaware of entitlements for free treatment for sick infants up to 1 year of age. OOP are incurred on USG, transport (in case of non-availability of Khushiyaon ki sawari) and delivery at private facilities due to referrals as District facilities are unable to cater to emergencies.
- ▶ State has 140 NBCCs, 29 NBSU and 3 SNCUs operational while one SNCU is in the process of operationalization. Most of the clinical newborn & child health services are lacking in Tehri and only one SDH has a pediatrician. There was no functional SNCU and NRC in both districts.
- ▶ Birth dose of BCG is given only on fixed days in Tehri i.e, given only on first Wednesday by ANM during facility immunization session. Shortage of Measles vaccines at few facilities and session sites was reported.



## UTTAR PRADESH

- ▶ In Meerut district, out of 360 facilities only 25 facilities (7%) are functional as Delivery Points and in Shrawasti delivery services were provided in DH, 6 CHCs and in 42 sub-centres. None of the PHC was working 24x7 or sharing the load of deliveries. PHCs were providing only routine health care services.
- ▶ In district Shrawasti, public health facilities were not equipped to handle obstetric emergencies. Only two facilities (DH and CHC Ikauna) were designated as FRU but their capacity to provide CEmOC services was limited. Also there is no presence of private sector in the district and cases are mostly referred to district hospitals of adjoining districts of Behraich and Gonda
- ▶ ANC services are being institutionalized at higher level health facilities and quality of ANC in some sub-centers was poor. Line listing of high-risk pregnancies/severely anemic women was not found in any of the facilities visited.
- ▶ Despite having the highest IMR in the country, the facility as well as community based newborn care services are yet to be fully operationalized in Shrawasti. SNCU is yet to become functional in Shrawasti while SNCU of Meerut was not in accordance with the design protocols of SNCUs. NRCs were non functional in both the districts.
- ▶ Fixed day services for Family Planning is being implemented but few facilities are providing PPIUCD services due to inadequate trained manpower. Door step delivery of Contraceptives by ASHAs functional in Meerut but in interior villages of Shrawasti it was affected due to irregular supply.
- ▶ While no OOP was reported in Meerut, beneficiaries reported high OOP on drugs, consumables, transport and informal payments (taken as badhayee) in Shrawasti at all levels of facility from SC to DH. Awareness of community about JSSK entitlements was also found to be low.
- ▶ A centralized call center has been established at State level with a toll free no.1800-180-5145 as a grievance redressal cell. Beneficiaries can register their complaints and authorities have to respond within 48 hours but awareness about the cell or process was found to be very poor.
- ▶ Maternal Death Review needs to be strengthened in the state. Higher level health functionaries/facilities like DM, CMO & Medical colleges need to actively participate in MDR
- ▶ RBSK team conducts fixed day Clinics (on Saturday) at PHCs but inadequate skills of staff were observed due to lack of adequate training. DEIC are yet to start in both the districts

## WEST BENGAL

- ▶ Pending JSY payments to the beneficiaries below 18 years of age were reported on account of not being able to open bank accounts. OOP on informal payments and on transport because of poor availability of transportation was reported.
- ▶ Inadequate physical infrastructure in respect to space in Labor Room (LR) and PNC wards in facilities with high case loads such as Amarkanand RH and Bankura Medical College hospital (BSMCH) with bed occupancy Rate 150-180% was noted.
- ▶ Sub-optimal utilization of trained HR due to irrational deployment at non-high case load facilities is a major issue observed.
- ▶ State has 59 State supported and 4 NACO supported BBs along with 60 BSUs. Bankura has 5 BSU and 2 BB whereas Uttar Dinajpur has 2 BSUs and BBs each. Blood banks/BSU at Medical College Hospital and RH Amarkanand were well-equipped

- ▶ Maternal death reviews (MDR) were being regularly conducted in the districts with regular monitoring by MD (NHM) & PS (Health).
- ▶ SNCU infrastructure was not adequate as basic requirements like radiant warmers and centralized oxygen facility were not present. This was also affected by shortage of trained staff and irrational deployment of trained staff.
- ▶ NBSU have been operationalized but were not in accordance to Gol protocol in terms of Infrastructure, equipment, HR and Admission and Discharge criteria
- ▶ NRCs in both districts (at Jorhira BPHC and Simlapal CHC in Bankura, Dalkhola in Uttar Dinajpur) have infrastructure as per Gol guidelines but HR was found to be inadequate.
- ▶ RBSK has been launched but it does not cover the entire gamut of services outlined in the program and children in schools are screened for few diseases only
- ▶ Health providers continue to use outdated technology for abortion as they are not trained in MVA.
- ▶ FP acceptance and service delivery is good in the districts and available at all the Delivery Points and SCs. Fixed Day camp approach for sterilization was found in most health facilities visited. PPIUCD has not taken off as the training has not been initiated so far.
- ▶ Fixed ARSH clinics are available at BSMCH and Khatra SDH



## TOR 3

# Disease Control Programs

### Guiding Principles/Strategies of the NHM

- i. The NHM will continue to focus on communicable disease control programmes and disease surveillance (Para 6.2.1)
- ii. The rising burden of NCDs calls for concerted public health action. In addition to clinical approaches, preventive action and policy responses involving multiple stakeholders are required, and the NHM will need to address the growing burden of Non-communicable diseases (Para 6.3.1)

## COMMUNICABLE DISEASE CONTROL PROGRAMMES

### National Vector Borne Disease Control Programme (NVBDCP)

- ▶ Malaria has shown a declining trend in Punjab, Kerala, Assam, Chhattisgarh, Uttar Pradesh, Odisha, Rajasthan, Bihar; However, there appears to be a persistent number of cases in Tamil Nadu, Telangana, Mizoram, Uttarakhand and a rise in cases in Madhya Pradesh and West Bengal. Number of deaths due to Malaria have reduced in Punjab, Assam, Chhattisgarh, Uttar Pradesh, Odisha and Bihar. Anti-malarial Drugs were available at various levels of health facilities visited. Bivalent Rapid Diagnostic tests (RDT) and Artemisinin Combination Therapy (ACT) have been provided upto the village level and are being optimally used by trained ASHAs in Odisha and Mizoram.
- ▶ There is a shortage of human resources at different levels- Vector Borne Disease Consultants, Malaria Technical Supervisors

(MTS), Multi Purpose Workers (MPWs) and Health supervisors in Chhattisgarh, Odisha, Bihar, Telangana and Tamil Nadu. The officers functioning as District Malaria Officers (DMOs) are also managing other programs. This impedes strengthening of active surveillance in states such as Madhya Pradesh, Rajasthan and Mizoram. Decreasing ABER is an area of concern in some states like Tamil Nadu, Chandigarh, Uttar Pradesh and Bihar.

- ▶ The number of cases of Dengue too has declined compared to last year in Punjab, Chandigarh, Rajasthan and West Bengal while they have increased in Tamil Nadu, Odisha and Madhya Pradesh. Telangana, Bihar, Mizoram, Kerala and Uttarakhand continue to report cases. In 2014, the number of deaths due to Dengue could be contained as a result of efficient case management in Odisha, Telangana, West Bengal and Bihar.



- ▶ A rising trend in Chikungunya has been observed in Odisha and Madhya Pradesh while Telangana shows a declining trend. Five sporadic cases of Chikungunya were reported this year in Tamil Nadu.
- ▶ AES and JE cases have increased in Assam and Bihar. Kerala continues to report cases of Leptospirosis. West Bengal has shown improvement in morbidity and mortality due to JE. A declining trend in number of cases and deaths due to Kala Azar (upto October 2014) compared to same period in 2013 was seen in Bihar.
- ▶ Lymphatic Filariasis program is doing well and Mf prevalence is declining in Tamil Nadu, Chhattisgarh, Telangana and Uttarakhand. Cases of Hydrocele and Lymphoedema are still pending for operation and management in Madhya Pradesh and Bihar. Bankura district in West Bengal has shown an increase in Microfilaria rate from 1.11% (2013-14) to 1.81% (2014, Sep).

### **Revised National Tuberculosis Control Programme (RNTCP)**

- ▶ Tamil Nadu, Telangana, Punjab, Chandigarh, Uttar Pradesh, Rajasthan, West Bengal and Assam are showing satisfactory performance in achieving targets for diagnosis and cure. However, Madhya Pradesh, Bihar, Odisha, Uttarakhand and Kerala need to strengthen implementation to reach program goals.
- ▶ Infrastructure norms were being adhered to in Uttar Pradesh, Madhya Pradesh, Rajasthan, Punjab, Mizoram and Tamil Nadu. However, the required number of TB Units (TUs) and Designated Microscopy Centers (DMCs) were not functional in Bihar;
- ▶ A well-established human resource base with trained District TB Officers (DTOs) and supervisory staff was available in Punjab, Mizoram and Assam. However, positions in these cadres were vacant in Uttar Pradesh, Chhattisgarh and Tamil Nadu. Training of the newly recruited staff needs to be conducted in Rajasthan, Punjab, West Bengal and Madhya Pradesh.
- ▶ Laboratory registers, TB registers, treatment cards were found to be complete, and IEC material was well displayed in health facilities visited in Tamil Nadu, Punjab and Assam but not in Uttarakhand, West Bengal and Chhattisgarh.
- ▶ PMDT (Program Management of Drug Resistant TB) is well established with suspect identification, sample collection decentralized to DMC level and good linkage with Culture and Drug Sensitivity (C&DST) labs for all the districts for diagnostic and follow-up testing services. Adequate service provisioning was found in Tamil Nadu, Telangana, Rajasthan, Uttarakhand, Uttar Pradesh, Bihar, West Bengal and Assam. Involvement of Medical Colleges was found to be deficient in Uttar Pradesh, Madhya Pradesh and Kerala; Patients were not getting support & transportation charges for visiting DRTB centres in Chhattisgarh.
- ▶ Effective TB-HIV collaboration with Provider Initiated Testing and Counselling (PITC) of all TB suspects for HIV was seen in Telangana, Rajasthan and Chandigarh. However, there is scope for improvement in Bihar, Chhattisgarh, Mizoram, Uttarakhand, Tamil Nadu, Odisha and Punjab.
- ▶ Involvement of private practitioners, laboratories and hospitals for notification of TB cases under Nikshay has been initiated in Rajasthan, Telangana, Bihar, Uttar Pradesh, Mizoram, Chandigarh, West Bengal, Uttarakhand, Punjab and Kerala.
- ▶ Nikshay Registration status was adequate in Tamil Nadu, Odisha, Uttar Pradesh, West Bengal, Chandigarh and Assam; Entry and updation not being done at block level by the block level DEO in Bihar, Chhattisgarh, Madhya Pradesh and Uttarakhand.
- ▶ Low pediatric case detection was seen in Uttar Pradesh, Madhya Pradesh, Uttarakhand and Tamil Nadu.

## Integrated Disease Surveillance Programme

- ▶ Surveillance units have been established in all states/districts. All major components including integration and decentralization of surveillance and strengthening public health laboratories of IDSP are being implemented across states.
- ▶ There has been improvement in reporting status on 'S' syndromic; 'P' probable; & 'L' laboratory formats using standard case definitions. More than 90% districts reporting weekly data through e-mail/portal ([www.idsp.nic.in](http://www.idsp.nic.in)). However, in Chandigarh peripheral units are still sending manual data and in Kerala there is no mechanism to gather data from outpatient department of medical colleges and private hospitals.
- ▶ Most outbreaks were reported and responded to by the district/states surveillance units; States also received media alerts from central surveillance unit as seen in Kerala, Telangana and Bihar to verify and take appropriate action.
- ▶ Internet connectivity and uninterrupted electricity supply is a major requirement for effective operation of IDSP.
- ▶ Maintenance of computers (hardware and software) is another concern for implementing IDSP programme. Only a few districts/states were using analyzed IDSP data for District Health Action Plan (DHAP).
- ▶ Referral lab network has been established by utilizing the existing functional labs in medical colleges and various other major centers in the States and linking them with adjoining districts for providing diagnostic services for epidemic prone diseases during outbreaks.
- ▶ Position of epidemiologist is vacant in Chhattisgarh, Mizoram, Madhya Pradesh and Telangana. District surveillance officers have been given several additional responsibilities leading to neglect of the primary task.

## National Leprosy Eradication Programme

- ▶ In Bihar, 18 districts are yet to achieve the target of leprosy eradication, i.e., prevalence rate less than one per 10,000.
- ▶ ASHA payments under the program are irregular and IEC plan for reduction of stigma and discrimination is not available in both the districts visited in Bihar.
- ▶ In Chandigarh, four leprosy clinics are functioning, which also act as drug delivery centers. Chandigarh reported the prevalence rate of 1.64 per 10,000 and annual new case detected rate of 10.39 per 100,000 in the year 2014.
- ▶ In Chhattisgarh, disability register was not updated and yet to implement the Upgraded Simplified Information System (USIS). Management of lepra reactions/neuritis and disability care was inadequate. Involvement of ASHAs was poor in suspect identification and referral for diagnosis.
- ▶ In Madhya Pradesh, newly appointed Medical Officers (MOs) are not trained in leprosy. Treatment completion rate is poor in urban areas in comparison with rural areas.
- ▶ In Mizoram, the new case detection rate is lower than expected and child MDT is not available in the districts visited. Awareness campaigns are regularly held in different blocks.
- ▶ In Odisha, 15 districts reported the prevalence of more than 1/10000. AYUSH Medical Officers were trained in leprosy to manage DPMR clinics at block CHCs. 'SambhaRath' organized during Intensive Case Detection Drive (ICDD) to generate awareness on leprosy among the community. Around 42,000 ASHAs have been trained for suspect referral and treatment follow-up.
- ▶ In Tamil Nadu, special efforts are made for early detection of leprosy through trained ASHAs and good referral and feedback mechanism is in place for early detection and treatment

of leprosy cases. In Telangana, involvement of general health staff in NLEP was not visible. Adilabad, Medak, and Nalgonda are the identified high endemic districts for leprosy in the state.

- ▶ In Uttar Pradesh, 10 districts have more than the prevalence rate of 1 per 10,000 population however, 64 districts have achieved the target of elimination, which is less than 1 per 10,000 by September 2014.

## **Non-Communicable Disease control Programmes**

### **National Programme for Control of Blindness**

- ▶ National Programme for Control of Blindness is being implemented in all the visited states. The progress in cataract surgeries is satisfactory across all the visited states. While some states reported adequate infrastructure, Bihar, Odisha, Rajasthan and Uttarakhand have inadequate human resource for blindness control programme.
- ▶ In Kerala, eye bank/eye collection centers are established in every district and also identified eight districts where village level blindness registry has been prepared to facilitate eye care services. Mizoram and Uttarakhand reported eye bank in Aizawl and Dehradun respectively.
- ▶ School based eye screening programme reported from Kerala, Odisha, Tamil Nadu, Telangana and Uttarakhand. In Tamil Nadu, screening of school children for refractive errors was established at two levels- initially by school teacher and then by ophthalmic assistants.

### **National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)**

- ▶ Well-functioning NCD clinics providing regular OPD services were seen in Tamil Nadu and Kerala. However, the programme



is still evolving in other states visited. It has been launched in pilot districts and is being scaled up.

## **Status of other programmes**

- ▶ National Programme for Prevention and Control of Fluorosis is being implemented in Madhya Pradesh, Rajasthan, Telangana and West Bengal. Fluorosis control units have been established in selected districts to carry out regular surveys to assess the prevalence and to coordinate with public health engineering department.
- ▶ Implementation of National Tobacco Control Programme is being reported from selected districts of Bihar, Mizoram, Rajasthan, Tamil Nadu, Telangana, Uttarakhand and Uttar Pradesh.
- ▶ National Programme for Trauma Care reported from Madhya Pradesh and National Iodine Deficiency Disorder Control Programme reported from Kerala and Telangana.
- ▶ National Mental Health Programme is being implemented in selected districts of Assam and West Bengal.
- ▶ Implementation of National Programme for Health Care of Elderly is reported from five districts of Madhya Pradesh.



## RECOMMENDATIONS

### Recommendations under NVBDCP

- ▶ States must fill-up the key posts of DMO and other HR on a priority basis, to enable adequate attention to the program
- ▶ Training of LTs is needed to ensure quality in microscopy services. Supportive supervision is also required at the field level. Efforts must be made to provide the report and initiate treatment within 24 hours.
- ▶ Capacity building of all programme officers at state and district level, orientation of doctors, including specialists, quality and effective trainings of ASHAs and other key staff needs to be ensured.
- ▶ Effective IEC/BCC activities are needed for removing fear and developing trust in public health services.
- ▶ Quality Mass Drug Administration must be ensured and pending cases of Hydrocele must be operated. Close supervision and monitoring of programme implementation needs strengthening.
- ▶ States like Kerala and Punjab need to strengthen active and passive surveillance and work towards elimination.

### Recommendations under RNTCP

- ▶ States should implement the current policy of using pooled Lab Technicians for General lab, ICTC and TB to strengthen lab services.
- ▶ Focus on early identification and testing of MDRTB suspects. All DRTB centers to be made functional and Medical colleges to be involved in PMDT service delivery as DRTB centers and for seeking expert opinion for admitted patients.
- ▶ All diagnosed TB patients to be offered HIV testing as per policy and guidelines after counseling, so that all TB patients are aware of their HIV status.
- ▶ Nikshay entry mechanism to be made as real time entry system by doing it at PHC/CHC/DH level. All doctors practicing to be registered under Nikshay.

- ▶ States to focus on diagnosis of Pediatric TB cases and improve involvement of Pediatricians in the programme with the support of medical colleges and professional bodies like IMA etc. Newer initiatives need to be taken up to identify more cases.
- ▶ Involvement and accountability of the private sector needs to be strengthened through mixed approaches such as e-mails, SMS, toll free number, missed call, IVRS, direct entry, post card, data collection in person.

### Recommendation under IDSP

- ▶ Analysis of IDSP data should be incorporated in the preparation of district health action plan. Reporting of private sector needs to align and strengthen with IDSP.
- ▶ States need to ensure dedicated district surveillance officer without any additional responsibility and needs to fill all vacant positions under IDSP.
- ▶ Ensure regular feedback to the block and PHC for taking appropriate action as per the forecasting with special focus on seasonal trends.
- ▶ Need to strengthen record and reporting processes and feedback mechanisms, through ensuring weekly analysis of reports and providing feedback.
- ▶ Fund flow under IDSP needs to be regularised for proper programme implementation and regular release of monthly salaries.
- ▶ Training process of all staff under IDSP needs to be streamlined.

### Recommendation under NLEP

- ▶ Strengthen urban NLEP activities, treatment and completion rate. Ensure regular ASHA payment for suspect referral and maintain district level ASHA incentive data for disease control programmes.
- ▶ Leverage with National Health Mission to develop proper IEC plan for early detection, reduction of stigma and discrimination.
- ▶ Strengthen regular training programme of all healthcare providers under NLEP.

- ▶ Strengthen the existing reporting and record keeping mechanisms, as per the guidelines
- ▶ Strengthen planning for disability prevention, organization of disability camps at block level and medical rehabilitation
- ▶ Ensure availability of pediatric MDT at all levels.
- ▶ Ensure availability of human resources through any other mechanisms, in absence of regular staff under the programme.



### Recommendation under Non-Communicable Diseases

- ▶ Need to prepare a clear plan backed with adequate infrastructure, human resource and logistic support to implement NCD programmes.
- ▶ State needs to fill the vacant positions at the field level, e.g., ophthalmic assistants to promote

active eye screening at the field and facility level, State may also need to undertake multitasking.

- ▶ Maintain records and reports at all levels and focus on backlog of cataract surgeries.
- ▶ District level fluorosis control units need to closely collaborate with public health engineering department to overcome fluorosis problem. National mental health programme needs to expand phase wise across all the districts to cater to the needs of the population.
- ▶ States should find out ways to ensure additional manpower for ICUs through GOI support.
- ▶ Ensure regular fund flow, provision of additional funds for training & capacity building activities for different cadres of personnel.

## FINDINGS FROM STATES

### ASSAM

- ▶ LLINs were distributed through NVBDCP and PRIs; Indoor spray and fogging done at sub-center level.
- ▶ New Smear Positive (NSP) case detection rate in Tinsukia district was 85% in 2013 and 93% till 3<sup>rd</sup> quarter in 2014.
- ▶ All laboratories in the private sector including tea estate hospital, Coal India etc. are submitting monthly reports to IDSP.
- ▶ The new case detection rate of leprosy has reduced from 10.02% in 2010-11 to 5.29% in 2014-15 (upto September). Similarly, the treatment completion rate remained consistent between 40-50% in the state.
- ▶ Cataract surgeries are being regularly conducted in the district hospital, NGO as well as in private sector hospitals.

### BIHAR

- ▶ State has taken a proactive role in 2014 to come closer to Kala Azar elimination target by 2015. State has started single day treatment with Liposomal Amphoterecin B (free supply by WHO) in 4 districts and shall expand this in a phased manner in all the 33 KA endemic districts.
- ▶ RNTCP is still considered a vertical program and efforts for integration with general health system is lacking.
- ▶ There is gross dissatisfaction among the RNTCP contractual staff due to unpaid salary, unpaid POL, irregular supply of drug and logistics especially Streptomycin. Another reason for demotivation is disparity of salaries among various contractual positions with equivalent TOR.

- ▶ Collaboration between leprosy department and Kala Azar PKDL cases needs to be established and state needs to strengthen IEC plan for reduction of stigma and discrimination.
- ▶ Streamlining of IDSP fund flow is a concern in Bihar, which led to delay in salary release. Need to strengthen regular reporting by referral lab, private and NGO hospitals.
- ▶ No functional ophthalmic ward reported in the visited district. Periodic camps organized for Cataract surgery at health facilities by NGOs and OT is used only during camps. Ophthalmic Assistants are inadequate in the state.
- ▶ Screening for Cancer, Cardiovascular disease and Stroke need to be strengthened in the State.

## CHANDIGARH

- ▶ The Union Territory is consistently achieving targets as laid down by RNTCP.
- ▶ Chandigarh reported 1.64/10,000 prevalence rate of leprosy, which is higher than the target of less than 1 per 10,000. Urban leprosy activities need to be strengthened to achieve the target of eradication.
- ▶ The state has adequate IDSP infrastructure and the IDSP data is utilized by the districts in planning for control of locally endemic diseases.
- ▶ Only 14 out of 116 health establishments which are registered are notifying cases.

## CHHATTISGARH

- ▶ Mitanins have the necessary knowledge but lack skills in terms of preparation of slides for Malaria. They are not equipped with all necessary drugs (including ACT). Recording and reporting by them leaves a lot to be desired.
- ▶ Bivalent RDT Kits are used at microscopic centres also, which is strictly against the guidelines of the programme.
- ▶ DDT spraying was done as per schedule and coverage is >80% but spray wages are pending for the year 2008 and current year.
- ▶ Regarding anti-larval measures, no hatchery is maintained and no water bodies seeded with fish in the visited areas of the district.
- ▶ Isoniazid Chemoprophylaxis is not being provided to children less than 6 years of age who are in contact with sputum positive cases. There was no evidence of contact tracing being conducted. Very poor display of IEC materials even in the health facilities.
- ▶ There is a declining trend in Leprosy epidemiological indicators of the state; however, Korba district has yet to achieve the target of leprosy elimination.
- ▶ The post of epidemiologist under IDSP is vacant long due to legal issues. The IDSP programme is being regularly reviewed by District Collector and CMHO.

## KERALA

- ▶ Control measures for vectors like source reduction were observed to be poor in respect of Dengue, Malaria and Leptospirosis.
- ▶ Need to develop a mechanism to gather data from outpatient department (OPD) to IDSP from medical colleges and large corporate hospitals.



- ▶ The integration of TB programme with the general health system, and leveraging field staff for home-based case finding needs strengthening.
- ▶ Screening, diagnosis and management services for NCDs were observed to be well integrated at all levels of general health service delivery. NCD Clinics have been established at all CHCs, PHCs and Sub-centers, with the staff providing basic screening for diabetes and hypertension. The Sub-centers however lacked basic equipment such as hemoglobinometer.
- ▶ Cancer registry has been established in the State.
- ▶ The health service providers are sensitized, motivated and result-oriented in terms of delivering NCD care.
- ▶ The state has rolled out an excellent model of community based palliative care. Under the model, home based palliative care teams have been constituted at health facilities up to PHC level, which are responsible for making home visits and provide care. ASHAs and PRI members are also facilitated for making home visits by the palliative care team.

## **MADHYA PRADESH**

- ▶ Bivalent RDT kit for diagnosis of Malaria was not available with most ASHAs and some health facilities visited. Antibody based RDT kits, which are not recommended by GOI, were being used for diagnosis of Malaria.
- ▶ Sanctioned new TUs are non-functional in both the districts, Katni and Panna.
- ▶ State needs to give greater emphasis to urban leprosy activities to achieve treatment completion rate. Trainings of NLEP for newly recruited medical officers has not been conducted.
- ▶ IDSP reporting appears to be weak, only 50% to 60% of the units are reporting and feedback to the non-reporting units was irregular.
- ▶ Overall progress in cataract surgery is satisfactory and State has been consistently achieving the targets since 3 years. Only 2 eye surgeons are available in Katni district.
- ▶ NPCDCS and NPHCE have been functional in 5 districts in the State and need to be expanded to all the districts by the end of 12<sup>th</sup> Five Year Plan.

## **MIZORAM**

- ▶ Despite repeated efforts, the National Anti-Malaria Management Information System (NAMMIS) is not yet functional in the state. There is inadequate IDSP infrastructure at the district level CHCs and PHCs.
- ▶ Though supply of logistics was found to be good, there was a shortage of ACT-AL for distribution at ASHA level. There was low awareness about the new drug regimen among many PHC staff.
- ▶ Construction of C&DST laboratory at Falkwan hospital, Aizawl needs to be expedited, so that sputum samples need not be transported outside the state for examination and follow up on drug resistant TB.
- ▶ State needs to ensure regular supply of child MDT for leprosy and further strengthen case detection and treatment through involvement of ASHAs in the programme.
- ▶ The state has support of trained ophthalmic surgeon; although the position of ophthalmic assistants is vacant in some PHCs.
- ▶ Key human resource under NPCDCS such as Medical Officers, finance consultant, co-ordinator, counsellors, physiotherapist and data entry operator are in place in the Aizawl and Lunglei districts. However, the existing manpower is yet to be supplemented by formal training under the programme.

- ▶ There is no separate room for NCD clinic in some of the districts like Lunglei and adequate supply of equipment is not found under the programme. The flow of funds also needs to be regularized.

## ODISHA

- ▶ Bivalent Rapid Diagnostic tests (RDT) and Artemisinin Combination Therapy (ACT) have been provided up to the village level and are being optimally used by trained ASHAs.
- ▶ Trainings of ASHAs, MPHs, LTs, MOs, Specialists, Tribal school teachers on their respective roles in Malaria management and control being conducted.
- ▶ In Urban areas there is inadequacy of human resources and funds hindering vector control activities. ASHA incentives too need to be released on time.
- ▶ RMRC Bhubaneswar has been declared as a new National Reference Laboratory (RNTCP) for the Eastern and North Eastern region of India.
- ▶ Low case detection districts have been identified and the process of Intensified Case detection from the community has been initiated.
- ▶ State has implemented innovative programmes like 'SAMBHA RATH' to generate awareness on leprosy among community members. One major challenge remains to have dedicated manpower at district and Block level for management of NLEP activities and Disability Prevention and Medical Rehabilitation (DPMR) services.
- ▶ Rapid response teams are constituted and trained for 16 vulnerable districts for outbreak investigation. Around 600 paramedical staff, 390 MOs, 15 epidemiologist and two microbiologists were trained under IDSP.
- ▶ Acute shortage of PMOAs and absence of cataract surgery under insurance coverage and underutilization of treatment is major cause of concern for national programme for control of blindness in the state.
- ▶ Training manual has been developed on NPCDCS for ASHAs & Health workers in local dialect.

## PUNJAB

- ▶ Parasite smear preparation is being done by ASHA, ANM and MPW. District drug store monthly stock is well documented. There has been no stock out of pyrethrum, Temephos etc.
- ▶ Line listing of adult patients with TB-HIV co-infection, MDR patients and paediatric patients (71) done with pulmonary and extra pulmonary disaggregation. District TB-HIV Coordination committee formation is under process.
- ▶ Sentinel site for outbreak investigation with good infrastructure created at District Hospitals. District has constituted Rapid Response Team (RRT) in July 2013, involving 9 members and headed by District Health Officer.
- ▶ Trends in leprosy reported to be decreased in the last five years and district action plan was available. All diagnosed patients put on treatment and 100% treatment completion rate achieved in the state.
- ▶ Blindness registers are not well maintained and irrational deployment of eye specialist (CHC, Ahmednagar - Sangrur) is a concern.

## RAJASTHAN

- ▶ Anti-malarial Drugs were available at various levels of health facilities visited. Some sub-centres visited were not using RDT kits. Hatcheries were found with larvicidal fishes in District Rajsamand.
- ▶ Post of District TB Officer (DTO) is vacant in some districts (Jhunjhunu and, Sirohi and Rajsamand).
- ▶ Both districts have achieved and sustained leprosy elimination target. Program monitoring needs to be further strengthened to sustain the elimination.
- ▶ There are inadequate number of ophthalmologists in the Rajsamand district and only 34% (2259/6500) of the targeted population have undergone cataract surgeries so far.
- ▶ Newly created PHCs/CHCs are not included in IDSP reporting. Medical colleges need to be encouraged to provide weekly reports to their respective District Surveillance Unit.
- ▶ Dialysis unit and cardiac care unit is functional in DH, Rajsamand.
- ▶ Screening for diabetes and hypertension is being done, but no screening mechanism for common cancers is in place.

## TAMIL NADU

- ▶ Vector Surveillance and Source Reduction awareness in community is in place. Youth wings and NGOs are roped in to promote IEC activities and awareness generation campaigns for Malaria and Dengue.
- ▶ AYUSH convergence with NVBDCP was very much evident in both the districts and includes provisioning of Siddha drugs for Dengue.
- ▶ 100% coverage of JE vaccination has been achieved in Madurai as it is well integrated into routine vaccination.
- ▶ TB Notification from private sector is remarkable. A cafeteria of options like e-mails, SMS, toll free number, missed-call, call, IVRS, direct entry, post card, data collection in person are in place to strengthen notification.
- ▶ Fever alert surveillance and collaboration with IDSP for Malaria is good. However, IDSP data is not being collected/collated or utilized by RNTCP or TNSACS.
- ▶ Special efforts are made for early detection through well trained ASHAs who are exclusively working for the disease control programmes including leprosy. Incidence of Leprosy has been maintained well below the target of PR less than 1 case per 10,000.
- ▶ Fully functional NCD clinics - as a state initiative itself with well trained staff are in place at all levels. Screening for Diabetes, Hypertension, Breast and Cervical cancers is done at all levels. All drugs are in place and patient ID cards and follow up cards well maintained. Tertiary services in terms of cancer treatment are being offered at Medical colleges. Systematic data entry in HMIS on a regular basis is ongoing with data analysis at district level. Display of IEC materials in all places visited was exemplary both within and outside the NCD clinic.
- ▶ National Deafness Control programme was well implemented in Kancheepuram district, with excellent follow-up through corrective action, including cochlear implants.



## TELANGANA

- ▶ No mechanism in place for source reduction in Dengue control, water treatment and Larvae control. Vector Surveillance, Source Reduction awareness and IEC in community is minimal.
- ▶ State is an identified facility for National Trainings on PMDT and completed 14 batches of National Trainings so far.
- ▶ Line list of all the MDR TB suspects and patients exist based on which patients are tracked individually for diagnosis, initiation of treatment, follow-up and reasons for leaving treatment.
- ▶ IDSP in the state is able to handle cases of ADD and suspected cases of JE very well. Rapid Diagnostic Kits and new drug for treatment of falciparum malaria i.e. Artemisinin Combination Therapy (ACT) has been introduced in the state up to the village level. However, the kits designated for emergencies or remote areas are being used in labs in most of the PHCs where microscopy is readily available.
- ▶ It is observed that early detection of leprosy cases is poor in the state and no special efforts are visible for early detection. Involvement of general health system staff in NLEP is poor in the state.
- ▶ NPCDCS has been launched; however there is no active implementation in the state though there is high incidence of diabetes in Hyderabad.

## UTTARAKHAND

- ▶ Trainings of ASHA and MPWs were conducted on malaria control; District action plan for JE control was available and district level rapid response teams for Dengue and Chikungunya control were functional.
- ▶ Monitoring and supervision activities in RNTCP at all levels were sub optimal. DOTS therapy was not implemented especially by Community DOT providers. In few sites, treatment cards were not updated. Many defaulted patients were not traced and re-initiated on treatment.
- ▶ NPCDCS was launched in two districts (Almora and Nainital). District Tehri Garhwal will be part of the program along with six other districts from this financial year.
- ▶ IDSP data is not utilized for district planning and control of local endemic diseases. IDSP appears to be a data collecting centre rather than public health tool for local action.
- ▶ District Leprosy Officer (DLO) was not trained/oriented on the NLEP programme. However, Master treatment register, individual patient treatment and disability registers were well maintained.
- ▶ Huge human resource crunch reported for blindness control programme in the state. Out of sanctioned 62 posts of eye surgeons, 39 posts were vacant, which is hindering achievements in the state.

## UTTAR PRADESH

- ▶ State has taken positive initiatives to combat JE in affected districts. There was some delay in fund release in current financial year.
- ▶ First line TB drugs are available as per guidelines. However, there was a shortage of second line TB Drugs in both Districts and Shortage of Injection Streptomycin in Shravasti & Kanamycin at Meerut. The overall supply chain management is poor at district level and needs improvement.
- ▶ Under IDSP, at the district level only district epidemiologist has been trained and other nodal officers like DEO are untrained. Below the district level MOs, LTs, ANMs and ASHAs have not been trained.

- ▶ Leprosy elimination achieved in 64 districts as on September 2014 however, there are 10 districts which have more than one per 10,000 leprosy cases in the state.
- ▶ NPCDCS is ongoing in select districts in the state. Only 28 districts including 09 existing districts will be implementing the program in this financial year.

## WEST BENGAL

- ▶ The staff was rationally deployed in Malaria endemic blocks (Ranibandh, Khatra, Onda and Raipur). The MO/MPW/ASHA were well trained.
- ▶ The anti-malarial drugs (Tab Artesunate, Chloroquine) were by and large available in visited health facilities. RDKs were available with ASHAs at village level. There is need to enhance the skills of ASHA in RDK testing. In endemic blocks, 10,145 LLINs have been distributed.
- ▶ The district administration in Bankura has initiated “Prayash” and “Pusti” for TB patients and malnourished children. Inclusion of BPL TB patients in “Antordaya Anna Yojana” and other social welfare schemes were also initiated.
- ▶ The MDA coverage of the target population is only 88.56% in Bankura district. Good IEC/BCC activities were done for Filaria in the visited blocks.
- ▶ Critical human resource like epidemiologist, microbiologist & entomologist posts are largely vacant. Regular training under IDSP has been done to sensitize the health personnel of different levels. However, training of newly appointed District Surveillance Officers needs to be conducted.
- ▶ The number of new leprosy cases detected has declined over last two years. The active case detection search is done in blocks where ANCDR is more than 10 per 1 lakh population. In that case Bankura stands with ANCDR of 38.55 and Uttar Dinajpur with 27.63.
- ▶ A new project of Tele-ophthalmology has been started in the BSMCH since Jan2014 and more than 11,497 patients from 10 block PHCs have availed service from this centre. However, irregular supply of IOL is a cause of concern.



## TOR 4

# Human Resources and Training

### Guiding Principles/Strategies of the NHM

- i. NHM shall focus on creating/strengthening institutions for building capacity at state and sub-state and regional levels. States will be supported to develop strong HR Management systems with improved practices for decentralized recruitment, fair and transparent systems of postings, timely promotions, financial and non-financial incentives for performance and service in underserved areas, measures to reduce professional isolation by provisioning access to continuing medical education and skill up gradation programs, provide career opportunities for frontline workers, and utilize the enormous flexibility available under the Mission (5.8.2)
- ii. NHM will support development of a course for B.Sc in Community Health for mid-level clinical care provider (5.8.5)
- iii. Nurses will serve as the backbone of clinical facilities and NHM will support the expansion of their role as clinical care providers (Para 5.8.6)

## KEY FINDINGS

- ▶ Despite scaled up efforts, shortage of specialists and doctors still remains an impediment to providing universal access to quality health care. Significant vacancies of doctors, nursing and paramedical staff observed in Uttar Pradesh, Odisha, Telangana, Chhattisgarh and Uttarakhand, Bihar, Madhya Pradesh
- ▶ Irrational deployment of available human resources adds to the challenge of ensuring adequate staffing in health facilities with high caseload and those located in the difficult-to-access underserved areas.
- ▶ Recruitment process in several states like Kerala, Punjab, Odisha has been streamlined by adopting innovative measures like web-enabled procedures, decentralizing recruitments, direct walk-in interviews and constituting specially empowered committees for expediting recruitment processes.
- ▶ Retention strategies have been adopted by many States including differential salary for postings in difficult areas (Mizoram, Bihar & Madhya Pradesh); Performance Based Incentives (Odisha); credit marks for admission to PG courses (Tamil Nadu); reserved seats in PG programmes (Uttarakhand); Compulsory One Year Rural Posting for MBBS doctors to get admission in the PG Courses (Assam) and CRMC (Chhattisgarh)



- ▶ Competency assessment tests are required to evaluate skill gaps of the existing care providers and to identify competent candidates during recruitments. Tamil Nadu and Madhya Pradesh have developed skill labs and started baseline skill assessment tests but the overall progress has been slow.
- ▶ Performance appraisal systems followed in Chandigarh, Mizoram, Bihar are still in the preliminary phase with minimal linkages with incentives and salary increments of the staff. States like Assam and Kerala utilize such systems for identifying non-performing staff for further capacity building or punitive action
- ▶ Training calendar was in place in most of the states with appropriate details of training sites, trainers and batches but post training deployment plans were not prepared in any state
- ▶ Online Human Resource Management Information System (HRMIS) enables the states to maintain updated personnel details including their qualifications, training details, posting location and service duration. Inter-state variation in implementation and utilization was observed among states. States like Jharkhand, Bihar, Assam and Odisha have HRMIS in place and certain other states are in process of setting it up. However, its application in planning of human resources, trainings and post training deployment is still limited.
- ▶ A well-implemented Public Health Cadre in Tamil Nadu is a good example but most states do not

have them, while some are in the planning phase. This is leading to compromised leadership at state, district and sub district level.

## RECOMMENDATIONS

- ▶ States should consider framing an HR policy with an emphasis on recruitment procedures, retention strategies and rational deployment of HR to ensure the health care providers remain into the system.
- ▶ States need to deploy health work force rationally to ensure their availability in high case load and underserved areas. In addition to a transparent Posting and Transfer policy, there is a need to categorize the areas based on the degree of hardship for an equitable distribution of staff
- ▶ Adequate tools must be developed and adopted by all states for carrying out baseline skill gap assessment of the existing care providers and recruitment of appropriately skilled personnel in the system. Comprehensive Job Descriptions for the staff are required for clarity about their responsibilities.
- ▶ Strengthen existing HR cells under NHM and establish HR cells where they do not exist in order to streamline workforce management procedures in the states.
- ▶ Mentoring systems to be institutionalized in the states for adequate hand-holding and supportive supervision to carry out skill based activities competently and responsibly.



- ▶ Trainings should be rationalized based on need assessment of the individual staff rather than random selection of the candidates. There should be post training follow up and support at all level for those who have undergone trainings.
- ▶ Teaching institutes need strengthening in terms of faculty and infrastructure to maintain the quality of nursing graduates. Guidelines for clinical and theoretical trainings should be strictly adhered to.
- ▶ State should establish/strengthen online Human Resource Management Information System (HRMIS), and used extensively for HR planning, training need assessment, performance assessment, promotion, postings and transfers of employees.
- ▶ There is a need to institutionalize separate cadres for clinical specialists and public health specialists. Most states have a mixed pool of doctors with varied specialties placed at posts not appropriate to their educational backgrounds.

## FINDINGS FROM STATES

### ASSAM

- ▶ NHM has provided staff in facilities where regular staff is unavailable or not sanctioned. Contractual Specialists have been posted at FRUs and District Hospitals. But instances of inappropriate deployment and unequal distribution of specialists and other cadres across facilities still exist in the state. A majority of the MOs trained in LSAS and EmOC are yet to perform their skills as they are not posted in a designated FRU.
- ▶ State has also enforced Compulsory One Year Rural Posting for MBBS doctors to get admission in the PG courses.
- ▶ Other approaches adopted to increase availability of health workforce include introduction of diploma courses for specialty subjects and mid-level care providers. 324 Rural Health Practitioners posted at Sub-centers are able to conduct deliveries, hence expanding the areas of service delivery.
- ▶ e-HRMIS, the online portal for HR database is being updated monthly. However, its application is limited and should be linked to salaries and other workforce management practices.
- ▶ Insufficient GNM and BSc Nursing training schools limit their availability in DH, CHC and PHCs. Infrastructure for the PG and in-service training is also inadequate.
- ▶ The performance appraisal system under NHM is being utilized to issue warnings or even terminate contracts for non-performers.
- ▶ The lack of a Public Health cadre is leading to compromised leadership at state, district and sub district level.

### BIHAR

- ▶ In spite of the efforts to increase the seats in medical and paramedical courses the number of seats and availability of quality trained HR remains a problem for Bihar especially for Specialists, MBBS doctors, staff nurses and ANMs. The doctor-population ratio in the state is 1:3500 compared to the national average of 1:1700
- ▶ To strengthen the pre- service education of the nursing midwifery cadre the state has established a State Nodal Centre (SNC) at IGIMS, Patna. This will support to increase the quality of educational and clinical processes & practices at the 21 ANMTCs and 7 GNM schools of Bihar.

- ▶ The state has also made efforts to develop the nursing cadre. A separate nursing cell and directorate is being established to ensure focused leadership and regulation for better development of nursing midwifery cadre
- ▶ The Human Resource Information System (HRIS) in the state is utilized for quantifying human resource at all levels, postings and deployment and vacancy identification.
- ▶ The State has taken steps to ensure rational deployment of specialist and multi-skilled MOs at functional facilities. Officials from regular cadre are being selected on deputation to hold critical management posts.
- ▶ Differential remuneration based on geographical distribution, difficult and high focus areas have been implemented.
- ▶ Performance appraisal system has been put in place for NHM staff. However, its purpose seems to be only punitive with no rewards and benefits to better performing functionaries leading to lack of motivation.

## ■ CHANDIGARH

- ▶ Overall vacancy rate is not very high but significant vacancies in some of the individual disease control programs exist.
- ▶ Revision in the regular cadre strength has not been done since 1997 and hence the proportion of regular staff is less as compared to contractual positions in the U.T. A significant section of regular staff is not from the indigenous U.T cadre but on deputation from Punjab and Haryana.
- ▶ E-recruitment procedure has helped streamline recruitment processes. Walk-in interviews of certain positions are done to fast-track recruitment process.
- ▶ Innovations in workforce management such as contracting-in of specialists were adopted, in line with the recommendations of the 4th CRM report. However this practice was discontinued in 2012 due to availability of sufficient specialists from the regular cadre.
- ▶ The UT also has a web-based system for distributing salaries of regular staff but not contractual staff.
- ▶ Though performance assessment is done on a 6 monthly basis, which evaluates staff members on essential parameters across levels, there is no linkage with annual increments. Performance based incentives are also not yet in place.
- ▶ An annual training plan is in place but there are no training institutes in Chandigarh and training progress has been slow. The UT's HR policy prevents ANMs or SNs to conduct deliveries.

## ■ CHHATTISGARH

- ▶ The state health department doesn't have any specified policy for recruitment and performance monitoring of professionals working in public health sector.
- ▶ Significant vacancies exist for Specialists (82 per cent), Staff Nurses (52 per cent), Lab. Technicians (52 per cent) and LHV's (43 per cent). In the LWE affected Bastar region, 255 out of 277 sanctioned posts of Specialists are lying vacant.
- ▶ The Chhattisgarh Rural Medical Corps (CRMC) is an attempt to address the critical gap in human resources in the state by offering a bouquet of incentives as part of rural retention strategies. The scheme aims to increase availability of medical services in difficult and remote, rural areas of the state.



- ▶ Currently there is no dedicated staff to coordinate and monitor training programmes under NHM.
- ▶ The state is in the process of establishing Skill Labs.

## KERALA

- ▶ Recruitment process has been decentralized for most management and medical staff. For paramedical staff like lab technicians and JPHN the available state panel is considered first.
- ▶ However the deployment of the health staff is not on the basis of caseload. Many health facilities with heavy caseload are functioning with minimum staff, while a whole complement of staff is posted at facilities with low footfalls.
- ▶ The State has a regular and robust performance appraisal system in place. Staff members who are unable to clear the minimum standards undergo retraining and orientation. The State has developed a HR management tool (HR APPS) at DPMU level.
- ▶ Teaching institutes need strengthening in terms of faculty and infrastructure to maintain the quality of graduates. Financial issues such as fund allocation, non-payment of stipend is affecting their functioning.
- ▶ The state has established AYUSH dispensaries with one MO and one attendant to increase the availability of skilled HR. Junior Public Health Nurses are involved in providing MCH services, NCD care, Palliative care as well as School Health programmes.
- ▶ There is a huge difference in salaries between regular and NHM staff. The remuneration of NHM staff in the state is low, which is a cause of dissatisfaction and high attrition rates
- ▶ Volunteers from self-help groups are also supporting public health services, especially in polio vaccination, health surveys, source reduction, community mobilization and diet provision for indoor patients at hospitals.

## MADHYA PRADESH

- ▶ There are large gaps in regular cadres of service delivery staff. To fill gaps the State has recruited nearly 10,000 HR under NHM. However, a high proportion of vacancies remain across the state
- ▶ Recruitment of MOs, LHVs, ANMs and Staff Nurses is taking place at the district level through walk-in interviews on a fortnightly basis. But significant vacancies exist for Specialists (61 per cent), especially for Gynecologists (72 per cent) and Anesthetists (70 per cent). Vacancies were notable also for Medical Officers (38 per cent), Pharmacists (56 per cent) and Staff Nurses (32 per cent).
- ▶ To add to the large gaps, available HR is also not being efficiently used and several instances of irrational deployment of critical resources is seen
- ▶ Differential salary packages are offered to the doctors working in High Priority Districts (HPDs) with a 40 per cent higher salary at district level and 60 per cent higher salary at the sub-district level.
- ▶ In spite of the efforts of multi-skilling of doctors, various CEmOC facilities in the state are devoid of the required skilled care providers
- ▶ Baseline assessment of 3,000 ANMs and Staff Nurses has been carried out to identify core skills.
- ▶ The state has developed annual performance appraisal systems for service delivery and Programme Management Unit staff, measuring Key Performance Areas related to their TORs and their competencies.

## MIZORAM

- ▶ Though there are vacancies in the state for both regular as well as contractual staff, the state has adequate sanctioned human resources to cater for delivery points. Due to the recent government initiative to absorb contractual MOs in to regular services, all regular posts of Medical Officers and Specialists are filled but contractual positions are largely vacant.
- ▶ The recruitment process is centralized at the state level for all positions in regular and contractual cadres.
- ▶ Differential salary packages are offered to HR posted in difficult and very difficult areas based on the degree of difficulty involved. However, the state has not institutionalized performance based incentives and hardship allowances for staff working in the difficult-to-access hilly areas
- ▶ The current performance appraisal system in the state is limited to renewal of contracts. The state provides normative increments to all staff, irrespective of performance
- ▶ There is no training institute at state or district level. The annual training plan prepared at the state level does not include a systematic training needs assessment.

## ODISHA

- ▶ In spite of initiatives taken by the state such as decentralization of recruitments at the district level, over one-third vacancies exist for Medical Officers and Staff Nurses posts. There is also significant shortfall of Gynecologists, Anesthetists and Pediatricians in FRUs.
- ▶ The State does not have a specialist cadre - Medical Officers and Specialists join services at the same level as Assistant Surgeon. There is irrational postings for specialists leading to their underutilization
- ▶ AYUSH MOs have been trained in SBA, NSSK, and Routine Immunization etc. to assist in implementation of National Health Programmes
- ▶ There are no differential pay structures devised for the Nursing and Paramedical staff working in the notified hard-to-reach areas. But Performance Based Incentives (PBIs) have been started for AYUSH doctors, nursing and paramedical staff, SNCU staff and for the paramedics serving at V3/V4 institutions.
- ▶ The State has developed IT based HR-MIS software for the contractual employees working under NHM, which helps in managing the contract terms and salary payments.
- ▶ State Institute of Health and Family Welfare (SIHFW) has been designated as a nodal institute for coordination and monitoring of the RCH/NRHM training and communication for development activities in the state. Training Management Information System (TMIS) has also been developed in collaboration with NIHFW and MoHFW.

## PUNJAB

- ▶ Punjab Civil Medical Services (PCMS) (Class I and II) has been laid out in the state, which entails rules for recruitment, promotion and conditions of service. According to this, 25 percent of the vacancies are to be filled through direct appointment and the remaining 75 percent through the promotion/transfers of the staff.
- ▶ The terms and conditions of employment of contractual staff are formulated by the State Health Society (SHS).
- ▶ Punjab has 9 Government Medical Colleges with total annual intake of 1070 seats. Apart from the government colleges, there are 9 Private Medical Colleges offering an annual intake of 995 seats.

- ▶ PHCs and CHCs were adequately staffed specifically in case of Staff Nurses and LHV. But In spite of walk-in interviews for specialists, the state is facing a shortage of Gynecologists, Pediatricians, Anesthetists and Radiologists.
- ▶ Designated FRUs lack required specialized care providers such as Gynecologists, Anesthetists, Pediatricians or the Medical Officers trained in EmOC, LSAS and F-IMNCI.
- ▶ The State has two nodal centers for training are present in the State – One at Mohali and the other at Amritsar and training plans are in place, though NHM doctors have not received induction training as yet.

## RAJASTHAN

- ▶ Even with increased capacity through recruitment of contractual staff under NHM, the state is unable to meet the requirements of health providers, especially in the hilly, tribal and desert areas
- ▶ Despite the efforts made by state such as revision in salaries, there is huge shortage of specialists and Staff Nurses with more than half of the regular posts vacant.
- ▶ Since the state has not carried out any recruitment since 2011, the District Health Society are addressing their HR needs by hiring Third Party Agencies for HR recruitment and placement. But salaries of these contractual staff were delayed by more than 9 months due to delay in renewal of their MOU.
- ▶ The Government of Rajasthan has removed the recruitment ban in June 2014 allowing the state to restart their recruitment process with flexible norms, especially for doctors and specialists. The state has recently issued advertisements for walk-in interviews for recruitment of doctors and specialists.
- ▶ The state has planned to introduce one-year certificate course in gynecology, pediatrics, anesthesia and radiography in the government medical colleges to address the shortage of specialists. There is also a process underway for relocation of contractual manpower working under NHM to ensure postings in HPD and high caseload facilities.
- ▶ State NHM has taken the initiative of designing and developing a web-based software application, 'Computerized HRMIS (CHRIS)' to improve human resource management of non-gazetted and NHM employees and to provide real time information on vacancies.
- ▶ With the help of SIHFW (Rajasthan), AYUSH doctors are being provided 30 days training to incorporate SBA, RTI/STI, CAC, NSSK, IYCF, RI, IMNCI and IUCD skills.
- ▶ There is an established system for performance appraisal for both regular as well as contractual staff.

## TAMIL NADU

- ▶ There is adequate generation of skilled human resources in the state through 49 Medical Colleges and 218 Nursing Institutes.
- ▶ With more focus on recruitment of MOs, SNs, ANMs, shortage of human resources in the state is more among the lower level support staff
- ▶ Medical Officers are appointed through Medical Recruitment Board (MRB) and Staff Nurses are recruited through employment exchange, and regularized after completion of the probation period. There has not been any direct hiring of the Nursing and Paramedical staff for the last 4 years due to some pending court cases. To fill the service delivery gaps, the state recruits staff from third party agencies such as NGOs.



- ▶ Rational deployment of staff to operationalize operation theatres in PHCs has been done by posting specialists and multi-skilled MOs. Contracting of specialist services is done through private specialists where vacancies exist
- ▶ Regulatory mechanisms for retention such as reservation and credit marks for admission to PG courses for medical officers within the system are in place.
- ▶ The State is utilizing their AYUSH practitioners to contribute in School Health Programme, MMU activities, RKS committees under NHM etc.
- ▶ Baseline assessment of competencies of SNs and ANMs is being done in the state through skill labs over certain predefined parameters.
- ▶ The Mission has designated training officers at different levels who are supporting SIHFW in conducting in-service training for different staff. Supportive supervision of staff nurses and ANMs is achieved by posting mentoring nurses.

## ■ TELANGANA

- ▶ Human resources in the state come under the purview of Directorate of Medical Education, *Telangana State Vaidya Vidhan Parishad* and Directorate of Public Health. There is lack of integration in planning, implementation and monitoring of the process and large vacancies exist in some of the categories in the regular cadre.
- ▶ Directorate of Public Health does recruitments under the NHM and contractual staff recruitment is decentralized. But the process is pending since 2 years due to lack of funds at the district level.
- ▶ Lack of rational deployment is an area of concern. Shortage of specialists in the state is compounded by fact a number of them are in administrative and management positions.
- ▶ There is adequate number of teaching hospitals for generation of skilled doctors and paramedical staff but limited attraction and retention strategies under NHM are leading to a shortage of human resources.
- ▶ There are no objective mechanisms to assess performance of regular and contractual staff. Appraisals are basically confidential reports and are largely subjective
- ▶ Delay in disbursement of salaries up to 4-6 months across cadres under various National Health Programmes due to regular administrative and legal issues is demotivating for the staff.
- ▶ Indian Institute of Health and Family welfare (IIHFW), which is the State nodal institution for training needs strengthening to handle the training load.

## ■ UTTARAKHAND

- ▶ Since the inception of NRHM, sanctioned posts have increased for specialists – maximum for Physicians (44 per cent) and Pediatricians (33 per cent) at CHCs. But the number of in-position Specialists has declined by 38 percent. Maximum vacancies were seen for MOs (MBBS) at 76 per cent and Specialists, in particular for Gynecologists (63 per cent), Anesthetists (65 per cent) and Pediatricians (40 per cent).
- ▶ Walk-in interviews are held every Tuesday for recruitment of MOs. In order to increase retention of MOs, doctors are given reserved seats in PG programmes against a bond to serve in hard-to reach areas. But the difficulty of retention of staff in hard to reach areas is an added challenge to the overall shortage of skilled human resources.

- ▶ There has been an exponential surge in the number of in-position Staff Nurses (253 per cent) and Lab. Technicians (391 per cent).
- ▶ Since September 2014, the state transfer policy has been implemented and more than 90 doctors have been transferred to hilly areas. But frequent rotational postings were reported by SNs and ANMs.
- ▶ Strengthening of Pre-service nursing and midwifery through setting up of State Nodal center is a good initiative by state but there have been no recruitments for ANMs since 2009 resulting in large vacancies.
- ▶ Sufficient trainings on SBA have been conducted, but there is no robust post-training deployment system to make use of acquired skills. On-site training for ANM/SN by mobile training teams, which has been rolled out in 3 districts has been very successful in addressing training needs.

## UTTAR PRADESH

- ▶ Huge proportion of regular posts of Doctors, Nursing and paramedical staff are vacant. Shortage of specialists was significant at the district level and CHCs
- ▶ Recruitment of higher regular posts is done through UPPSC, and completion of processes takes a long time resulting in delays in filling vacancies.
- ▶ The state is yet to start competency tests for baseline assessment of existing staff and for facilitating recruitments.
- ▶ The State has not developed strategies such differential remuneration, benefits and allowances to retain staff in difficult rural areas
- ▶ Capacity building of AYUSH Doctors to effectively involve them in National Health Programs is lacking
- ▶ Training plans, achievements, post-training utilization and deployment are not properly maintained.

## WEST BENGAL

- ▶ The number of sanctioned posts as well as those in position are adequate for Staff Nurses and Medical Officers
- ▶ There is no policy for career progression and retention including hardship allowances for those working in High Priority Districts (HPDs).
- ▶ LSAS trained doctors are utilized sub-optimally in the state with postings at Sub-district and Regional hospital level only.
- ▶ The state is in the process of developing a Human Resource Management Information System (HR-MIS)
- ▶ As a policy, the state does not train ANMs for Skilled Birth Attendance (SBA). As a result, no deliveries are conducted at Sub Centers and PHCs.
- ▶ Local Birth Attendants called "*Sahiya*" take care of post-natal mothers during their stay in the facility and also counsel mothers on childcare.



# TOR 5

## Community Processes and Convergence

### Guiding Principles/Strategies of the NHM

- i. Empower the ASHA to serve as a facilitator, mobilizer and provider of community level care (2.4.2.14)
- ii. Community mobilization will also include action in convergent areas such as importance of sanitation facilities, safe drinking water and health and hygiene education programs, in schools and Aanganwadi centres (5.5.1.1)
- iii. The VHSNC will act as a platform for convergence between different departments and committees at village level (5.5.2.3)
- iv. Encourage and enable the involvement of Panchayat Raj institutions (PRIs)/Urban Local Bodies (ULBs) representatives in the governance and oversight in governance and oversight of health services, and undertake proactive efforts for convergence and concerted action on social determinants of health such as food, nutrition, safe drinking water, sanitation and hygiene, housing, environment and waste management, education, child marriage, gender and social inequity. (2.3.14)

### KEY FINDINGS

Of the 15 states that were visited as part of the CRM the six high focus states and the two North Eastern States have been implementing the ASHA programme since 2005. Among the non high focus states visited, the Union territory of Chandigarh does not currently have an ASHA programme although the UT is now selecting ASHAs as part of the NUHM. The state of Tamil Nadu opted to select a limited number of ASHA oriented largely to disease specific interventions.

#### Panchayati Raj Institutions (PRI)

- ▶ PRIs play an active role in VHSNC in many states, with Kerala reflecting the most well defined and institutionalised systems. PRI

involvement in the RKS was seen only in Odisha, Kerala, Chhattisgarh, Mizoram and Tamilnadu. Mizoram is an exception with 'strong involvement' of PRIs in functioning of health institutions, VHSNCs and RKS.

- ▶ Where PRIs are better nurtured with systematic training, and supported by decentralization of funds, functions and functionaries, as in Kerala and Mizoram, a more active role in health and other social sector interventions is seen. In Odisha which has made efforts to engage PRIs in community platforms, particularly the VHSNC, there is more active participation. Tamilnadu has made councilors of district



Panchayat and president of village/town panchayat, members of the Governing Board of RKS at all levels.

- ▶ Institutional Convergence between committees under the NHM and other departments has been reported by a few states. West Bengal reports 'Convergence Committees' with representation from PRI, Department of Women and Children, and Public Health and Engineering Department and others from block to the State'. Madhya Pradesh, Kerala and Rajasthan also report institutional convergence. Madhya Pradesh has merged the three village level committees related to WATSAN, ICDS & Health, for action on health and its social determinants.



### **Village Health Sanitation and Nutrition Committees (VHSNCs)**

- ▶ VHSNC have been constituted in all states. In Bihar, UP, Telangana, and West Bengal, VHSNCs are constituted at the level of Gram Panchayat, with bank accounts being operated by Sarpanch/Panchayat Secretary and ANM. In other states, the VHSNC are at the level of the revenue village. In West Bengal VHSNC has no separate account, with funds deposited in the bank account of Gram Unnayan Samiti, operated by Gram Pradhan. Bihar has VHSNCs at GP level, but untied funds @ Rs 10000/year are given for each of its revenue villages.
- ▶ The process of restructuring of VHSNCs as per the new GOI guidelines, which requires the local GP representative to be its Chairperson, the ASHA its member secretary, and expanding the membership to allow for more inclusion of marginalized groups and women, is pending in most states. Uttarakhand, Punjab and Rajasthan report restructuring VHSNCs.
- ▶ In Rajasthan, though the ASHA has been made the member secretary and signatory of the VHSNC, discrepancies in VHSNC fund flows were noted and the CRM team reports that no VHSNC funds were disbursed in last two years in some blocks.
- ▶ Kerala has integrated Panchayati Raj Department and elected Panchayat Representatives with VHSNCs (known as Ward Health Sanitation and Nutrition Committee). For Palliative Care and Mental Health funds and strong community support are enabled by elected representatives. The VHSNCs also obtain funding from sources other than the untied funds – Rs 10,000 from Sanitation Programme and Rs 5000 from Panchayat grants. PRIs also support routine maintenance of health facilities using their funds.
- ▶ Well functioning and active VHSNCs are also seen in Odisha and Chhattisgarh. In Odisha, low performing VHSNC (about 45% of total) were identified and provided capacity building inputs. Swasthya Gaon Puraskar is awarded to better performing GKS committees.
- ▶ The Sarpanch and ANM are joint signatories of VHSNC account in Bihar and UP, but the role of ASHA in VHSNC in these two states is weak. In West Bengal, in the early years of NRHM, Gram Unnayan Samitis which existed at the level of Gram Panchayat, were co-opted as VHSNC, with funds being routed through Panchayat Department. PRI members and most ASHAs were not aware of VHSNCs, though the ANMs had some knowledge about the committees and the untied fund allocated. No fund transfer to VHSNCs was reported in last two years. In Bihar, untied funds appear to be spent by the Sarpanch with little community consultation.
- ▶ In Madhya Pradesh, VHSNCs are reported to be taking local initiatives around issues of water and sanitation, spray of DDT and Gammaxine. In MP, supporting purchase of equipments and supplies for sub centre through a state directive is another area of fund expenditure, under its Gram Arogya Kendra initiative (GAK). Uttarakhand reports an innovative support from VHSNC funds for providing locally made 'Doli' for transport of patients to nearby hospitals.
- ▶ VHSNC members in many states reported that they were given one to two day orientation.

Awareness and knowledge levels of the PRI representatives were reported to be weak in most states, except Odisha. No state reports issuing of state specific guidelines or training material for VHSNCs except for Madhaya Pradesh and Chhattisgarh.

- ▶ Regularity and quality of monthly meetings of VHSNC were weak in most states. In Punjab no VHSNC meeting has been held in one of the districts visited since July 2014. In Uttarakhand, findings from Almora district indicate that VHSNC meetings are irregular, with no involvement of ASHAs and ANMs. No systematic health planning roles were seen being played by VHSNCs.
- ▶ GPs in Chandigarh were oriented on their role and the CRM report highlights 'enthusiastic' involvement of PRI representatives in VHSNC processes, in health schemes and in building awareness regarding the national health programmes.

### **Convergence**

- ▶ Kerala has institutionalized decentralization mechanisms and convergent processes, including a nodal officer for convergence measures at state level. Local bodies have been given additional dedicated funds and flexibility for plan formulation with mandatory ceilings on infrastructure projects. In an innovative



measure, 10% funds have been earmarked for women welfare and 5% for children, elderly and other vulnerable population groups. Palliative care is now mandatory for all Gram Panchayat/ Municipalities/Corporations. Comprehensive Health Plan has been prepared for a period of five years under the leadership of Local Self Governance Department. School children have been involved in Sanitation, and Vector control activities and generating awareness on hazards of alcoholism among students.

- ▶ While effective convergence is reported from several states, between ASHA, ANM and AWW, for organizing VHSNC meetings, VHND, convergence between the Health, ICDS and PHE departments appears to be a challenge at the block and district level. In UP a "AAA" (ASHA, ANM and AWW) platform is being implemented in 25 high priority districts for effective convergence between frontline workers.

### **Village Health and Nutrition Day (VHND)**

- ▶ Across the states, the focus of VHND appears to be on immunisation. Where ANC is provided, the quality of services is weak, and the full complement of ANC services, like, Hb test, BP check-up, and abdominal examination is not being provided in most states.
- ▶ No specific mechanisms for monitoring of VHNDs have been reported from most states. West Bengal reported monitoring mechanisms to be in place, however, major discrepancies were found between the number of VHNDs planned and held and those attended by ANM, AWW and ASHAs.
- ▶ Activities related to nutrition, adolescent health and follow-up visits at village level are weak in many states. In UP it appears that the focus is entirely on immunization. The ASHAs have been provided with a flip chart but no evidence of this being used for counselling was observed. In Chhattisgarh, VHNDs have been reported to have good participation

from ANMs, AWW, Mitani (as ASHA is called in the state) and PRI members, and the state also has its own initiative called Health Wednesday Programme, where AWW brings malnourished children and their mothers to nearest facility. Madhya Pradesh is the only state which reports a set of tests being provided (Hb, Urine test for pregnancy & Albumin, Antigen test for P, Vivax), and 16 drugs through the Gram Arogya Kendras in AWC, which function as the VHND site. However MCP cards were not being filled, and counselling and IEC efforts need strengthening. Mizoram in a noteworthy aberration reports very little involvement of ASHAs in VHND, where they were not even fully aware of the incentives for mobilising children for VHND.

- ▶ While in all other states, immunisation session and VHND are being organised together, Odisha and Tamilnadu report holding separate sessions for immunisation and VHND. In Tamilnadu immunization session is held on a Wednesday and VHND on Friday every month and in Odisha VHND is held on a Wednesday followed by VHND on a Thursday. Both reports highlight positive findings of this delinking as this allowed for more time available for immunization, growth monitoring, ANC and counselling services. The reports also highlight the well coordinated efforts of front line workers (ANM, ASHA and AWW) in both states and monitoring of VHND by VHSNC members in Tamilnadu.

### **ASHA Training & Performance**

- ▶ ASHAs have been, once again, recognised across the states as 'the most prominent face' of the NRHM, who are 'very active in implementing various health programmes', and the critical role that they play is also being recognised by the health system. While CRM report of Chhattisgarh calls ASHAs, 'backbone of the community based health programmes', the Telangana team observes that 'beneficiaries had a very positive outlook about the ASHA'. Uttar Pradesh team also observes that 'across the facilities visited ASHA were very active,

motivated and knowledgeable' and they have become 'Carriers of Change' in the community. Assam also reports ASHAs as being 'enthusiastic and vibrant'. In Kerala, the report highlights a general reluctance (at state level) towards the programme. One reason for this was reported to be the belief that Kudumbashree health volunteers have already been performing the role of health activists in the community and ASHAs are seen as duplicating this role.

- ▶ Selection of ASHAs is complete across most states. Except UP, that has only 81% and Rajasthan that has 87% ASHAs in place against the target, all high focus states have close to or above 95% ASHAs in place. The gap in both these states is based on revision according to the 2011 census and identification of non functional ASHAs, but their inability to recruit new ASHAs to fill this gap in the last two years, is an issue of concern. Mizoram also has not been able to recruit ASHAs to fill the gap of about 37% that was created after it raised the target as per the 2011 census. In Bihar, delays in nomination of new ASHA by village Pradhans, was reported as causing the gaps in selection. West Bengal also has major gaps to fill with total 61,008 ASHAs sanctioned, but has only 45250 in position. In Hemtabad block of Uttar Dinajpur, no ASHAs had been selected. In Ganganagar district, Rajasthan, a gap of 20.1 %, with resultant high population coverage of upto 2000 per ASHA was reported.
- ▶ In West Bengal ASHA selection is based on marks obtained by the candidate in the Madhyamik or equivalent examination (90% weightage) and Score in the interview (10% weightage). District officers felt that this distribution skewed in favour of exam marks results and led to inappropriate selection. In Kerala, the existing mechanism of ASHA selection is reportedly robust and includes selection through PRI member, members from civil society organization and representatives from community.
- ▶ Tamil Nadu has an entirely different programme design, and has selected ASHAs



for specific programmes, like HBNC, Leprosy and Malaria, with ASHAs having an average coverage population of 700-800 households and 4-5 villages, and process of ASHA selection has been led by the village panchayat.

- ▶ The database of the ASHA programme across states has become more robust with information on selection, training, ASHA drop-out, and incentive payments. Rajasthan, Punjab and Maharashtra, have developed a web-based software for database management and updating, but the field experience reflected limitation of these systems in improving programme effectiveness.
- ▶ The average drop-out rate of ASHAs is reported to be in the range of 2-5% per annum across the states.
- ▶ Across the states the following roles of ASHAs are reported: support to pregnant women, counselling for birth preparation, serving as facility escort, post-partum visits for providing care of mother and newborn, supporting diseases control programmes, mobilising families, supporting VHND and Immunisation services. The focus and skills of ASHAs in undertaking Nutrition counselling for mother and child differs across states and is generally reported to be weak. In Kerala, ASHA play a key role in Palliative Care (under the leadership of the Gram Panchayat Nurse) and Non Communicable Diseases. Madhya Pradesh also reports registration of birth and deaths, listing of high risk pregnant women and low birth weight and malnourished children, referral and escort through Janani Express/EMRI. The UP CRM team reports lack of clarity among ASHAs about their roles, and low levels of motivation.
- ▶ Module 6&7 training is still in its initial phase in UP, although the momentum has increased. Rajasthan has also only recently stepped up the pace of Module 6&7 training and has trained 87% ASHAs in round 1 and 57% in round 2, with Round 3 yet to start. Refresher training on the skills taught in Module 6&7 training

rounds, have been planned across many states. Uttarakhand has started refresher trainings. The pace of training in Module 6&7 training has also slackened in Bihar and MP, which were near completion in Dec 2013 in round 1 and 2 training for ASHAs, and had trained 19 and 12 percent respectively in round 3, but have been able to train only 54 and 40 percent respectively at the time of CRM visits. Madhya Pradesh is also training their ANMs along-with the ASHAs. Bihar which showed good progress over the last three years has lost momentum due to large delays in fund releases.

- ▶ Eight days Induction Training for new ASHAs, which replaces the Module 1 to 4 training rounds, has been initiated in Madhya Pradesh (428 ASHAs trained). A challenge in MP and other states is that in absence of a systematic training structure in district and sub district levels, it is difficult to organize training for newly recruited ASHAs since they are few in number.
- ▶ The pace of Home Based New born Care (HBNC) interventions and related ASHA skills is variable, but steadily improving in most states. Several states report a low level of HBNC skills among ASHAs, particularly where Module 6&7 training rounds have been conducted without giving HBNC kits to ASHAs during training (MP, WB, and Bihar), hampering skill practice under supervision. In Bihar, the trend of home visits by ASHA is increasing, but outcomes in the face of poor skills are likely to be poor. In Kerala ASHAs were conducting home visits for newborn care, but implementers questioned the need for this. In Karimganj district, Assam no HBNC visits were reported to be taking place. In MP the role of the ASHA in HBNC was compromised due to her having to stay in the Gram Arogya Kendra for most of the day.
- ▶ In Kerala the knowledge and skills of the ASHA on basic RCH issues were found to be weak. Reports from Assam, Chhattisgarh, Mizoram, Telengana, and UP indicate that ASHA are not able to identify pregnant women with complications.



- ▶ The role of the Asha in the disease control programmes especially malaria and leprosy was well appreciated in West Bengal, Odisha, and Tamil Nadu. (for leprosy). The supply of RDT kits and drugs are regular and this facilitates the role of the ASHA in these states. In MP and Chhattisgarh irregular supply was reported.
- ▶ No state reports specific involvement of ASHAs in sanitation related programmes and the ASHA's role is limited to awareness building as part of her work in the community, through the platform of VHSNC and VHND. Odisha reports that ASHAs are not even aware of the incentive for motivating household to build toilets under the Nirmal Bharat Abhiyan.
- ▶ States of Uttarakhand, Mizoram, Assam, Punjab and Odisha, report the 'Performance Appraisal System' for assessing ASHA Functionality on ten indicators, being in place. Odisha also shared a state level analysis of ASHA functionality, which shows only 44% ASHAs being functional as DOTs provider and 57% on Family Planning related roles, with better functionality on other indicators.
- ▶ Across the states, problems in drug kit replenishment were reported. Delays in drug replenishment from sub centre were reported from Chhattisgarh and Bihar. In Shrawasti in UP, replenishment of drugs and family planning related supplies was being done from PHC, and the process was quite irregular, due to which even ASHAs were reportedly

losing interest in asking for replenishment. West Bengal reported that 'ASHAs have not been provided with the HBNC kit' in both districts.

### **ASHA Incentives & Support Systems**

- ▶ The strength of the ASHA programme has a direct correlation to the level of support provided. Support structure at all four levels (state, district, block and ASHA Facilitator levels) is in place only in states of Bihar, CG, MP, Rajasthan & Uttarakhand, but Chhattisgarh and Uttarakhand are the two states with no vacancies at any level. In Rajasthan, Madhya Pradesh and Bihar, gaps are persistent, affecting supervisory and handholding support to ASHA was weak. Punjab and Mizoram retain the same support structure at three levels, with none at block level, but report better retention. All other non high focus states have only existing health system staff to support the programme. The CRM team of Odisha has appreciated as a 'best practice', the monthly evaluation to test knowledge and skills, followed by refresher training and repeat testing of ASHA facilitators.
- ▶ Most state reports the average incentive earned by ASHAs between Rs 1500 to 2000 per month. In Madhya Pradesh, average incentive reported in both districts visited, was Rs. 1500 to 2000, and about 94% ASHAs have bank accounts. In Odisha average take home incentive of ASHAs has been reported as Rs. 1735. Electronic transfer or direct bank transfer based incentives payment system is reported from most states and that the payments are regular. Problems of delay of between three to over six months was specifically reported from Shrawasti of Uttar Pradesh (in the other district payment were being done on time on monthly basis) and Chhattisgarh. In Chhattisgarh the system of incentives payment in cash, through panchayats, has been reported as a concern and a cause for delays in incentives, and need for direct bank account based payment system has been suggested in the state CRM report. Delays were reported from Kerala with

no incentives paid from NHM funds since April 2014, Uttarakhand also reported average incentive of Rs 1500 to 2000, but problems in payment of selected incentives has been reported. In West Bengal ASHAs also get a fixed incentive of Rs. 1500 per month from state funds and the average incentive varies in the range of Rs 1500 to Rs. 4000, made via electronic bank transfer. In Rajsamand district of Rajasthan, a local innovation is the ASHA Diary, in which details of beneficiary families, and a record of activities is used as the basis for making payments and assessing ASHA performance. States are yet to begin paying the routine and monthly recurring incentive of Rs. 1000.

- ▶ Systems of Grievance Redressal Mechanism are in place, but structures vary. A committee with intersectoral representation exists in Punjab, and an average of 8-10 cases per block were reported during last year, and resolved at block level. Madhya Pradesh has merged Grievance Redressal Committees with Monitoring Group on Community Action (MGCA), but no system/mechanism was found functional. Most states lack a formal structured mechanism for grievance redressal. West Bengal did not have any grievance redressal mechanism in place, and also the LHVs, who are field level supervisors of ASHAs reportedly do not listen to the complaints of the ASHAs. In Uttar Pradesh, a toll free helpline was in place as a part of grievance redressal system, and information about it was displayed as wall paintings, but the number of grievances being handled was very small. In Assam misbehaviour of hospital staff was reported, but no mechanism for redressal was seen.
- ▶ ASHA Rest Rooms: While in some states, ASHA Ghar are in place mainly in district and block level facilities (in Madhya Pradesh 35/50 DHs have it in place, but none were found at CHC/PHC level in Panna, one of the districts visited), states like Odisha have taken a different approach, and set them up in all 143

L3 delivery points of state, managed by ASHA, are well set up and functional. Chhattisgarh has ASHA Help Desks, where the Mitani provide navigation support to patients. In Assam and West Bengal no rest rooms were found in place.

- ▶ Career Opportunities: Among the states visited, Chhattisgarh, Madhya Pradesh and Odisha have a provision in place for reservation of a percentage of seats in the ANM schools for ASHAs. States of Bihar and Chhattisgarh also support ASHAs for enrollment in education equivalency programmes in National Open School, to help them study further. In several states, selection of ASHAs as ASHA Facilitator is also a mode of career progression.



## Community Action for Health

- ▶ Punjab has initiated interventions in Community Action for Health programme in two pilot districts. Bihar CRM report has shared that state had undertaken a pilot initiative on community action for health. From among nine states which were part of the pilot phase, in Madhya Pradesh, CAH intervention is in the initial phase of implementation in five districts (covering a total of 225 villages). Rajasthan team reports finding no CAH programme interventions on the ground, though state has funding for initiating the process in three districts. No CAH interventions have been reported from Assam. Odisha has planned to implement CAH interventions in five districts during FY 2014-15.
- ▶ Chhattisgarh has a variant of community action for health since 2007. Community Based Monitoring is now a part of VHSNC monthly meetings using a public services monitoring tool. Social audit of deaths related to maternal, child, fever, TB etc, and community feedback regarding services being provided by govt health facilities and block level public hearings are undertaken. No CAH related programme interventions were reported from Odisha, Mizoram, Chandigarh, Uttarakhand, Telanagana, West Bengal and Kerala.



## RECOMMENDATIONS

- ▶ Engaging representatives of Panchayati Raj institutions in health committees at various levels is an area that needs action by the Departments of Health as well as by the Department of Rural Development/PRI. District and sub district implementers in the health department will not be able to promote PRI participation or build capacity to understand and take action on health issues unless there are proactive efforts to strengthen and involve institutions that are involved in PRI training and support. The Punjab, West Bengal and Kerala experiences while following different paths have demonstrated that this is possible.
- ▶ The persistent and wide spread finding of varying and limited functionality and limited or mis use of untied funds of VHSNC is partly a result of the lack of effort at systematic capacity building, but also a matter of the human resources required to support the committees and facilitate regular meetings and action on local issues. The Odisha and Chhattisgarh experiences show that functional VHSNC are possible with active and sustained facilitation. Indeed, strengthening PRI knowledge and understanding of health issues are also likely to benefit VHSNC functioning. Building capacity of VHSNC is a mammoth effort and states will need to involve NGOs and other training institutions to undertake training of VHSNC members and continuous support provided by frontline workers appropriate to state contexts.
- ▶ A conscious attempt to address the stalled efforts or non starters in community action for health requires sensitization of not only state level policy makers but also district and sub district implementers on the necessity of such action and how this can be leveraged to improve outcomes on social and environmental determinants and accountability. This would also necessitate linking with existing community structures such as the ASHA and the VHSNC thereby mutually strengthening both efforts, and ensuring that the support of this intervention is provided by the management structures created for community processes.
- ▶ The “presence and visibility” of the ASHA in the face of systemic gaps related to selection, skill building, supportive supervision, payment and replenishment of kits, is a testimony to the exercise of individual agency by the ASHA themselves. This year’s findings pertaining to the ASHA programme are mixed, highlighting that more of the same may not work in all contexts.
- ▶ ASHA selection must be expedited especially in the underserved areas. Learning from the past, where the pressure of time resulted in inappropriate and patronage based selections, and the fact that such ASHAs tended to drop out anyway, the opportunity to use community based selection and the “right fit” ASHA must not be squandered. States must prioritize the selection of ASHA and household allocation so as to ensure appropriate population coverage so that there are no left-outs.
- ▶ The finding of weak skills and poor performance among the ASHA relates to the need to improve training quality, post training assessments, refresher trainings, and ongoing field level mentoring. This requires that urgent attention be paid to training structures and systems and to strengthening the support structures created. States need to use conventional (audiovisual,/ print) and newer methods of technology to enable refresher training for additional skill building.
- ▶ While on the training front, substantial progress is reported from most states, barring a few, the need for continuous refresher training even where “training is completed” is the next step forward. Adhoc training systems will need to be replaced by institutionalized mechanisms for ongoing training. The certification process planned for this year provides an opportunity for states to initiate this process.
- ▶ Progress on recruitment of support staff for the ASHA is notable across all high focus states, but states in this category would need to undertake serious efforts to build on the opportunity provided. The support staff at all levels need to be sensitized to their roles, and provided with

appropriate support by their district counterparts in NHM to undertake their tasks of mentoring and supporting the ASHA and VHSNC. In non high focus states, existing staff who are expected to provide the potential outcomes need to be strengthened to undertake this additional task through appropriate training and monetary/non monetary incentives. States need to undertake an analysis of the existing HR at block and district level, develop appropriate job descriptions and allocate work equitably.

- ▶ A linked recommendation to this is that states must ensure provision of kits, drugs and communication material to serve as aids to the ASHAs work in order to strengthen her role in motivation for behaviour change and to provide

community level care. Strengthening her in both these roles will serve to enhance her effectiveness as a social mobilizer.

- ▶ A decade after the launch of the ASHA programme, particularly in non high focus states especially those such as Kerala and Tamil Nadu where there is evidence of the ASHA being an underused human resource, states must seriously start thinking of engaging ASHA in areas such as screening, preventive and promotive measures for chronic diseases and palliative care linked to certification in a set of relevant skills. Viewing the ASHA as a frontline worker located in her community and supporting the Primary health care team offers an important venue to facilitating universal health coverage.

## FINDINGS FROM STATES

### ASSAM

- ▶ 27673 Village Health Sanitation and Nutrition Committees (VHSNCs) have been formed.
- ▶ VHND are held weekly, with services for ANC, PNC and immunization being provided.
- ▶ With over 95% of the target ASHA selected, they are a prominent face of the NHM, actively involved in mobilization of women and children for RCH services, but home visits are not regular.
- ▶ The pace of training slow but has recently picked with completion of Round 2 of Module 6 and 7 for all ASHAs. ASHAs have received drug and equipment kits with replenishment from the block PHC.
- ▶ Support structure is in place and performance monitoring helps in programme improvement except in Tinsukia district where huge vacancies of support staff affected the feedback process.
- ▶ The average monthly incentive is Rs 1500 per month.
- ▶ No grievance redressal cell has been constituted for ASHAs

### BIHAR

- ▶ VHSNCs are constituted at Gram Panchayat level, with limited involvement of community, ASHA or ANM and are weakly functional.
- ▶ VHNDs are combined with routine Immunization days, services for ANC are limited to Weight, BP, and immunization.
- ▶ Over 90% of ASHA are in place but ASHA training has slowed down due to non release of funds.
- ▶ Large vacancies in support structures and lack of regular review and support at all levels have affected programme functioning.

- ▶ Aids such as Mobile Kunji and Academy provide some support to the ASHA but have limited ability in substituting poor training and support systems.
- ▶ Chandigarh (UT)
- ▶ 22 VHSNC constituted, and members oriented on utilization of untied fund and village planning. Training needs to be strengthened.

## CHHATTISGARH

- ▶ VHSNC meetings are regular with active participation of ANMs, AWW, Mitnin, and PRI representatives. Meeting minutes and registers are well maintained. VHSNC constitute a platform for discussing social, environmental determinants such as water, sanitation, nutrition and also serve as an accountability mechanism.
- ▶ The state has a mature community processes programme with effective support structures, established welfare measures and well thought out career progression plans.
- ▶ Mitnins (state nomenclature for ASHA) are effective in all three roles of mobilization, facilitation and care provision.
- ▶ The role of navigation for patients and their families in health facilities is successfully facilitated by Mitnins managing a Help Desk at the District Hospital level.
- ▶ Early experiences with Panchayat level payments for Mitnin indicate payment delays.
- ▶ Drug kit replenishment is a challenge.

## KERALA

- ▶ Community health care and support is effectively integrated into the PRI system. In the palliative care initiative, a Panchayat appointed community health nurse, supported by the ASHA in the community and the JPHN at the sub center, provides home based palliative care. In order to decentralize care for patients with mental illness, funds for drugs are routed through PRI with follow up care provided at the PHC. PRI also provide mobility support for outreach services and Facility maintenance.
- ▶ VHSNCs (VHSNCs at the level of a ward) are actively involved in issues related to water and sanitation, and creating awareness on ill effects of alcohol and tobacco. Apart from NHM untied fund, the state provides Rs. 10,000 from Sanitation Programme (Suchithra Mission); and Rs. 5,000 is provided by the Gram Panchayat.
- ▶ Targets have been achieved for ASHA selection and training and the state has adapted national training modules to state context, adding on palliative care and NCDs.
- ▶ Knowledge and skills of ASHA were limited even on basic RCH issues, indicating the need for refresher training.
- ▶ Apart from a state nodal officer, the state uses existing staff to support the ASHA, but mechanisms for supportive supervision, post training support and performance monitoring for ASHA are limited.
- ▶ Despite the existence of an online data base for performance monitoring ASHA payments are delayed.

## MADHYA PRADESH

- ▶ 49,567 VHSNC (state nomenclature: Gram Sabha Swastha Gram Tadarth Samiti (GSSGTS)) (89.57% of the target) are in place at the revenue village level, and include 12-20 members, 50% female representation, ASHA being Member Secretary and treasurer for untied funds and woman ward the Chairperson.



- ▶ Instructions on spending untied funds by VHSNC are sent by the state to develop the Gram Arogya Kendra leaving little scope for local planning and action.
- ▶ The pace of ASHA training is moderate. NGO involvement in ASHA training has improved the quality of logistics, but follow up action on monitoring is weak.
- ▶ Dropout of state trainers because of delays in fund releases for travel and allowances, is slowing the pace of training.
- ▶ Performance monitoring for all districts is reported from the state level, but district level understanding of the process in the visited districts was low.
- ▶ The skills and potential effectiveness of the ASHA are impeded by lack of ongoing support and shifting her job responsibilities to managing the Gram Arogya Kendra, (leaving little time for home visits).
- ▶ There are vacancies in the support structures at all levels, and no mechanisms for periodic review and experience sharing mechanisms at any level.
- ▶ District and Block MGCA teams for additional support to community monitoring have been formed.

## MIZORAM

- ▶ VHSNCs have been formed across the State. Meetings are held regularly and funds are utilized mainly for purchase of dustbins, award for constructing septic tanks and cash assistance to the poor patients.
- ▶ VHNDs are regular, but the focus is on Immunization and nutrition services for children and pregnant women.
- ▶ ASHA have been trained upto Round III of ASHA Module 6 and 7 and provided HBNC kit.
- ▶ ASHAs are mainly involved in taking women for institutional deliveries, HBNC visits, collection of malaria slides and distribution of contraceptives, but little involvement in promotion of PPIUCD, WIFS.
- ▶ Support structures are in place at state, district and PHC level.
- ▶ The performance monitoring system is in place in all districts, but there is no feedback mechanism.
- ▶ Payment of ASHA incentives is a challenge, with irregular and fragmented payments.
- ▶ Non monetary incentives such as ASHA awards and supporting higher education among ASHA have been instituted recently.
- ▶ There is no systematic/defined grievance redressal mechanism for ASHAs, though ASHAs may voice their complaints to ASHA mobilizers and even to MO I/C PHC.

## ODISHA

- ▶ 45, 407 VHSNCs, (Gaon Kalyan Samiti (GKS)) are formed at revenue village level, but the AWW serves as Convener and the role of the ASHA is limited. All members have been trained.
- ▶ The Swasthya Kantha, an interactive health bulletin board enables community sharing of health related information. 227 GKS were awarded the Swasthya Gaon Puraskar.
- ▶ VHND and immunisation day are separately implemented to ensure effective service delivery.
- ▶ The pace of ASHA training is good with 90% ASHA trained up to Round III. State has also undertaken more intensive training on malaria, and the contribution of ASHA in addressing malaria is well recognized. ASHAs were also reported to be active in identification and referral of leprosy cases.

- ▶ There is effective coordination between ASHA, AWW and ANMs.
- ▶ ASHAs are visible across State and fulfil the key tasks allocated to them. Performance monitoring of ASHA enables monitoring, supportive supervision and review of key outcomes.
- ▶ ASHA payments are regular and the introduction of a slew of non-monetary incentives serve as motivating factors.
- ▶ ASHA Facilitators cover about 25-35 ASHAs, and continue to work as ASHA which reduces their ability to support the ASAH in their coverage area. Efforts are underway to improve their skills.

## PUNJAB

- ▶ 13104 VHSNC have been restructured as per recent guidelines with PRI playing an active role and well maintained records. Untied funds are used for cleanliness drives, vector control and support of destitute women.
- ▶ VHND held every week but focused primarily on immunization.
- ▶ The state has selected about 96.84% of its target ASHAs, with all support structures in place except at district level, with seven districts not having a District structure.
- ▶ Drug and equipment Kits have been provided and sub centre replenishment appears to be working. Bank payments are regular with an average monthly incentive of Rs. 1500.
- ▶ 63% of ASHAs have been trained up to Round 3 of Module 6&7 and are undertaking home visits for care of the newborn.
- ▶ Grievance redressal committees in place and functioning.
- ▶ A pilot intervention in Community Action for Health has been started in two districts, with involvement of NGOs at state level and in field implementation. Effective convergence with related departments visible.

## RAJASTHAN

- ▶ VHSNCs have been reconstituted, but participation of PRI representatives and community is low. Training was provided early on, in NRHM but not since then.
- ▶ The state has selected 91% ASHA against its target, but shortfalls exist and there was a 21% gap in Ganganagar district.
- ▶ The pace of training is slow with low numbers being trained even in Round 2.
- ▶ The state has not invested in strengthening its support structures across all levels – there are vacancies, and the support staff are poorly trained with low motivation.
- ▶ The level of the skills among the ASHA is variable, and can be attributed to long delays in training and poor support.
- ▶ ASHAs receive monthly payments of Rs. 1600 from the health and ICDS system and incentive linked payments through the NHM, averaging about Rs. 4000 per month. This necessitates their spending time at the AWC, leaving little time for home visits.
- ▶ Performance monitoring of ASHA in Rajsamand district was reported as being functional with ASHA being aware of all priority families in her area.

- ▶ No ASHA rest rooms exist, forcing the ASHA to incur expenditure for lodging when escorting patients.
- ▶ There is no system of career progression for ASHAs in the state.

## TAMIL NADU

- ▶ VHWSNC have been formed across the State at the Gram Panchayat level. Representation of poorer and more vulnerable sections is seen. However, the training of VHSNC members has not been conducted.
- ▶ VHND and immunisation day are organised separately on a monthly basis and are held regularly.
- ▶ State has selected programme specific ASHA for high endemic districts – for Leprosy, Malaria and HBNC.
- ▶ Six regional training Institutes across the state provide training for ASHA. All ASHAs of the State have been trained for their tasks. There is a 20% gap in HBNC training.
- ▶ ASHA are supported by Block Medical officer and Deputy Director (Leprosy) during weekly visit to the patients as part of their supportive supervision activities.
- ▶ Since ASHAs are deployed as only for specific programmes, the incentives are quite low.

## TELANGANA

- ▶ VHSNCs are formed at Gram Panchayat level, and are yet to be reconstituted as per the revised guidelines has not been done yet and ANM rather than ASHA is the convenor.
- ▶ Untied funds are utilized primarily for cleaning the drains, purchasing Gemaxin/DDT sprays and for hiring manpower for DDT spraying and Chlorination/purchase of bleaching powder.
- ▶ VHSNCs are not involved in community based monitoring of health activities or village planning.
- ▶ Coordinated efforts between ASHAs, AWWs, ANMs and women's groups are attributed to MAARPU – a state initiative for convergence between health, ICDS and women groups to improve health behaviors and outcomes. Women's groups and Village organizations are actively involved and collaborate with the Anganwadi centers (AWC) in implementing the nutrition program called AMRITA HASTAM where the nutritious meals are provided for the pregnant women, lactating mothers and children every day.
- ▶ ASHAs are largely in- place but there is a shortfall of 2201 ASHA. Community representation in ST areas is a challenge.
- ▶ Training pace is slow and training quality of ASHA is variable.
- ▶ ASHAs are provided with HBNC Kit but her role in newborn care is still limited to breastfeeding and nutrition counselling
- ▶ ASHA's skills are weak on account of poor monitoring and supportive supervision for HBNC and delayed dissemination of HBNC guidelines to district and sub district levels.
- ▶ The state relies on existing structures to support the ASHA programme but poor orientation and lack of time hampers effective handholding and mentoring.

## UTTAR PRADESH


- ▶ VHSNCs were formed at Gram Panchayat level with ANMs and Pradhan being joint signatory in the committees. The role of the ASHA is limited.
- ▶ VHND services are limited to immunization of mothers and children.



- ▶ ASHA were active and motivated, but pace of training is slow. State has created a pool of 800 district trainers in the state to expedite ASHA training. Support structures are now being instituted at all levels.
- ▶ Drug kit replenishment is an issue with drug kits being replenished from block CHC/PHC level only. Door step delivery of contraceptives seen in Meerut was not possible in Shravasti as ASHA had no supply.
- ▶ An externally assisted Technical Support Unit provides support to the ASHAs in 25 districts and also facilitates the convergence platform for ASHA, ANM and Anganwadi (AAA platform) for improved health outcomes.
- ▶ ASHA awards are given annually at block level for best performing ASHAs
- ▶ Village Health Information Register (VHIR) has been introduced for ASHAs and modified in view of the new incentives & newer role of ASHAs in various health programmes.
- ▶ ASHA rest rooms are available only in some facilities.
- ▶ Grievance Redressal system and toll free number for ASHAs has been set up in the state. However in Meerut, the reports show poor reporting of grievances.

## UTTARAKHAND

- ▶ 15,431 VHSNCs have been established, with ASHA as the member secretary. Meetings are not regular and capacity building of PRI members is necessary. ASHAs in Uttarakhand are a very visible face of the programme, and the state has achieved its selection target.
- ▶ Training pace is good with trainings being organized in residential mode. The programme is supported by NGOs in each district acting as DARC. ASHA have been trained in topics such as disaster management, ARSH, RSBY, Maternal Death audits, and WIFS.
- ▶ The average monthly incentives amount to Rs.1500-2000. ASHA payments are through e-transfers, but there are long delays reported.
- ▶ Recall of key messages by ASHA is an issue indicating the need for additional refresher training.
- ▶ The ASHAs are required to maintain a diary and to fill in several formats but little monitoring or feedback of this is visible.
- ▶ Drug kit replenishment is a challenge.
- ▶ ASHA grievance redressal systems at district and block level appear to be limited to delay of payment, but the monthly meeting also serves as a forum.
- ▶ Well equipped rest rooms for ASHAs have been set up at all District hospitals
- ▶ Monthly meetings for ASHAs are held at the Sub-centres and PHCs with 80-90% of ASHAs attending the meetings.
- ▶ WEST BENGAL
- ▶ 1831 VHSNCs (Gram Unnayan Samiti) are in place against a target of 1896. Since PRI elections in 2013, no new training of newly elected members has been undertaken. ASHA has appears to have little role in the VHSNC.
- ▶ Monitoring mechanisms for VHND are in place. As per the data received from the State, 11839 meetings have been held out of the total 12673 planned.

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- ▶ There is a 20% gap in ASHA selection. ASHA selection is based on interviews with 90% weight age given for educational qualification and only 10% for other attributes.
  - ▶ The pace of training is slow with only Round II of ASHA Module 6 and 7 being completed. Trained ASHAs have not yet been provided with the HBNC kit.
  - ▶ ASHA receive a state level fixed incentive of Rs.1500 and incentives from NHM. The average monthly payment is about Rs. 1500-4000. ASHA payments are through E-transfer.
  - ▶ The state is still in the process of instituting support structures. Currently support is through existing mechanisms but this is sporadic. State has recently mandated Gram Panchayat health supervisors to play the role of ASHA facilitators.
  - ▶ No grievance redressal mechanisms exist in the state.
  - ▶ ASHA help desks exist in some facilities, but appear to be non functional.



## TOR 6

# Information and Knowledge

### Guiding Principles/Strategies of the NHM

- i. Enhance the use of Information and Communication Technology to improve health care and health systems performance (2.4.2.21)
- ii. Strengthen Health Management Information Systems as an effective instrument for programme planning and monitoring, supplemented by regular district level surveys and a strong disease surveillance system (2.4.2.22)
- iii. NHM envisages a fully functional health information system facilitating smooth flow of information for effective decision-making (5.13)

## KEY FINDINGS

### Health Information Systems

- ▶ All states are reporting facility-wise data into HMIS web Portal except for Tamil Nadu (due to lack of integration between local state system and HMIS Web Portal) and Kolkata-West Bengal (where urban facilities under Municipal Corporation are not reporting in HMIS). Few private and accredited private institutions are also participating in HMIS reporting across states. In comparison to previous years the quality and use of HMIS data has improved across states especially in those where local HMIS system is used for flexible data analysis and feedback.
- ▶ Punjab, Kerala, Odisha, Madhya Pradesh, and Bihar have reported duplication of data entry efforts in the absence of data exchange interface between HMIS Web Portal and local HMIS system. It has been observed across states that performance audit of the districts and the facilities are being done on the basis of HMIS data.
- ▶ HMIS data quality is still being affected by the use of non-standard registers especially at the secondary and tertiary care institutions. In addition manual compilation of HMIS reports from the register leads to computation errors as also reported by previous CRM reports. Integrated RCH register is made available at sub centre level, however ANMs find it cumbersome and expressed need for training to use these registers.
- ▶ Several functional health information systems were noted across states; most promising among them are Human Resource Management Information Systems (HRMIS)



in Bihar, Chhattisgarh, MP, UP, Odisha, Tamil Nadu, Kerala, Assam and Drug Vaccine Logistics Management Information Systems (DVLMIS) in Punjab, Rajasthan, Kerala, Tamil Nadu, Telangana. However multiplicity of information systems has also brought problems like increasing data entry burden and data duplication which is compounded by lack of interoperability among these information systems.

### **Mother and Child Tracking System (MCTS):**

- ▶ States' effort to make MCTS functional is appreciable. Distribution of Closed User Group (CUG) Sim cards to the ANMs for real time updation of services delivered via Unstructured Supplementary Service Data (USSD) gateway is in process. ANMs in few states (Chhattisgarh, Rajasthan, Punjab, Assam, Kerala, Telangana and Odisha) have started reporting via USSD.
- ▶ "Swasthya Seva Sandesh" initiative taken by Rajasthan has shown significant progress by sending almost 30 lakh SMSes to beneficiaries upto Nov'14.
- ▶ Progress on registration is fairly good across all states. However, the use of MCTS data by the states to close the gap in service delivery is still sub optimal.
- ▶ Effective monitoring and supportive supervision to improve tracking and follow up of identified beneficiary is a challenge.

### **External Survey:**

- ▶ Annual Health Survey (AHS) for the year 2012-2013 for nine high focus states and District Level Household Survey (DLHS-IV) for twenty one states that were conducted in the year 2012-2013 are available for review and planning.

### **SHSRCs and SIHFWs:**

- ▶ The role of SIHFWs is limited to planning, coordinating and conducting training programs across states.

- ▶ SHSRC are established in the state of Odisha, Chhattisgarh, Punjab, Kerala and West Bengal (Strategic Planning & Sector reform Cell SPSRC). Among these states Chhattisgarh has extremely well functioning SHRC with adequate human resource and is playing an active role in addressing health system challenges in the state. SHSRCs in Odisha, Punjab, Kerala and West Bengal are grappling with limited resources along with role clarity vis-à-vis state health society.
- ▶ NE-RRC in Assam provides technical support to all the North eastern states and also supports in capacity development and conducting health systems research.
- ▶ The availability of ANMTCs was not uniform across states. Where they were visited, the infrastructure needs up gradation.

## **RECOMMENDATIONS**

- ▶ HMIS Web Portal has helped to establish discipline of monthly facility-wise reporting across states. However a large number of states are also utilizing local HMIS systems. It is an appropriate time for HMIS Web Portal to be made interoperable with these systems to reduce reporting burden and allowing flexible reporting in HMIS Web Portal. Similar efforts should also be made to make HMIS and MCTS system interoperable so that duplicate reporting efforts are avoided.
- ▶ Various household surveys need to be streamlined to reduce overlap and improve information availability on all health system components. Information sources related to non-communicable diseases, communicable diseases and cause of death reporting need further strengthening.
- ▶ States are creating various Health IT systems to accommodate local data requirements. However these systems are created without rationalizing existing processes of data collection and reporting. It is extremely important that IT systems are developed following proper system requirement assessments to reduce duplication and process errors and follow semantic standards (Metadata

& Data Standards) to enable data exchange across systems.

- ▶ The data collection and recoding formats are not yet standardized at secondary and tertiary institutions. It is important that facility registers are standardized following basic semantic standards to provide quality input in all reporting systems.
- ▶ Use of data for decision making at local level needs to be strengthened further by using data from various sources and summarizing it in the local decision making context. This requires additional capacity building and support at local level.
- ▶ Skype based video conferencing is being set up in Adilabad district of Telangana to follow up

with service delivery and reporting at the facility (PHCs). This method should be scaled up to rest of the districts in and across the states as per feasibility.

- ▶ Despite nearly a decade of implementation of NHM, SHSRCs that were visualized as a key technical support mechanism are yet to be institutionalized with a few exceptions. Better understanding of their role vis-à-vis SIHFW and the State Health Society is needed. States are in a better position to articulate their technical assistance needs. They also need to consider existing institutions such as state medical colleges and other public health agencies, before making plans to strengthen SHSRCs.

## FINDINGS FROM STATES

### ASSAM

- ▶ All public health facilities are reporting data into the HMIS Web Portal and about 97% of facilities are reporting data into MCTS. HMIS Data is used at the district level for formulating the District health plan and is also used by various partner agencies for program review and monitoring. Feedback on 16 dashboard indicators is shared from state to districts and from districts to block. It was observed that there is a huge back log of data entry in MCTS and issues related to Internet connectivity persists throughout.
- ▶ Most of the ANMs were unaware of USSD method of data reporting. Though RCH register was printed, it wasn't distributed among the ANMs since the training on RCH register is yet to be done. Utilization of MCTS generated work-plan by ANMs is low.
- ▶ The role of the SIHFW is limited to providing venue for coordinating training/workshop on payment basis. The Regional Resource Centre (RRC), Guwahati is providing technical support to all North-Eastern States including Assam.
- ▶ Although Tele-radiology is available in the state; facilities in both CRM districts (Tinsukia and Karimganj) have yet to initiate this service.

### BIHAR

- ▶ Facility wise data is being reported in DHIS and from here data is being uploaded in HMIS Web Portal.
- ▶ HMIS is used as the single source of data for program monitoring and planning at the state and district level. Block Health managers provide regular feedback to the ANMs on data quality in weekly review meetings.
- ▶ MCTS is implemented in the state since 2012, but the progress of MCTS in terms of data updation is poor due to frequent log outs, session time outs and slow portal.
- ▶ ANMs did not receive MCTS generated work plans and Integrated RCH Register was not available at the SC.
- ▶ Other than GoI Web Portals, Sanjeevani- a Hospital Management Information System is being implemented in all the facilities above SC level. More than 2.28 crore patients have been registered till now.

- ▶ SIHFW is well equipped with good Infrastructure and adequate capacity. Various training were conducted by SIHFW in FY'13-14. However, there is shortage of technical staff at SIHFW.

## CHHATTISGARH

- ▶ HMIS data is used for ranking districts and blocks in order to assess their performance.
- ▶ Other than HMIS, e-mahatari (MCTS), Online Epidemic Reporting System 'Sachet' and HRIS are the other Health IT applications in the state.
- ▶ Mobile-based reporting in e-mahatari has enabled state to improve data reporting into MCTS.
- ▶ For reporting Vital Events, ANM has been recognized as the Birth registrar at all facilities; however the process is yet to be operationalized in the state.
- ▶ Online Epidemic Reporting System 'Sachet' is a good state initiative to enable practitioners in public as well as private domain to register and send information regarding occurrence of Infectious disease.
- ▶ SHRC in the state is playing a vital role in supporting health system strengthening.

## KERALA

- ▶ Data entry and reporting in HMIS/MCTS is being done by the JPHNs; who are well versed with computers and data entry in these systems is up-to-date.
- ▶ There are about 90% public facilities reporting data into HMIS Web Portal. Data from few accredited private facility is also being reported in HMIS web portal.
- ▶ Other than HMIS and MCTS, DHIS-2, EC Man, Sampoorana, Janani and Jatak, HRIS, SIMS are the other IT system functioning in the state..
- ▶ The State uses DHIS system as primary source for data collection and reporting however due to lack of integration between DHIS and HMIS Web Portal manually data entry is being done at the state level in HMIS Web Portal.
- ▶ There is under reporting of Maternal and Infant deaths. There is limited use of data generated from routine reporting systems by programme managers. However Jatak System has helped state to identify SAM and MAM children from the community, who are referred for higher level care.
- ▶ Manual record maintenance is weak- the severely anaemic cases were tracked through the Janani software in the district of Palakkad, but no line lists were available in the facilities.

## MADHYA PRADESH

- ▶ There is 100% facilities uploading data into HMIS Web Portal.
- ▶ Systems and processes for correcting and improving data quality seem inadequate.
- ▶ There was discrepancy in the HMIS and MCTS data. USSD services are used by the ANM for updating service delivery (barring two blocks visited due to connectivity errors). However, the ANMs were unaware of the proposed USSD incentive structure.
- ▶ Other than HMIS and MCTS, the state has more than 14 IT systems and all of them are functioning in silos, which need to be integrated for reducing duplications. NGOs are involved in supporting service delivery in the state. It is important to bring alignment and coordination in the activities for holistic management of services.



## MIZORAM

- ▶ Over reporting of data was observed at the facilities visited. Moreover, there is limited use of existing data in preparation of District Health Action Plans.
- ▶ It was observed that MCTS registers were maintained at the facility but the use of data for generating due list of pregnant women and work plans was limited.
- ▶ Limited internet connectivity and difficulty in merging Hospital data at the district level with the district consolidated report in HMIS were the other issues identified at the state.
- ▶ North East Regional Resource Center (NERRC) is providing technical support to the state for NHM implementation and strengthening the public health system.

## ODISHA

- ▶ Facility wise reporting is done in DHIS-2 and is then uploaded in HMIS web Portal. The overall reporting in MCTS is poor as compared to HMIS. There is limited utilization of Work Plans generated from MCTS.
- ▶ The verification of HMIS data before uploading it into the Web Portal is poor as MOI/Cs do not screen the data before approving it.
- ▶ SAS VDD software was installed at State HQ but uptake for data analysis is low.
- ▶ Record Keeping is not uniform. Nonstandard ANC, delivery and Immunization Register are maintained at many facilities
- ▶ ANMs received USSD training however this service could not start due to technical issues with mobile operator.

## PUNJAB

- ▶ To rationalize reporting across various programs the state has initiated integrated data reporting using DHIS. From this system GoI HMIS reports are generated and uploaded into HMIS Web Portal.
- ▶ The state has set targets for various services and HMIS data is used to monitor performance on these targets.
- ▶ MCTS data is being used by ANMs to generate their work plans. However, Supervisory monitoring of data needs to be strengthened. Birth registrations are being done online in the state.
- ▶ The State has adequate number of training centres; However the infrastructure needs upgradation for optimal performance of these centres..
- ▶ SHSRC is functional. However, there is a small team and a lack of role clarity. The SHSRC therefore is engaged in routine work of the State Health Society.

## RAJASTHAN

- ▶ The state has its own integrated Pregnancy Child Tracking System (PCTS) software for mother child tracking and line listing; and nearly 17,000 facilities are reporting data in the system since 2009. PCTS generated aggregate reports are uploaded in HMIS Web Portal. PCTS is also synchronized with MCTS portal.
- ▶ HMIS data is being used for monitoring and for planning at the state and district level but there are no targets set to assess performance. However reviews are held at frequent intervals.

- ▶ There are multiple IT systems in the state other than PCTS. This leads to duplication and poor data quality..
- ▶ Sonography centers are monitored on real time basis through tracking devices.
- ▶ Civil registration (births and deaths) is being done by local bodies, Gram Panchayat and there is no mechanism to engage the health department to improve registration of births and deaths.

## TAMIL NADU

- ▶ State government has created TN-HMIS which is used at state level for data collection and reporting. Due to lack of integration between HMIS Web Portal and TN-HMIS, facility-wise data entry could not be initiated in HMIS Web Portal. PICME is the local version of MCTS application in the state. However due to lack of auto sync between these two systems data, is found to be different.
- ▶ It is impressive that records of the beneficiaries are being entered and updated by VHNs through laptop and data card provided to them by the State Government.
- ▶ State Government has introduced several Web based IT application such as TN- HMIS, PICME, Hospital Management Application, Drug and Vaccine distribution system, MDR, DBT, NIKSHAY, IDSP, 108 and 104 services etc. However all these applications are functioning as silos with high levels of duplication.
- ▶ Birth and Death certificates are being issued by designated health officials or Panchayat Pradhans based on the data reported under PICME application. As private institutional births are not being reported in PICME; 100% registration of births could not be achieved.
- ▶ Integrated Village wise RCH register has not been introduced yet for reporting the service delivery at the HSC level.

## TELANGANA

- ▶ At the state, Deputy Director (Demography) is the nodal person for HMIS and MCTS. Position for State Data Manager or HMIS Consultant at the state is vacant.
- ▶ The state has started facility wise data reporting in HMIS Web Portal but reporting is inconsistent. Non Uniformity/Multiplicity in reporting formats maintained at the facilities is an issue.
- ▶ MCTS is operational in the state and is effectively utilized and line listing of high risk mothers and eligible couples is done through MCTS. However, all services provided are not being reported into MCTS portal.
- ▶ Orientation training of HMIS and MCTS to the Medical Officers is not done as reported by MO during field visit. Display of performance indicator is missing in PHCs as well as at SCs.
- ▶ USSD based entry has been initiated in the state. Verification of MCTS data through call centres is being done. Skype based Video Conferencing for follow up with PHCs from District HQ has been initiated in the state.
- ▶ It was observed that a large proportion of pregnant women access private facilities however their service utilization information is not reported in HMIS or MCTS.

## UTTARAKHAND

- ▶ The state has 97% facility wise reporting in HMIS web portal. The HMIS data is used for district review meetings. However during facility visit it was identified that monthly HMIS report did not match the physical registers at the facilities visited.

- ▶ Outlier analysis is being done for data validation, but data quality still remains a major challenge, while the districts generate RCH report from routine reporting data. There is mismatch with HMIS data.
- ▶ Uptake of new integrated RCH registers is slow and ANMs are finding it difficult to use these without training.
- ▶ The districts are reviewing the MCTS data quality by calling sample of beneficiaries and matching their details with the MCTS records.

## UTTAR PRADESH

- ▶ Currently all 75 districts of Uttar Pradesh are reporting facility level data in HMIS portal. SAS VDD is not being used by the State, although WRS is being used for monitoring purpose by state data officers.
- ▶ Sub Centre HMIS forms are available in Hindi. In MCTS, Work Plan is generated in English which is difficult for ANMs to understand.
- ▶ In MCTS, training of ANMs on USSD based reporting is being done but the reporting has not yet started due to technical errors.
- ▶ Use of MCTS data is done primarily for Routine Immunization services and monitoring of due vaccines. There is a need for Capacity building of the State, District and Block level officers on the Health IT applications functioning at the state.
- ▶ Maternal Death Review is not done as per guidelines, and the cause of death are not recorded in the registers.
- ▶ Audits are irregular and do not mention the cause of death most of the times. Audits are not done regularly, when done were without knowing the cause of death.
- ▶ PRC (Population Research Centre) is involved in the studies conducted by the state.

## WEST BENGAL

- ▶ All districts in West Bengal are reporting facility wise data on monthly basis in HMIS except Kolkata which is reporting Consolidated District data. HMIS data is being utilized by the state and the districts in PIP formulation and for facility performance assessment.
- ▶ MCTS is not fully used and there is a huge difference in the figures recorded in MCTS and HMIS. To overcome this USSD enabled mobile tracking by the ANM has recently been initiated in the state.
- ▶ Other than HMIS and MCTS the State has developed another software "Neonet"- A web based system used to monitor day to day activities of SNCUs.
- ▶ Registration of Births and Deaths is done by the Pradhans of Gram Panchayat in the rural areas and nominated officers in the municipality in urban areas. State Bureau of Health Intelligence does the final compilation at the state-level.
- ▶ SIHFW plays a pivotal role in conducting training programs. SPSRC has been instrumental in implementation of RSBY scheme, Clinical Establishment Act and Constitution of State Supportive Supervision team.





## TOR 7

# Health Care Financing

### Guiding Principles/Strategies of the NHM

- Establish Accountability Frameworks at all levels for improved oversight of programme implementation and achievement of goals (2.4.2.24)
- Support and supplement state efforts to undertake sector wide health system strengthening through provision of financial and technical assistance (2.4.2.1)
- Reduce out of pocket expenditure on health care, eliminate catastrophic health expenditures and provide social protection to the poor against the rising costs of health care, through cashless services delivered by public health care facilities, supplemented by contracted-in private sector facilities wherever necessary (2.3.5)

## KEY FINDINGS

### Finance Management and Administrative Capacities

- ▶ Financial and administrative power from State Health Society to District Health Society (DHS) has been delegated in most of the States.
- ▶ Digitalized office procedures through Digital Document Filing System at DHS has enhanced financial and administrative efficiency e.g. in Kerala.
- ▶ States like Bihar, Rajasthan, Madhya Pradesh and Assam still have vacant positions for finance and accounts. The key post of Director is still vacant in Bihar, Chhattisgarh, Kerala and Uttarakhand.
- ▶ Training in financial management under NHM has been provided at state, district and block levels.

In Rajasthan no training was undertaken at block level and in Bihar training was provided in 2013-14 only up to PHC level. No training in Public Financial Management System (PFMS) has been provided in Mizoram.

- ▶ Frequent change in software for reporting has left many accounts officers poorly trained.
- ▶ Shortage of staff and inadequately trained staff impact the financial management in terms of delays in allocation of budget to facilities; release of funds to ASHAs and beneficiaries; preparing Bank Reconciliation Statements (BRS) etc.

### Processes and Ease of Fund Flow

- ▶ In almost all the states funds are being transferred from state to the district level via Electronic

transfer (e-transfer). Direct beneficiary transfer (DBT) to the last facility and beneficiaries is being implemented in few states like Odisha, Punjab and Kerala.

- ▶ Cheque transfers are still being made in some states from District Health Society to CHC/PHC and also for ASHA and JSY beneficiaries. Delays in opening of bank accounts have led to further delays in fund transfer. Some states continue to use direct cash payments for ASHAs e.g. Kerala, Assam, Mizoram.
- ▶ The new banking guidelines issued by the Government of India have been implemented in all states. All required bank accounts have been opened except in Kerala, Assam, Telangana. Linking of bank accounts has just started in many states.
- ▶ The transfer of funds from State Health Societies (SHS) to District Health Societies (DHS) is still according to District Health Action Plan and activity wise instead of pool wise as in Uttarakhand, Kerala, and Tamil Nadu.
- ▶ Delays in fund transfer from SHS to DHS due to several reasons were observed, such as, absence of any standard operating procedure (SOP) for the new arrangement of money passing through treasury route since 2014-15 (taking between 60-90 days in states); untied funds not released e.g. in Uttar Pradesh as some vouchers were not certified; delays in receiving the state shares e.g. Bihar.
- ▶ Underutilization of funds was found in several states. Reasons noted were - money allocated for National Urban Health Mission was not utilized as the States have just initiated the scheme; transfers being made without considering the unspent balance already with DHS e.g. in Assam and Odisha; delays in transfers to ASHAs and JSY beneficiaries; and delays in release of untied funds.



### Measures for ensuring Accountability

- ▶ Statutory and concurrent audit is being conducted regularly covering all programs under NHM. However finalization of the reports is pending in most of the states. Most states have completed the CAG audit up to the FY 2013-14.

- ▶ TDS returns were filed on timely basis. In some states no uniform practice has been followed in TDS deduction for consultants e.g. Odisha, Uttarakhand.
- ▶ Most States accounted for and utilized interest earned on unspent balances as per guidelines of GOI. Interest earned at state and district levels are converted into grant and utilized on the PIP approved activities only.



### Financial Management and Monitoring

- ▶ States are maintaining books of accounts as per NHM guidelines.
- ▶ Majority of states maintain and prepare accounts through double entry book keeping system using the software Tally ERP 9. In Madhya Pradesh single entry system is used and in Telangana, Mizoram and at the District level in Tamil Nadu the accounts are still maintained manually. In most states over 50% agencies have been registered under Public Financial Management System (PFMS).
- ▶ In Punjab and Bihar TA/DA is being paid from the training programs as per the norms made by State Health Society taking into consideration guidelines from GOI. Bank Reconciliation Statement (BRS) was prepared on monthly basis in most states whereas in Bihar the facilities do not prepare the BRS on monthly basis. In Uttarakhand, the District Health Society has not maintained the Salary Register under any programme.
- ▶ In most of the states, physical progress is not captured in the FMR along with financial progress. Only Chandigarh, Odisha and West Bengal have reported both physical and financial data in the Financial Monitoring Report (FMR) and expenditures are monitored on monthly basis at all levels from state to blocks on the basis of SOE and FMR submitted by them.
- ▶ In some states expenditures on all programs are consolidated at state level and not at the districts, blocks and facility level.
- ▶ In Kerala and Assam, consolidated financial reports are not available in FMR and non-

compliance of rules was observed at facility level. Single signatory for use of untied funds was observed instead of joint signatories under GOI guidelines and no cash books are maintained for untied and annual maintenance grant funds at facility level.

### Trends in Costs of care

- ▶ In most states, the cost of care in public facilities (other than minimal registration charges) especially for students and BPL families is low. Most of the health care benefits such as drugs and diagnostics, consultation and counseling are being provided free of cost.
- ▶ However, interviews with BPL patients revealed they had to pay for drugs and diagnostics. This was due to unavailability of certain drugs and non-replacement by the pharmacist with an alternative. In Bihar, patients were not aware of availability of free diagnostics.
- ▶ User charges are implemented for secondary care and are deposited in the Rogi Kalyan Samiti (RKS) Accounts and are used for the benefit of patients.
- ▶ Patients mostly spend on transport. They are not utilizing the emergency care transport services available in several states. In some states, patients had to pay some amounts for services running on PPP models e.g. West Bengal.

## RECOMMENDATIONS

- ▶ Shortage of human resources and appropriate training for financial management and accounting at the state and district level needs to be addressed on priority basis. Training to all finance and accounting staff should be provided at district and block levels in the Tally ERP 9, Operation Guidelines and Model Accounting Hand Book.
- ▶ State should focus on the PFMS and use it to track availability and underutilization of funds at each level. Release and utilization under the selected activities like untied funds, AMG and RKS funds needs to be monitored. GOI guidelines need to be explained to all cadres of staff involved in planning of services and disbursement of funds.
- ▶ State should use PFMS for Direct Benefit Transfer (DBT) for ASHA and JSY incentives and salary to project staff. Bank Accounts for JSY beneficiaries and others should be opened on zero balance basis.
- ▶ Bank accounts should be maintained as per new guidelines issued by the Ministry of Health and Family Welfare. Allocations of funds from State Health Societies to District Health Societies should be done according to the pools.
- ▶ The States should submit timely the Statutory Audit Report and Selection of Blocks/Facilities for Concurrent Audit should be on rational basis.
- ▶ Documentation and maintenance of records/ vouchers needs to be meticulous. Journal Entry must be passed in the journal and supporting vouchers should be filed. All records should be filed in chronological order.
- ▶ Bank Reconciliation should be prepared on monthly basis at PHCs and CHCs. Unspent balance should be reconciled on monthly basis between State, DHS and CHCs/PHCs. Income Tax provision for deduction of TDS must be followed as per Income Tax rules and regulations.
- ▶ Health facilities below the district should report physical as well as financial progress on monthly basis.
- ▶ Supportive supervision should be made on regular basis to improve fund utilization and availability of services at the facility level. Action taken report should be prepared at DHS level for concurrent auditor observations.
- ▶ As the public health care system is moving towards achieving universal health coverage, the state governments should plan to waive user charges for all those attending public facilities. It is important to make available and raise public awareness about free transport, drugs and diagnostics.



## FINDINGS FROM STATES

### ASSAM

- ▶ Funds for VHSC for the FY 2013-14 were not transferred and RKS audits were not conducted since last three years.
- ▶ The fund flow from the State Health Society to District Health Society is based on the District Health Action Plan, which is not as per the requirement. The State also does not deduct the unspent balance of the District while releasing the funds for the next year which increases the Unspent balance.
- ▶ The state has not opened the bank accounts as per new Banking Guidelines either at State or at District Level.
- ▶ The concurrent Audit appointment is very late. Monthly state report is not submitted.
- ▶ The State Health Society is not maintaining the Cash and ledger Accounts separate for each programme. Only one cash book is maintained for all programmes.
- ▶ The expenditure of the District Health society and other agencies are not incorporated in the books of accounts.
- ▶ Presently the State is not accounting for the interest income in State, District and sub District.
- ▶ Expenditure reported in FMR is not tallied with Books of Accounts of the SHS. The State is not capturing the Physical progress in the FMR submitted to Gol. The Bank Account is operated by Single Signatory i.e. Addl. C.M. & H.O. (F.W.) at Additional Chief Medical & H.O. (F.W.).
- ▶ There is no cash book maintained for the united fund and AMG Funds at sub centre for the FY 2013-14 and 2014-15.

### BIHAR

- ▶ Post of Director Finance, State Account Manager, District Account Manager, 52 posts of Block Accountants and 48 posts of CHC/PHC Accountant are vacant. Training has been provided to finance personnel up to PHC level. Delegation of financial and administrative powers has been done as per GOI guidelines.
- ▶ District Health Societies and Rogi Kalyan Samities (RKS) of various health facilities have been registered.
- ▶ Time taken by the state treasury for release of funds is more than 90 days. National Urban Health Mission has just initiated in the State hence most of the funds are not utilized. Bank accounts for several programmes as per the new guidelines are yet to be opened.
- ▶ Funds are being transferred from State to District, District to Block on the basis of the approved budgetary allocation for execution of approved activities. More funds have been allocated to high priority districts in comparison to other districts for addressing the equity concerns.
- ▶ Statutory audit for the year 2013-14 been completed. Concurrent auditor for the year 2014-15 has been appointed in all 38 districts. Direction for the re-appointment of concurrent auditor issued by state and not by the district. Statutory provisions of income tax have been complied. Interest earned against NHM funds has been accounted for.
- ▶ Maintenance of records/books of accounts/reporting are maintained based on double entry system through the accounting software of Tally ERP 9. In Patna district most facilities do not prepare Bank Reconciliation

Statement (BRS) on monthly basis; do not separate BRS for each account; cheque issue register is not being maintained properly.

- ▶ Rogi Kalyan Samiti (RKS) ledger is not being maintained making it difficult to know the purpose of fund utilization; in some PHCs RKS funds are not being entered in the books of accounts though separate cash book is available.
- ▶ JSY payments are being done through account payee cheques and delay (up to 4 months) in payment was found.
- ▶ Physical progress is not being reported by the blocks and district along with the financial progress in the Financial Monitoring Report (FMR). Progress on implementation of Public Financial Management System is not satisfactory in terms of increasing the coverage of agency registration and filing of expenditure etc.
- ▶ Drugs and diagnostic facilities including consultation and counseling are being provided to the general public free of cost. In Madhubani district, there were instances when the patients had to pay for drugs and diagnostics even though they were BPL patients. This was due to unavailability of certain drugs and non-replacement by the pharmacist with an alternative. Majority of patients were also not aware of free diagnostic facilities.

## ■ CHANDIGARH

- ▶ Almost all sanctioned posts are filled with respect to Finance and Accounts. State has not imparted any Finance Management trainings since FY 2010-11. Delegation of Financial and Administrative Powers has been followed.
- ▶ Accounts for NUHM have been opened recently, New Banking Guidelines need to be implemented yet. Funds transfer to the Units is via Account Payee Cheques only and not e-transfer system.
- ▶ CAG audit has been done in FY 2012-13 and FY 2013-14. The Concurrent Audit report for 1<sup>st</sup> and 2<sup>nd</sup> quarter of current year has not been submitted. Statutory Audit Report has been delayed. Compliance to deduction and deposit of TDS needs to be strengthened. TDS deposits and returns were filed on timely basis.
- ▶ Cash Books and Ledgers were duly prepared, but were not signed and updated. It was observed that the Fixed Asset and Stock Register have not been maintained properly.
- ▶ Both physical and financial data have been reported in the Financial Monitoring Report (FMR).
- ▶ Integration of all programme division (NDCPs & NCDs) with SHS has not taken place. Bank Reconciliation Statement has been prepared on monthly basis but Authorized signatures were not found in some statements.
- ▶ Neither customized Tally ERP 9 nor any other licensed accounting software has been operationalized.
- ▶ Direct Benefit Transfer has not started. Filing of expenditures and FMR generation through PFMS was not observed.
- ▶ Delay in JSY Payments to beneficiaries was observed. Payment is still being made through Account Payee Cheques instead of PFMS.
- ▶ In FY 2014-15, utilization (as on 30.09.2014) against its approved activities was only 38% and 45% under RCH and Mission Flexible Pool respectively.

## CHHATTISGARH

- ▶ Finance personnel at State and District level are adequate but the sub-district staff lacked training in financial management system under NHM. In most of sub-district facilities visited, financial records apart from the cash book and BRS, are not being maintained. In some institutions single entry system of adjustment of advances in the cash book was found. Only 54% agencies have been registered under PFMS.
- ▶ There has been considerable delay in fund release from the state treasury. The state has made provision of funds in the district PIPs for the FY 2014-15 under NUHM.
- ▶ Bank accounts have been opened as per new banking guidelines, but the procedure for flow of funds to the district and block level is not being fully implemented.
- ▶ Both the statutory and the concurrent audit are not being conducted as per prescribed timeline. The State is yet to submit the statutory audit report for the FY 2013-14 to Gol. The Districts have not received the concurrent audit report for Q1 of FY 2014-15 and audit for Q2 of FY 2014-15 is yet to be started. The statutory audit report 2012-13 has not been placed in the Governing Body's meeting.
- ▶ The maintenance of records/books of accounts at district level was satisfactory. In some block level facilities high cash balance was being maintained on account of family planning camps, training etc.
- ▶ The customized version of Tally ERP 9 software is being used at the District level but not at most of the sub district institutions.
- ▶ Payment to JSY beneficiary is being made through A/c payee cheques. Considerable delay in payment of incentive to ASHAs was found. In some cases cash disbursement of incentives were also reported.
- ▶ Physical progress against the financial achievement is not being reported in the FMR. Districts revealed under-utilization of funds.
- ▶ The user charges collected at all the institutions are being deposited in the JDS (RKS) accounts and are being properly utilized. Most of the population, especially students, APL and BPL card holders get exemption from the user charges levied for various services at the facilities.

## KERALA

- ▶ State has vacancies for positions of Director Finance, State Finance Manager, and State Account Manager. Financial management at Sub district levels are being handled by general staff and others with minimal experience in handling of financial matters.
- ▶ State has digitalized office procedures through Digital Document Filing System at DHS. This has enhanced administrative efficiency.
- ▶ State has a functional system of Electronic transfer of funds from DHS to the facilities (Blocks/CHCs/PHCs). However, in many facilities a delay in transfer of funds from State level was observed.
- ▶ The banking guideline issued by the Ministry for opening of Group Accounts pool wise and scheme wise have not yet been disseminated by SHS to the districts.
- ▶ Benefits are provided to all women delivering in public health institutions whereas as per Gol guidelines payment should be only for BPL/SC/ST. During the FY 2013-14, only 43% of the deliveries were paid through DBTs while others remain unpaid.
- ▶ ASHA Incentives have not been paid since April, 2014. ASHA payments at Sub district levels are being made through Lady Health Inspector instead of Electronic transfer (district Ernakulam).



- ▶ The expenditure details of funds for Ward Sanitation are not available at the respective CHCs/PHCs. (district Ernakulam). Single signatory were used for operating of accounts instead of joint signatories as per GOI guidelines. No reconciliation with Bank statements at CHCs, PHCs, SCs (Agali Block).
- ▶ Integration of all vertical programmes under NHM viz. NDCP and NCD pools is yet to be done, as consolidated financial reports in FMR and SFP are not available.
- ▶ Pool wise distribution of funds has been not done yet by SHS to the periphery. Sub Centres are running with nil balance as untied funds & Annual maintenance grants are not available. (SC Gonchiyoor, Agali Block). ANMs in Sub centres reported incurring expenditure from their own pockets. Non-compliance of rules and regulations was observed at facility level for procurement of services and goods under NHM.
- ▶ Health care facilities are being provided either free or at a very nominal fee.

## **MADHYA PRADESH**

- ▶ Posts of State Finance Manager, 43% of District Accounts Manager, 19% of Block Accountants and 70% of CHC/PHC Accountants are vacant. Training to accounts personnel is provided at both District and State levels.
- ▶ CHC/PHC accountants are maintaining books of accounts on single entry system instead of the double entry system. Cash Book was maintained manually at all levels.
- ▶ Electronic funds transfer system is being used in the State up to CHC/PHC level. Flexible Pool funds are transferred under NHM to DHS/CHC/PHC levels.
- ▶ Bank Accounts have been opened as per MoHFW guidelines for opening of Bank Accounts in Main Group Bank accounts and Sub Group Bank accounts.
- ▶ ASHA incentive and JSY beneficiary's payment is done through e-transfer and delays were observed in disbursements due to delays in opening of bank accounts by beneficiaries.
- ▶ Funds of National Disease Control Programmes are transferred from SHS in Sub Group bank accounts of concerned disease control programme at the District level.
- ▶ State has implemented the Concurrent Audit system in 2014-15, and the auditor has submitted the quarterly concurrent audit report for June 2014 to SHS. State has submitted the statutory audit report for FY 2013-14.
- ▶ The State has issued delegation of financial powers up to Sub centre level. Bank Reconciliation Statement are prepared at State/DHS levels. Consolidated FMR was not prepared at the state level through Tally ERP 9.
- ▶ Districts Health Societies are sending their accounts in FMIS software to state health society. State has not sent the books to DHS and to CHC/PHC/SHC/VHSNC level,
- ▶ Expenditure incurred in the State up to June 2014 was about 10.3% of approved PIP. No shortfall is noted in state share contribution up to FY 2013-14.

## **MIZORAM**

- ▶ There is no shortage of accounts personnel in the State at any level. Delegation of financial powers had been done at all levels. The State has not conducted PFMS training at any level in the State.
- ▶ The State has low utilization in programme budgets. Less than 50% expenditure has been reported under District Action Plans (Including Block, Village). It is observed that district health societies in the state

have not created their annual PIP/annual action plan. The State should take necessary steps for registering and separate audit for all the RKS.

- ▶ The SHS has transferred funds to all District Health Societies, activity-wise instead of programme wise under RCH & MFP. The funds from DHS to PHC/CHC are being released in cash for different programmes instead of PFMS, e-transfer or through cheque.
- ▶ The State Health Society had not taken into account the unspent balance as on 31<sup>st</sup> March 2014 while releasing the fund to districts.
- ▶ State has delayed the appointment of auditor for the FY 2013-14. As against the date of submission of audit report on 31<sup>st</sup> July, 2014 the appointment of the auditor is done in the m/o August, 2014.
- ▶ Books of Accounts under NHM are being maintained manually and not supported with Ledger Account or with supporting documents. Cash transaction is observed at all levels below SHS. Cheque issue register was not properly maintained.
- ▶ Funds from sources like renting of Staff Quarters & Ambulances have not been accounted for in some PHCs. The State Finance division has not conducted any financial monitoring for 2 years at district and sub-district level.
- ▶ There is complete absence of integration of RCH, Mission Flexi pool and all other programmes under NHM. JSY/JSSK payment has been made through cash at PHCs visited.
- ▶ RSBY & Mizoram State Health Care Scheme (MSHCS) - MSHCS was introduced in 2008 and a network of empanelled public healthcare facilities and private hospitals (for both APL & BPL). Sum insured for MSHCS is up to Rs. 3 lakhs. People are well aware of this scheme.

## ODISHA

- ▶ Almost all sanctioned posts are duly filled up to the District level with respect to Finance and Accounts. Delegation of Financial and Administrative Powers was seen at almost all visited facilities.
- ▶ District Health Societies (DHS) and respective Rogi Kalyan Samitis (RKS) have been registered.
- ▶ Financial allocation to HPD district as per norms of GoI is done. Accounts of City Health Societies (CHSs) have been opened. 75% of funds under NUHM have already been released to State Health Society.
- ▶ High proportion of advances observed against the total unspent balance which is 66% in Ganjam district and 81% in Kalahandi District. All the funds are being transferred from the State to the Districts via e-transfer.
- ▶ Audit reports of NHM and SHS up to 2011-12 have been placed in the Executive Committee & Governing Board. CAG Audit has been done and also performance audit of NHM from 2007-08 to 2012-13 in 2013-14. Statutory Audit Report is yet to be received at GoI level for the year 2013-14.
- ▶ Interest earned at State & district levels are converted into grant and utilized on the PIP approved activities only. No uniform practice has been followed in TDS deduction for consultants. Compliance/Review Action Taken Report with respect to IPAI observation report was pending.
- ▶ Cash Books and Ledgers were duly prepared. No cash balance was noticed. Both physical and financial progress is accounted for in the Financial Monitoring Report (FMR).
- ▶ Fixed Asset and stock Registers have been maintained. Bank Reconciliation Statement has been prepared. Credit Vouchers need to be prepared. Neither customized Tally ERP 9 nor any other licensed accounting software has been used, the State has developed ERP based accounting software recently and implemented.

- ▶ State is showing good performance in Agency Registration under PFMS. DBT is also observed. ASHA payment through PFMS is yet to start. Integration of all programme divisions (NDCPs & NCDs) with SHS has been done. There was a delay in payment to JSY beneficiaries.

## PUNJAB

- ▶ Accounts personnel have been positioned at all levels. Delegation of financial and Administrative powers has been done as per GOI guidelines. Training in Financial Management under NHM has been provided at all levels.
- ▶ PFMS Registration of all DHS and 65% RKS has been completed.
- ▶ Funds are being released to implementing agencies on the basis of the approved activities in the PIP. For the financial year 2014-15 mandatory grants have been allocated to the extent of 50% of the total allocation and the rest to be allocated considering case load.
- ▶ Funds transferred to the DHSs for the financial year 2013-14 and 2014-15. National Urban Health Mission (NUHM) has just been initiated in the State hence funds are yet to be utilized.
- ▶ The new banking guideline issued by GOI has already been implemented at State and District level. All required bank accounts have been opened. E- Transfer of funds is implemented up to block level. Transfer of funds through Direct Beneficiary Transfer (DBT) to the last facility is a good practice.
- ▶ Regular concurrent audit/Statutory audit/AG audit has been completed covering all the programs under NHM. The CAG audit up to October 2013 has been done. Concurrent audit for all districts has been completed. Statutory provisions of income tax have been complied. Interest earned against NHM funds has been considered as Grant in Aid and accounted for the same.
- ▶ Maintenance of books of accounts was satisfactory. JSY payments have been done through cheques except in the district (SBS Nagar) where DBT has been adopted. JSY payments remained withheld in DH, Sangrur. TA/DA is being paid from the training programmes as per the norms made by SHS as per GOI. Physical and financial progress is not captured in FMR at District level. The license for tally requires renewal. Training of staff is required for implementing PFMS in the State for NHM programme.
- ▶ User charges are being collected for secondary health services in the health facilities under the control of Punjab Health Systems Corporation. Most of the medicines, consumable and diagnostic tests are being provided free of cost to the patients.

## RAJASTHAN

- ▶ Training of finance and accounts staff at block levels has not been undertaken since 2010. Guidelines on financial powers are being followed.
- ▶ All RMRS are duly registered with the Registrar of Societies. All units are regular in providing UC/SOE on monthly basis.
- ▶ At the State and district level, bank accounts have been opened as per new Banking guidelines issued by GOI on 10th March 2014. The State is regularly following up the status of all advances.
- ▶ Auditor has issued separate audit report for each district consolidating all the programmes of NHM. Institute of Public Auditors (IPAI) has done a financial review in the state covering two districts (Udaipur and Chittaurgarh). Concurrent Audit at state and districts has been completed.
- ▶ Books of Accounts are being maintained regularly till the Sub centre level. Payments for JSY and ASHA incentives are being made through Account Payee Cheques only.



- ▶ Reporting of Physical Progress is not being done for activities such as family planning. Expenditure of all the programmes is being consolidated at state level but not at district level. Concept of RKS through Rajasthan Medical Relief Society (RMRS) at each facility is functional.

## TAMIL NADU

- ▶ All financial management staff is in place, only 25 positions are vacant. Three batches of training on PFMS have been conducted during the year 2014-15. The delegation of financial and administrative powers has been done.
- ▶ All NRHM bank accounts (except PWS) operated on single signatory, not in line with guidelines. Renewal of registration of PWS (RKS) is under process.
- ▶ Funds are being released by the State Health Society to lower levels electronically except in Madurai District. Funds are being released activity wise instead of pool wise to Districts and Blocks. The District is getting 50% of the untied fund in the beginning of each fiscal year. Based on the utilization within the first six months, the State releases the balance amount after six months based on expenses incurred and utilization against approved activities.
- ▶ Funds under NUHM have been released to districts in the year 2014-15. The State has not implemented banking arrangement guidelines regarding group bank accounts by the Gol.
- ▶ No concurrent and internal audits have been conducted since March 2014. Statutory Audit for the year 2013-14 is completed in the State and District Audit Reports submitted by the State is not complete. There is substantial delay in the appointment of concurrent auditor for District Health Societies for the year 2014-15. Delay in appointment of concurrent auditor defeats the purpose of concurrent audit system.
- ▶ Double entry book keeping system is being followed at district level and facility level. Manual books of accounts are maintained at block level and facility level. It is observed that in the State all payments to JSY beneficiaries are made through bearer cheques instead of A/c payee cheques.
- ▶ In Kancheepuram District, no facilities are collecting user fee for services. However in Madurai district pregnant women are incurring expenditure on transportation.

## TELANGANA

- ▶ Some posts of financial personnel are vacant at SPMU. All RKS have been registered. Financial powers have been delegated from State health society to district level and below. The allocation to high focus districts is 30% more than the non high focus districts.
- ▶ The e-transfer has already been implemented to sub-centre level. The State of Telangana has implemented new banking guidelines at SHS but at DHS, Adilabad is yet to open bank accounts as per new banking guidelines.
- ▶ Statutory Audit Report, 2013-14 has not been submitted. The Concurrent Audit has been completed for 2013-14 but audit report is yet to be submitted to state. IPAI has completed audit report and action taken has been sent by the state to district Adilabad.
- ▶ Manual Books of accounts have been maintained by the state and districts which have been updated. Cash book has been updated.

- ▶ Payment to JSY beneficiaries are being made through Direct Beneficiaries Transfer (DBT-PFMS) in district Adilabad. In district Medak the payment to JSY beneficiaries is through bearer cheques, and delays up to one year are reported in making payments.
- ▶ State and DHS, Adilabad and Medak are not reporting physical progress report in the FMR.

## UTTARAKHAND

- ▶ Rogi Kalyan Samiti registration certificates were not renewed at most of the SDH/CHC/PHCs. Financial Power has been delegated from State Health Society to districts and sub-district levels. The District Health Society Almora and Tehri completed 80% registration under PFMS.
- ▶ The transfer of funds is through e-transfer until PHC level. Bank reconciliation has been prepared by the District Health Society Almora and Tehri for RCH and MFP as on 31<sup>st</sup> October 2014.
- ▶ The District Health Society has not maintained the Salary Register under any programme. District Health Society Tehri is using DBT for JSY beneficiary payment.
- ▶ The State has submitted audit report for the year 2013-14. As per the report, District Health Society has not maintained records as per guidelines. Concurrent Auditors have been appointed for 2014-15 by the SHS and DHS. Concurrent Auditors are not visiting the peripheral units since last 2-3 years. There is also no compliance to the observations made by auditor.
- ▶ Books of Accounts are being maintained properly as per guidelines at SHS/DHS/PHC/CHC/SC Level and were updated till 30<sup>th</sup> October, 2014. Tally ERP 9 is being used. Group Bank account has been opened in both the District Almora and Tehri.
- ▶ CHC and PHC level vouchers of cash/bank transactions are not properly maintained. The Financial Registers as well as Bills are not being signed by MOIC at any level. SoE is not being signed by MOIC at any level. Some PHCs are not deducting TDS on payment to contractor; also the return of TDS has not filed. The Model Accounting Handbooks are not being implemented.

## UTTAR PRADESH

- ▶ There are vacancies for District Account Managers, Senior Manager- Finance at the State level. The fund utilization in 2014-15 is only 41% in Meerut district and 33% in Shrawasti district (below state average).
- ▶ E-transfer is implemented by the state up to Block PHC level. Funds for VHSNCs are paid through cheques to bank accounts of the respective Sub Centers as there is no separate VHSNC bank account. Untied Funds for FY 2013-14 are still not received by almost all the Sub Centres and VHSNCs. In Shrawasti District, vouchers for expenditure incurred from the untied funds were not certified. (CHC- Hariharpur Rani).
- ▶ Tally ER 9 has been implemented up to block level. However accounts balances were not tallied with the balances of accounts in tally software. Pass books were not updated regularly at the blocks (CHC-Sardhana, Meerut). Cash book was available in all the facilities visited but were not being entered in some.
- ▶ PFMS registration is completed in 72% of the facilities. JSY payment is being done through account payee cheques.
- ▶ The State has re-appointed the Statutory Auditor of 2012-13 for F.Y. 2013-14 on 12.05.2014 and even then the state has not submitted the Statutory Audit Report in time. The State has appointed the Concurrent

Auditor for the state level and at all the districts for 2014-15 in the month of October, 2014. Compliance on the observations of the IPAI audit is pending from the state level and from the district level. Out of registered RKS, audit is completed in 62% only.

## **WEST BENGAL**

- ▶ 93% of the sanctioned posts for finance personnel have been filled up. However trainings are due for newly appointed personnel. Delegation of administrative and financial power in detail has been issued from State Health Society. RKS registration is undergoing at districts & block levels.
- ▶ The State shows an increasing trend of expenditure under NRHM since the beginning of NRHM. The total NHM funds utilization were consistently more than 100% of the releases made by GoI in last 5 years.
- ▶ The funds are transferred through E-transfer (RTGS) mode to all levels. No Utilization Certificates are pending for submission to GoI regarding the fund utilized upto the FY 2013-14.
- ▶ Expenditures are monitored on monthly basis at all levels from State to Blocks on the basis of SOE and FMR submitted by them. Route for allocation of funds under NUHM has been through municipal corporations. In all cases there is dedicated bank account for NUHM and the fund is kept in that account.
- ▶ Appointment of auditor is done as per guidelines of GOI through open tendering system. Statutory audit of State health society up to FY 2013-14 has been completed and audit report has been submitted to GOI and placed in the meeting of the Governing Body.
- ▶ Concurrent Audit system has been implemented up to Block level. Interest earned on unspent balances is utilized after taking decision in State Health Society/District Health Societies as per Guidelines Issued by GOI. TDS Return and Income Tax return of State Health Society and District Health Societies are regularly filed.
- ▶ The Cash Books for all programs are maintained physically and journal and ledger regarding fund received and expenditure are recorded on Tally ERP 9, up to block level.
- ▶ The accounts of State, District and Block Health Societies are prepared on cash based double entry accounting system and Tally ERP 9 (100 percent coverage all districts).
- ▶ Payment guidelines for JSY beneficiaries are not being followed as in most cases bank refused to open the zero balance account and also there are mothers below 18 years old.
- ▶ PFMS status – (1) Registration of agencies are under process and registration has been completed about 80% up to Sub centre level. (2) DBT payment has been taken up as pilot project in Howrah district.
- ▶ No User Charges are being levied for the services provided at public health facilities at all levels except those services which are run on PPP model. However patients still incur expenditure on medicines at public health facilities.





## TOR 8

# Quality Improvement

### Guiding Principles/Strategies of the NHM

- i. Every facility would have a quality management system in place to ensure quality assurance in all services (5.2.6)
- ii. The quality standards would follow national guidelines and allow for scoring quality achievements of each facility (5.2.6)

## KEY FINDINGS

### Planning and Implementation of Quality Assurance activities at State, District and Facility levels

- ▶ Orissa, Madhya Pradesh, Bihar, Uttar Pradesh have selected facilities for rolling out the National Quality Assurance Programme, but the others are yet to do so.
- ▶ Reconstitution of District Quality Assurance Committees and Units committees has not been done in any state except Madhya Pradesh, Uttar Pradesh and Orissa. Partial steps have been taken in Bihar and Chandigarh. It is observed that states are reconstituting the committees but there are concerns over the pace.
- ▶ Training and capacity building has been identified as a key strategy in the operational guidelines. Efforts have been taken up in Kerala, Assam, Uttar Pradesh and Bihar. States like Punjab, Uttarakhand, Chhattisgarh, Rajasthan, Mizoram, and Telangana and Rajasthan, Chandigarh,

Rajasthan, Madhya Pradesh and West Bengal are yet to streamline capacity building and training for the implementation of National Quality Assurance Programme.

### Measures for ensuring quality of care at public facilities

- ▶ Bio medical waste management, an important attribute of Infection control needs attention. Services for Bio Medical Waste (BMW) management have been outsourced in most public health facilities. Concerns related to collection, segregation, transportation were found in majority of the public health facilities during the review.
- ▶ Adherence to standards for Bio medical waste segregation was found to be appropriate only in Kerala and Rajasthan. The biomedical waste management was acceptable in the district hospitals in Mizoram but proper segregation was lacking in CHC as well as PHC. Outsourcing of sanitation services to third parties was seen



across all states visited. In UP, bio medical waste management is well managed. The staff is well versed with waste management protocols.

- ▶ The status of cleanliness and sanitation is relatively poor in the healthcare facilities of all states except Kerala which is reasonably clean. Upkeep of toilets was found to be unsatisfactory in West Bengal.
- ▶ Adherence to Standard Treatment Protocols needs improvement across states.
- ▶ The practise of capturing patient satisfaction through surveys was observed in Punjab, Kerala and Madhya Pradesh, but is yet to be initiated in Assam, Uttarakhand, Chhattisgarh, Orissa, Mizoram, Telangana, Bihar and Rajasthan.
- ▶ Reporting and analyses of key performance indicators has to be strengthened across states. Audits like medical audit, prescription audits as well as death audits need to be implemented to avoid the gaps.



### Grievance redressal mechanism

- ▶ Grievance redressal mechanisms are weak across states. In Rajasthan complaints/suggestion boxes exist but the mechanism to analyse and address the issues is absent, while many states do not have any complaint/suggestion boxes for the feedback of the patients. Kerala does have Suggestion boxes in hospitals for patients to share the grievance and these are opened once in a month which ensures monitoring. States like Madhya Pradesh have

Samvand Setu Yojna an indigenous scheme for grievance redressal launched by state. The scheme identifies authorities for grievance redressal at various levels, from the Principal Secretary and Health Commissioner at state level to CMHO at district level. Similarly in UP Grievance redressal mechanism is established. Committees are formed at DH & CHC level facilities for reviewing the complaints. A centralized call center has been established at State level with a toll free no.1800-180-5145.

- ▶ Community awareness on helpline number was low in the districts. In West Bengal Grievance redressal mechanisms were available but they were largely restricted to grievance boxes, which remained unopened and the details of the issues raised by staff or general public were not available in many institutions.

## RECOMMENDATIONS

- ▶ It is suggested that the state may prioritize the certification process and identify facilities for successful implementation of the quality assurance programme.
- ▶ State specific roadmap with a realistic time frame needs to be prepared, considering that critical factors like capacity building, number and level of the targeted facilities, supportive supervision and quality improvement activities are to be undertaken in due course of time
- ▶ The reconstitution of state and district quality assurance committees needs to be done on priority basis.
- ▶ Conducting patient satisfaction surveys by the method of random sampling from OPD and IPD should be undertaken to assess the quality of services, based on the findings. Low scores need to be addressed with a specific time bound action plan.
- ▶ Monitoring and analysis of KPI's (key performance indicators) has to be done on monthly basis and the data generated should be used for decision making process for allocation of resources based on demand.

- ▶ In order to make the systems more efficient and robust, Prescription, and Medical and Death audits should be carried out in the facilities, with corrective and preventive actions being implemented on the basis of the findings.
- ▶ To provide patient centric care at the public health facilities a grievance redressal mechanism needs to be established and implemented.
- ▶ Infection control methods like Bio-medical waste management needs to be strengthened, regular reviews need to be taken by the facility in charge to ensure compliance.
- ▶ Hand washing practices, physical standard methods of sterilizations should be implemented by indicators (biological/physical/chemical) checks.
- ▶ Internal Quality Assurance Programmes like regular monitoring, implementation of housekeeping checklist, conducting internal assessment at periodic intervals, mock drills etc. needs to be implemented.
- ▶ External Quality Assurance activities like validation of lab tests, calibration of equipment and instruments, monitoring of radiation exposures by the TLD badges needs to be done on regular basis.
- ▶ To address skill gaps, training needs assessment should be conducted at periodic intervals at the facility level. The training evaluation of the participants and trainers has to be recorded for improvement purposes.

## FINDINGS FROM STATES

### ASSAM

- ▶ SQAU (State Quality Assurance Units) and DQAU (District Quality Assurance Units) are yet to be established.
- ▶ No Awareness training, service providers training and Internal Assessors training have been conducted in the state.
- ▶ Facilities are not monitoring their KPIs (Key Performance Indicators).
- ▶ Medical and death audits are not being conducted.
- ▶ Public health facilities are yet to establish standard operating procedures (SOPs) and work instructions.
- ▶ None of the laboratory external quality assurance program.
- ▶ Biomedical waste management is a major area of concern. Segregation, Collection, transportation and disposal of biomedical waste are not as per Biomedical Waste (Management and Handling) rules 1998.
- ▶ Infection control practices are weak the Lab technicians and staff in Injection/Dressing room are not using PPE (Personal Protective Equipment-Gloves, Caps, masks etc.).
- ▶ There are no standard protocols for Sterilization and disinfection.

### BIHAR

- ▶ State has undertaken QI intervention during 2014 in 36 DH, 30 FRUs, 35 L2 PHCs & 2 maternal units of medical colleges under National Quality Assurance Standards Guidelines (NQAS) guidelines, and the gap assessment has been done for them.
- ▶ The state has initiated the process of conducting trainings as per the operational guidelines for quality assurance



- ▶ The processes for grievance redressal mechanisms were also found to be not well defined and were more informal.
- ▶ The bio medical waste management is not done as per the guidelines.
- ▶ Due to irregular waste collection, pits made at the facility are being used for bio medical waste disposal, and are badly kept, without adherence to standard guidelines.
- ▶ Diet supply is outsourced and quality is an issue.
- ▶ Signage's for patient information and entitlements of services, grievance redressal mechanisms, essential drug list etc are not seen in place
- ▶ Displays on JSY or JSSK entitlements were seen in most places.
- ▶ List of drugs available is displayed in most of places, but essential drug list was not displayed,

## CHANDIGARH

- ▶ The reconstitution of the committees State as well as District Quality Assurance is under process
- ▶ State has not proposed any trainings as per the operational guidelines of Quality Assurance
- ▶ Patient Satisfaction survey is not a regular activity in the facilities. Patient Satisfaction are carried out in the facilities of Punjab by School of Public Health, PGIMER Chandigarh
- ▶ State does not have institutionalized Grievance Redressal Mechanism in place

## CHHATTISGARH

- ▶ Biomedical waste was being segregated at the source but color coded bags were not available and disposal is not done as per the guidelines.
- ▶ Infection control practices are lacking in the facilities. Proper equipment sterilization facilities are not available in all the facilities which pose a serious threat for the staff as well as the patient.
- ▶ The facilities do not have a policy for expiry and near expiry drugs
- ▶ Facilities does not have any mechanism for equipment management, calibrations, AMC, CMC is not done.

## KERALA

- ▶ The bio medical waste segregation in Kerala is as per the guidelines. BMW is outsourced at the district level. Deep pit burial method is common in the SDH.
- ▶ The Standard Treatment Protocols are formulated in the facilities and are displayed.
- ▶ The facilities in Kerala have grievance redressal mechanism in place, complaints/suggestion boxes are present in facilities which are opened once in a month.
- ▶ Patient satisfaction surveys are carried out in facilities.
- ▶ State has taken several initiatives in order to improve the quality of services like NABH Accreditation and formulation and implementation of Kerala Accreditation Standard for Hospitals but sustainability is an issue.

- ▶ The housekeeping services in Kerala are fair; the labor rooms of the district hospitals were clean and well maintained.
- ▶ Neither the State nor the District Quality Assurance Committee has been reconstituted in Kerala.
- ▶ Accredited facilities have formulated various committees in the facility, but these facilities do not have a comprehensive road map.

## **MADHYA PRADESH**

- ▶ The reconstitution of state as well as district quality assurance committee has been done as per the operational guidelines of quality assurance in public health facilities
- ▶ The state has prepared a road map and selected facilities for implementation of the National quality assurance programme
- ▶ Reporting and analysis of Key performance indicators has not been initiated as per the operational guidelines
- ▶ Patient satisfaction surveys are being conducted only in 16 districts supported by MPTAST.
- ▶ Samvand Setu Yojna is an indigenous scheme for grievance redressal launched by state. The scheme identifies authorities for grievance redressal at various levels, from the Principal Secretary and Health Commissioner at state level to CMHO at district level.
- ▶ Citizen charter was not displayed at any of the facilities.

## **MIZORAM**

- ▶ State has not implemented any Quality Assurance Activities as per the operational guidelines of Quality Assurance
- ▶ The reconstitution of state as well as district quality assurance committee is not done as per the operational guidelines
- ▶ RRC- NE has done the baseline assessment of DH, Aizawl against the National Quality Assurance Standards which scored 62% as per the analysis.
- ▶ The bio medical waste management is reported poor in all the health facilities except District hospital.
- ▶ The facilities do not have Essential Drug List or Standard Treatment guidelines in any of the facilities.

## **ODISHA**

- ▶ The reconstitution of the state as well as district quality assurance committees is done as per the operational guidelines of Government of India
- ▶ Quality teams at the DH are formulated as per the operational guidelines of GOI
- ▶ State has taken initiatives in training and capacity building. Trainings are conducted as per the operational guidelines of Quality Assurance rolled by GOI
- ▶ DH Puri is an ISO 9001:2008 accredited hospital. Presently 6 facilities have ISO certified status.
- ▶ Patient satisfaction surveys are carried out only in the 9 facilities that are ISO certified.

- ▶ Standard operating procedures are only present for these nine facilities
- ▶ Segregation of Bio medical waste is not done as per the guidelines.
- ▶ The facilities do not have basic amenities in the waiting area.
- ▶ The awareness of staff is not adequate on infection control practices
- ▶ Patient rights and responsibilities is not displayed in the facilities at prominent places
- ▶ Grievance redressal mechanism need to be established for the patients.
- ▶ The facilities do not have AERB approvals and the safety devices like TLD badges, lead aprons are not used in the departments

## PUNJAB

- ▶ Quality Policy for facility level is in place. Patient satisfaction survey is being conducted and as per information given by the State, standard operating procedures are being implemented in 9 hospitals. The State had also formulated and shared the draft Standard Operating Guidelines with the team.
- ▶ State had initiated quality improvement programme and NABH and ISO Accreditation in 2010 but no facilities are accredited till date.
- ▶ States Quality Assurance committee is reconstituted but it is not functional.
- ▶ The District Quality Assurance Committees are not reconstituted.
- ▶ The Road map for the National Quality Assurance Programme is not clear in the state
- ▶ Trainings have not been planned and proposed as per the operational guidelines of Quality Assurance.
- ▶ The Bio medical waste segregation in the facilities is very weak. It is not as per the guidelines.
- ▶ Grievance redressal mechanism do not exist in the facilities of Punjab, there are no complaints/suggestion boxes in the facility.

## RAJASTHAN

- ▶ The state has not reconstituted State Quality Assurance Committee (SQAC) and District Quality Assurance Committee as per the operational guidelines of quality assurance
- ▶ The state is yet to plan and propose timelines for other trainings like internal assessors and service providers to build capacities.
- ▶ Most facilities have placed grievance Redressal boxes in the waiting area near the reception but there is no mechanism to address these grievances
- ▶ The Bio medical waste is being disposed according to set standards. Work instructions are well displayed on or near the bins.

## TELANGANA

- ▶ Baseline assessment has been conducted as per IPHS standards in 66 PHCs out of 67 facilities but there is no action plan to traverse the gaps
- ▶ Telangana is yet to re-constitute State and District committees as per the operational guidelines.



- ▶ State is yet to develop a 'Road-map' for Quality Assurance and to identify Number and type of facilities (District Hospitals or equivalents, SDH, CHC, PHC, public health facilities in urban areas) targeted for quality certification in the first year as per as Operational Guidelines.
- ▶ The facilities do not have Standard Operating procedures for the key processes of the hospital
- ▶ Biomedical waste management is a major area of concern. Segregation, Collection, transportation and disposal of biomedical waste are not as per Biomedical Waste (Management and Handling) rules 1998.
- ▶ Cleanliness and hygiene is not maintained in the facilities specially in the patient care areas
- ▶ None of the visited facility is conducting patient satisfaction survey
- ▶ There is no grievance redressal mechanism, suggestion/complaint boxes are seen in some facility but there is no mechanism of monitoring, the keys of the boxes are not traceable

## UTTARAKHAND


- ▶ The Quality assurance committees are not in place in State or district levels.
- ▶ The action plan at the State level and District level has not been formulated for implementation of Quality assurance.
- ▶ The trainings under Quality assurance for internal assessor and service provider have not started yet.
- ▶ None of the health facilities are reporting KPIs.
- ▶ Bio Medical Waste Management is an area of concern in all the facilities.

## UTTAR PRADESH

- ▶ The state has reconstituted the state and district quality assurance committees but they are not functional.
- ▶ State has initiated training and capacity building as per the trainings suggested in the operational guidelines of Quality Assurance
- ▶ Gap analysis has been initiated as per the Assessor guidebook and completed in many facilities
- ▶ The state has developed its road map and selected its facilities for the implementation of the National Quality Assurance Programme
- ▶ In UP Grievance redressal mechanisms are established. Committees are formed at DH & CHC level facilities and they are reviewing the complaints
- ▶ Citizen charter has been displayed in most hospitals.
- ▶ The support services in the hospital are well maintained, with safe drinking water and cleaned toilets.
- ▶ Bio medical waste management services are well managed. The staff is well versed with waste management protocols.

## WEST BENGAL

- ▶ State is yet to reconstitute State and District Quality Assurance Committees
- ▶ State is yet to propose trainings recommended in the operational guidelines for National Quality Assurance Programme

- 
- ▶ Cleanliness in the health facilities is a major area of concern.
  - ▶ There were infrastructural issues in the facilities, as there are no compound walls allowing animals to enter the facility
  - ▶ Display of Work instructions as well as standard operating procedures were not seen in any facility.
  - ▶ Grievance Redressal Mechanisms were not in place.
  - ▶ Bio Medical Waste Management is an area of concern.



# TOR 9

## Drugs, Diagnostics, Procurement & Supply Chain Management

### Guiding Principles/Strategies of the NHM

- i. Enable Social Protection Function of Public Hospitals through the universal provision of free consultations, free drugs and diagnostics, free emergency response and patient transport systems (2.4.2.17)
- ii. The route to ensuring free drug supply is to strengthen the capacity of the states in procurement, supply chain management and quality assurance, preferably through the establishment of a state level autonomous corporation/body which is in charge not only of transparent and efficient procurement of drugs, but also of quality assurance and logistics, including efficient distribution systems down to facility level (5.6.4)
- iii. Making diagnostics free in the hospital is also essential for eliminating OOP expenditure since it is another major cost centre and therefore an NHM priority (5.6.5)
- iv. The fund flow from the Central Government to the states would be as per the procedure prescribed by the Government of India (4.5)

## KEY FINDINGS

### National Vector Borne Disease Control Programme (NVBDP)

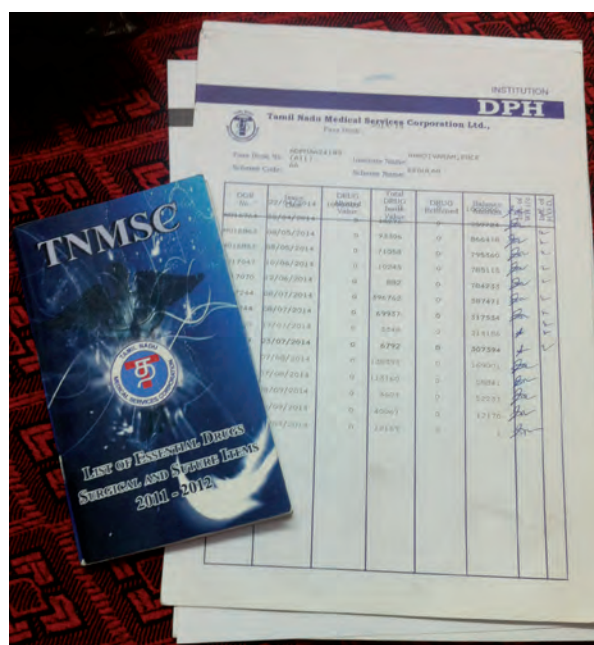
- ▶ Significant progress has been made in institutionalizing a centralized and transparent procurement system across most states. These were operational in states of Bihar, Chhattisgarh, Kerala, Punjab, Mizoram, Rajasthan, Tamil Nadu, Telangana and Uttar Pradesh. States of Assam, Chandigarh, Madhya Pradesh, Odisha and Punjab are in process of setting up these systems. In Uttarakhand and Mizoram although procurement was through Central Medical Store Depot (CMSD), this was found to be inefficient as delays in

procurement were common, leading to over 60% of the procurement being done locally.

- ▶ In order to create an efficient inventory/supply chain management system, some states have also invested in development of web based software. These were found functional in Bihar (Aushdhara online); Uttarakhand (ProMIS software); Uttar Pradesh (recently started – Drug Procurement and Inventory Control System) and West Bengal (State Management information system – SMIS). Limited functionality was reported in Chhattisgarh (Drug Procurement & Distribution Management information System) and Odisha (Odisha Drug Inventory Management System)

while in Punjab, a software- E- Aushadi is in the process of implementation. Odisha also plans to expand the scope of its ICT enabled logistics system (RHCLMIS) from contraceptives to also include essential drugs/supplies.

- ▶ The effectiveness of these mechanisms in terms of fewer episodes of stock outs at the public health facilities especially at the sub district level is yet to be achieved. We reported earlier that stock outs of one or more essential commodities (drugs/equipment and vaccines) as per RMNCH+A matrix were common across all states except in Odisha and Tamil Nadu.
- ▶ Storage facilities such as regional/divisional warehouses were available in most states except in Tinsukia, Assam where the drug warehouse was in a dilapidated building and Chandigarh where storage space was insufficient.
- ▶ Quality control measures with adequate number of functional laboratories was reported from only few states such as Chhattisgarh, Bihar, Kerala, Rajasthan, Tamil Nadu and West Bengal. Assam and Mizoram are yet to empanel any laboratory for testing the quality of drugs while in Bihar the empanelled labs did not follow standard operating procedures. Chhattisgarh and West Bengal had an inventory



management software and laboratories dedicated to ensure quality of drugs, but expired drugs were observed by CRM teams in few of the visited health facilities. This was also reported in Telangana.

- ▶ Although most states notified the Free Drug Scheme, unavailability of drugs at the peripheral i.e. sub district health facilities undermine the initiative to provide free drugs and eliminate out of pocket expenditures. Of the 380 drugs supplied by CGMSC, only 35 % were available in Rajnandgaon and 53% in the Bilaspur warehouse in Chhattisgarh. Community awareness about Free Drug Schemes was poor in West Bengal and Uttar Pradesh whereas in Chhattisgarh, even staff appeared to be to be unaware of the scheme. Free drugs were available only for JSSK beneficiaries and in case of some emergencies in Chandigarh. Madhya Pradesh launched 'Mamta Abhiyan' and also set up 'Arogyakendras' at AWCs where where 16 drugs and 5 investigations are provided free at the doorstep.
- ▶ Most states do not have a state or district level Drug and Therapeutic Committee except for Odisha where this has been set up in every district. Prescription audit was reported only from two states of Bihar and Chhattisgarh. In Chhattisgarh, the State Health Resource Centre undertook audits and reported that branded drugs were prescribed in nearly half of the cases. The practice of prescribing branded drugs was also seen at some facilities in Assam, Kerala, and Mizoram. Generic medicine prescriptions were seen in BS Medical College and Onda BPHC in West Bengal. In Mizoram, DH and SDH have rented out pharmacy shops commonly known as "Medical Canteens" which charge drugs at market price without any subsidy for patients.
- ▶ Standard Treatment Guidelines have been developed in Chhattisgarh, Mizoram, Odisha, Madhya Pradesh, Rajasthan, West Bengal and Uttar Pradesh but adherence to these protocols was limited in West Bengal and Mizoram while in Uttar Pradesh staff was unaware about STGs.





- ▶ States with EDL are – Kerala, Chhattisgarh, Odisha, Mizoram, Madhya Pradesh, Bihar, Rajasthan and Uttar Pradesh. The Essential Drug List is yet to be finalized in some states. Kerala has also added 73 anticancer drugs in the EDL; Odisha, Rajasthan and West Bengal have classified EDL as drugs for primary, secondary and tertiary care and Uttarakhand and Bihar have classified as per level of health facility – DH, CHC, PHC and SHC.
- ▶ In contrast to the free drugs made available to the community, the range of services provided free (or just made available) was not universal as it was limited mostly to beneficiaries for JSSK and BPL beneficiaries, as reported from Assam, Chhattisgarh, Mizoram, Odisha (also for freedom fighters) and Uttarakhand. Bihar has introduced an initiative 'Sankalp', through which Radiology (X-Ray/Ultrasound) & pathology services are made free to public but erroneous contract has allowed subcontracting leading to poor monitoring.

## RECOMMENDATIONS

- ▶ While the introduction of centralized procurement and inventory management processes, are an important first step, strengthening of such systems to avoid shortages and stock outs are a critical next step, to ensure free drug supplies.
- ▶ A centralized procurement process was functional in most states and remaining states are formulating such mechanisms, but more focused efforts
- ▶ are required to make the procurement process efficient, transparent and responsive. This needs to be complemented with an efficient inventory management system to ensure that there are no stock outs at any level.
- ▶ Quality control measures also need to be strengthened for ensuring good quality drugs at affordable (free) price at all public health facilities. A multi pronged approach is required for ensuring quality of the drugs procured. NABL accredited laboratories may be empanelled for quality control.
- ▶ Formulation of Differential Essential Drug List as per the needs and requirements of state is necessary to cater variations in geography, disease burden and health indicators as well as Standard Treatment Guidelines for different levels of care need to be developed and updated regularly.
- ▶ States need to take cognizance of the fact that despite the overall thrust on promotion of generic drugs, branded drugs are commonly prescribed by providers. This is also one of the most common cause of Out of Pocket Expenditure incurred by patients (even under JSSK). Monitoring mechanisms like Drug and Therapeutic committees need to be created and supported for regular monitoring of such practices.
- ▶ In addition to development of EDL and STGs, states should also invest in conducting regular periodic training of service providers (at all levels) with regards to EDLs and STGs to address the issue of irrational drug use.
- ▶ Diagnostics are an essential component of services delivery yet they receive limited attention in terms of ensuring availability of equipment/trained manpower and maintenance of equipment. This affects the range of diagnostic services available at the public health facilities leading to high OOP for community. Mechanisms for procuring equipment and regular maintenance need to be improved across all states.
- ▶ States should ensure a functional inventory of medical equipment on software provided by the service agency to track the down time of machines.

## FINDINGS FROM STATES

### ASSAM

- ▶ Free Drug Policy has been notified but not visible on the ground. Critical and life saving drugs e.g. Inj. Oxytocin, Inj. Atropine, Adrenaline, Hydrocortisone, ASV (Anti snake Venom), DNS were not available at point of use.
- ▶ Frequent and prolonged Stock outs of essential medicines were observed.
- ▶ State is yet to develop state-specific STGs (Standard Treatment Guidelines)
- ▶ Currently tendering procedure is manual and there is no e-tendering system. State is in process of setting up a centralized procurement agency in the form of a 'Corporation'.
- ▶ Dedicated Quality Control Cell has not been formed and no independent NABL accredited laboratory for testing quality of drugs is empanelled by state. Delays in receipt of quality testing report were observed
- ▶ State has no system of reporting of adverse drug reactions.
- ▶ District Drug store at Tinsukia was found to be located in an old and dilapidated building, with poor supply chain mechanism.
- ▶ Diagnostics were free for JSSK beneficiaries and BPL population but only basic investigations (Hb, Blood grouping, Urine albumin & sugar, MP) were available at PHC and CHC level.

### BIHAR

- ▶ State has launched Free Drug Scheme but all drugs were not available at various health facilities including SDH, PHC, SC.
- ▶ Essential drug list includes 65 OPD drugs and 120 IPD drugs for MCH and 33 OPD drugs and 112 IPD drugs for District Hospitals to APHCs. But it was not displayed at facilities. Preparation of differential EDL for facilities wise (for DH, SDH, CHC, PHC, SC) is underway.
- ▶ Bihar Medical Services and Infrastructure Corporation Ltd. (BMSICL) is the central agency for procurement.
- ▶ There are 3 warehouses with 1 Lakh Square feet of storage area and cold chain facility at Fatuha, Muzaffarpur & Purnia.
- ▶ Prescription audits have been done in the past by the state but not at facility level.
- ▶ RTGS payment system has been introduced for suppliers
- ▶ Drug testing Laboratories have been empanelled through a tender process but it was reported that no SoP and business rules were being followed.
- ▶ Radiology (X-Ray/Ultrasound) and pathology services are made free to public through 'Sankalp'. However poorly formulated contracts with the radiology agency hampers services.
- ▶ An IT based Tool 'Sanjivani' which provides on-line OPD registration and drug distributions is being introduced at all PHCs, SDHs, DHs and Urban Hospitals
- ▶ Online procurement & logistic chain management system - "Aushdhara online" is functional.

## CHANDIGARH

- ▶ Essential drugs like Vitamin A, Iron Folic Acid, Mifepristone, MUAC and testing equipment for Hb and Pregnancy testing kits., 5% dextrose, ringer lactate, Inj calcium gluconate, Inj soda bi-carb and surgical blade were in short supply.
- ▶ Free drugs are provided only to JSSK beneficiaries and for some emergencies.
- ▶ UT has not set up the therapeutic committee and there is no mechanism of prescription audits.
- ▶ Although procurement is being done through e- tendering, demand estimation is being done empirically. There is no scientific inventory management system.
- ▶ The storage facility of drugs at sub-district level was found to be inadequate with insufficient racks and storage space. There was no mechanism to track/monitor near expiry drugs.

## CHATTISGARH

- ▶ Though free generic medicine policy was notified in August 2013 and the entitlements were displayed but staff was found to be unaware of drugs that should be made available at the facilities.
- ▶ State budget for drugs has increased by 15% each year over last two years.
- ▶ State has in total nine drug warehouses and all are functioning at rented premises.
- ▶ Shortage of some essential drugs such as Misoprostol, Mifepristone, Mg So4, Vitamin A, Vit K, was observed. Of these, Misoprostol, Mifepristone not available at District and Drugware Houses.
- ▶ Only one EDL with (723 drugs) is formulated but drugs are not available at facilities. Out of the 380 drugs supplied by CGMSC, only 35 % were available in Rajnandgaon and 53% in Bilaspur warehouse
- ▶ Central Procurement and rate contracting is done by CGMSC. Chhattisgarh Medical Services Corporation Limited (CGMSCL).
- ▶ Prescription audit conducted by SHSRC reveal that 49.19% of the prescription are by brand names, an average 1.99 drugs/prescription were found to essential drugs while 1.37 drugs/prescription were irrational.
- ▶ Investigations for JSSK and BPL patients, tests for Malaria and Sputum for AFB are free. No USG, CT scan, MRI facility was available at any facility in district Jashpur.
- ▶ Drug Procurement & Distribution Management Information System (DPDMIS) Software is installed in all the 9 Drug Warehouses but is yet to become fully operational.
- ▶ State has a dedicated Quality Cell for Quality Control with seven Labs empanelled for Quality.
- ▶ State has no system of reporting adverse drug reaction.

## KERALA

- ▶ Kerala has a transparent and robust system of procurement through Central Procurement Agency Kerala Medical Services Corporation Limited (KMSCL) comprising of e-Tendering, pre-offer meeting, and payments through RTGS and NEFT.
- ▶ District drug warehouses were available in all 14 districts.

- ▶ All EDL drugs are free for all. EDL constitutes 771 Essential Drugs, including 73 anti-cancer drugs. Of these, IFA tablets, iron syrup, Zinc tablets, OCPs, condoms, antibiotics etc. were not available at sub-centres and PHCs.
- ▶ An extensive and diligent quality control mechanism through nine NABL – accredited empanelled labs and two government labs has been established.
- ▶ State has a toll free number for registering complaints with regard to free medicines scheme but the number was not displayed at facilities.
- ▶ With regards to storage of drugs, systematic arrangement, FIFO principle, labelling of shelves etc. was lacking.
- ▶ Prescription audits/monitoring was not in practice.
- ▶ Diagnostic services were found poorly delivered at the facilities at the periphery.

## MADHYA PRADESH

- ▶ Free drugs scheme has been launched and drugs available at facilities.
- ▶ State has Essential Drug List for various level of care. STG Standard treatment Guidelines were also available.
- ▶ **“MamtaAbhiyan”** launched by state ensures FREE ‘3Ds’ i.e Drugs, Diagnostics and Diet for ALL pregnant women and children. State is also guarantying availability of free drugs; 24 at Sub centre, 71 at PHC, 131 at CHC, and 300 at District hospital level along with free diagnostics; 5 tests at sub centre, 16 at PHC, 32 at SDH& CHC and 48 at DH. However patients were seen buying medicines from private pharmaceutical stores in Panna.
- ▶ **‘Gram Aarogya Kendra’** providing 16 drugs and 5 diagnostic services at doorstep are functional across all the villages in the State.
- ▶ Rate contracting is done by State Drug cell at DHS and supply monitored by SDNIS. State is yet to initiate the e-tendering process. Establishment of a centralized procurement system on the lines of RSMSC/TNMSC is in progress. State is procuring 80% of the medicines centrally, through TNMSC.
- ▶ Drugs are being prescribed by generic names as per EDL.
- ▶ New X-ray machine in PHC Raipura was *unused* for nearly 5 years. All 3 blood bank refrigerators in DH Panna were *not functioning*;

## MIZORAM

- ▶ EDL and STGs have been formulated but were not available with end users, except for DH Aizwal West.
- ▶ State is yet to introduce the free drug policy and there is no Drug and Therapeutic Committee for prescription audit. Drugs are being prescribed by brand names.
- ▶ Essential commodities such as emergency contraceptive pills. Inj. Magnesium sulphate, Inj. Labetolol, BCG, OPV and Hep B vaccine identified under RMNCH+A strategy were not available at all delivery points.
- ▶ At DH Aizwal all the lab tests including serology, cultures, histopathology, biochemistry were and radio-diagnostics were available. In DH, but at PHCs only basic tests like Hb, Urine R/M, pregnancy test, PS for MP were available.



- ▶ All procurements are done by “Central Medical Stores Depot” through open tender system.
- ▶ Different modes of payment to the suppliers are used, varying from check payment to electronic clearance directly into supplier’s account.
- ▶ There was no documented system for demand estimation and it was done manually without IT enabled supply chain management system
- ▶ There is no dedicated quality control cell or empanelled lab for quality control. Drug samples are sent to Guwahati only when some complaints are registered.

## ODISHA

- ▶ State has a notified free drug distribution scheme, but drugs were not available free at most of the facilities visited.
- ▶ State has prescribed Standard Treatment Guidelines (STG).
- ▶ Drug and therapeutic committees have been established at each district
- ▶ EDL has been revised and categorized into three groups primary care, secondary care and tertiary care but facility wise EDL has not been prepared.
- ▶ Formation of centralized Procurement agency “Odisha State Medical Corporation Limited” and setting up of 1102 Drug Distribution Counters is in process. Complete automation of Corporation by C-DAC is under process.
- ▶ Rate contracting and procurement is done through National Competitive Bidding (NCB) Process by DGS&D directly from the manufacturers. Indenting and maintenance of drug inventory is also done manually.
- ▶ Web based drug inventory management system called Odisha Drug Inventory Management System (ODIMS) is in place, but is non-functional.
- ▶ Diagnostic services are free under JSSK scheme, BPL and freedom fighters.

## PUNJAB

- ▶ State has taken several new initiatives like centralized procurement through Punjab Health System Corporation (PHSC), rate contracting, e-tendering, construction of warehouses and use of IT for supply chain management. However dual procurement of Nishchay kit (by state as well as district) was observed.
- ▶ Free Drug Policy notified in 2014. Jan Aushadhi stores were available in District & Sub – District Hospitals for providing Generic medicines.
- ▶ E-Aushadhi software for supply chain management was in process of implementation.
- ▶ State has no mechanism to track/monitor near expiry drugs.
- ▶ Sufficient stock in three Regional Warehouse namely Bathinda, Verka and Kharar but drug storage protocols were not being followed at Kharar.
- ▶ Quality control mechanism was weak with limited number of empanelled labs and considerable delays were noted in test reports.

## RAJASTHAN

- ▶ Rajasthan Medical Service Corporation Limited (RMSCL) is the nodal agency for procurement through open tender process as per the stipulated rules. Procurement is done by e-bidding and relies on technical evaluation prior to financial evaluation.
- ▶ EDL for various levels of facilities available and displayed. STG were available and are followed.
- ▶ Drugs under EDL are free for all and are available at facilities with minimal stock outs.
- ▶ Currently, about 400 essential medicines are provided free by RMSC for OPD and IPD patients at all (about 15,000) public health facilities through 16,053 free drug distribution centres (DDC).
- ▶ 57 essential investigations at the teaching hospitals, 44 in district hospitals, 28 in Community health centres and 15 in primary health centres are provided free of cost.
- ▶ Drugs are scientifically stored in well-designed warehouses (one in each district) with separate quarantine area and near expiry area.
- ▶ State has a robust system for quality control. Each and every batch of drugs/medicines supplied is subjected to quality test by NABL accredited laboratories empanelled by RMSC.
- ▶ A major observation was that most of the computer operators in the drug dispensing counters are on contract basis and have not received their salaries for more than 9 months because the contract with the third party agency was not renewed.

## TAMILNADU

- ▶ Tamil Nadu Medical Services Corporation Limited (TNMSC) is nodal agency of all medical procurements in the state TNMSC also plays a vital role in providing certain medical services like maintenance of CT/MRI Scan Centers
- ▶ Strong quality control and logistics management is being done on receipt of drugs at the warehouse.
- ▶ TNMSC has developed rigorous procedures for procurement, testing, blacklisting, and enlisting of blacklisting etc.
- ▶ The Corporation maintains about four months' physical stock in the warehouses and two months' stock in pipeline for ensuring uninterrupted supply of medicines to hospitals.
- ▶ Currently TNMSC has 25 Drug Warehouses in various District Headquarters. Warehouses in the remaining districts have been proposed in a phased manner.

## TELANGANA

- ▶ State has a centralized rate contracting mechanism but lacks a well-designed logistics chain management.
- ▶ Expired drugs were found at MCH Siddipet, PHC Gummadidala
- ▶ AYUSH medicines are supplied only once a year resulting in frequent stock outs
- ▶ Computerized monitoring of the drugs in stock, availability and expiry is maintained at the State and district drug store for stock position, re-appropriation of drugs within facilities and district and based on consumption pattern is done to minimize wastage.

## UTTARAKHAND

- ▶ Central Medical Store Depot (CMSD) is responsible for procurement in the state with no independent corporation in place. Because of tedious procedures and inordinate delays in procurement and distribution, 60% of the procurements are made locally.
- ▶ State has a facility-wise Essential Drug List (EDL) which is also available on the website.
- ▶ One state level drug & food lab and 4 labs are empanelled for quality testing.
- ▶ *Jan Aushadhi Kendra's* were established at seven District Hospitals in the State.
- ▶ State is in process of implementing the free drug scheme.
- ▶ Essential drugs like Oxytocin, misoprostol and mag sulph, were available, but there was shortage of IFA tablets in both Almora and Tehri.
- ▶ The ProMIS software, supported through the EPW (Govt. of India) is used for procurement and inventory management.
- ▶ There is no mechanism for prescription audits at present in the State.
- ▶ Diagnostic facilities are free for all JSSK beneficiaries and BPL patients. There was no provision for ultrasound at any of the public health facility in Tehri.
- ▶ Functional labs were available at all the facilities visited.
- ▶ State has one warehouse at the state level and two regional warehouses.

## UTTAR PRADESH

- ▶ State has established EDL and the same was displayed at the facilities visited. The essential drugs like IFA(L), analgesics, anti-pyretics, antibiotics, ORS and Zinc tablets were available in the facilities visited
- ▶ Standard treatment guidelines are established but staff is neither aware nor oriented about the guidelines.
- ▶ The State has recently started "Drug Procurement & Inventory Control System" to ensure regular supply of quality medicine, transparent drug procurement procedure and updated medicine inventory.
- ▶ Suppliers under rate contract often fail to provide all drugs within the stipulated time frame. There is neither penalty clause nor any monitoring mechanism from the state level to ensure the supply of drugs under rate contract.
- ▶ Estimation of requirement is done empirically. Indenting system by the CHCs and PHCs is not regular and FIFO or bin card system is not being followed.
- ▶ Lack of awareness amongst the beneficiaries about the availability of free drugs was noted.
- ▶ State has no mechanism of prescription audit
- ▶ The diagnostic facilities are available in the District Hospitals and CHCs and are free for all categories of patients in Shravasti district. The PHC and SCs do not have any diagnostic facilities.
- ▶ Ultrasonography facility not available in any Govt. Health facilities in the district visited

## WEST BENGAL

- ▶ Essential Drug list comprises of 600 drugs known as Vital-Essential-Desirable (VED) with generic names as per Primary, Secondary and Tertiary level of care. However EDL and drugs are not uniformly available in the facilities visited.
- ▶ Standard Treatment Protocol has been finalized. But it is neither available nor adhered to at facility level.
- ▶ Generic medicines are catalogued in the Store Management information System (SMIS) but fair priced shops are storing branded medicines also.
- ▶ Community awareness about availability of free drug and consumables was limited.
- ▶ Prescriptions are being made by generic medicines in the BSMCH and Onda BPHC.
- ▶ Prescription Audits are conducted at BSMCH only having e- prescription.
- ▶ Diagnostic services are outsourced at the sub-district level facilities.
- ▶ All available diagnostics services are free up to the level of secondary tier hospitals. Diagnostics are free under JSSK, while other users have to pay subsidized rates.
- ▶ Awareness on availability of free diagnostics is poor in the community.
- ▶ Central Medical Store (CMS) does all procurements with the help of Store Management Information System (SMIS); a software based drug management system.
- ▶ Central Medical Stores is the Nodal agency for Quality testing. State Drug Control & Research Laboratory is the State based lab. In addition, NABL Laboratories have been empanelled.
- ▶ Expired drugs were found at Simlipal BPHC. Injection mag.sulph was not available. Stock-out of Vit. A was observed in the Bankura district





# TOR 10

## National Urban Health Mission

### Guiding Principles/Strategies of the NHM

- i. "The sub-mission of National Urban Health Mission (NUHM) under the NHM strives to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections by facilitating equitable access to quality health care" (Para 5.11.1)
- ii. In urban areas, Urban Primary Health Centres (U-PHC) would serve as the first point of delivery of primary health care (5.4.3)
- iii. The U-PHC would be appropriately staffed with doctors, staff nurses, pharmacist, laboratory technician, and ANMs depending upon the caseloads and population covered (5.4.4)
- iv. The urban poor suffer from poor health status with a higher burden of mortality and morbidity (5.11.4)
- v. States will be required to plan for the specific needs of such areas and populations, city-wise and allocate higher resources to them in their plan (5.11.6)
- vi. "Under NUHM, the most vulnerable including construction site workers, homeless persons, street children, victims of communal violence, invisible habitations such as lime and brick kiln workers would be accorded focused attention and health care through strategies appropriate to the local situation" (Para 5.11.5)
- vii. "There is also a section of the population who is not only poor, but also suffers from additional cause of vulnerability and marginalization. This includes the migrant worker, the homeless, the street children, occupational groups like rag-pickers, sanitation workers, trans-gender population, commercial sex workers and so on. For these groups to access essential health care services affirmative action is needed. Efforts will be made to ensure that these populations are adequately covered by NHM's social protection initiatives" (Para 5.6.8)
- viii. "The National Urban Health Mission would aim to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies" (Vision statement of NUHM)

### KEY FINDINGS

- The NUHM Program is in varying stages of the implementation process in the states. Funding of NUHM for 2014-15 has been provided to

most states and they are still in the preparatory phase. Many states have not been able to utilize funds effectively. The pace of implementation

is brisk in the state of Kerala but slower in UP, Chhattisgarh, Bihar and Uttarakhand.

- ▶ Planning and mapping of slums is completed in Kerala and Odisha and is underway in other States.
- ▶ Facilities available under NHM have been mapped in the states of Punjab, Rajasthan, MP, Chandigarh, Uttarakhand, Odisha and it is in process in other states for instance Mizoram. States such as MP, Punjab and Chandigarh are also planning mapping activities in collaboration with other stakeholders and technical agencies.
- ▶ In many states, service delivery structures such as UPHCs have been created, along with strengthening of the existing structures in the identified cities with more than 50,000 populations. While up-gradation process is underway in some of the states, establishing new UPHCs is a challenge due to problems of acquiring land in congested urban spaces.
- ▶ Institutional structures such as urban health program management cells are created at the state level in most states except Chhattisgarh. State Mission Directors are in place and the recruitment process for positions at district and city level is underway in Madhya Pradesh, Rajasthan, West Bengal, Rajasthan and Odisha.
- ▶ Staff recruitment to the service delivery facilities is underway in most states. Recruitment of Medical Officers, Staff Nurses, and ANMs is incomplete and underway in most states.
- ▶ Involvement of urban local bodies (ULBs) in the implementation of the program is initiated in varying degrees across states, to a much greater extent in Kerala and Odisha and much less in states such as Chhattisgarh, Bihar, and Telangana.
- ▶ The selection of Urban ASHA is slow in many states. Where the management of the process is entrusted to the state ASHA resource centre and its district support teams the process is facilitated and strengthened by cross learning from the rural ASHA programme. Another factor expediting the

process in cities of Bihar, Odisha, Uttarakhand, and Rajasthan is through NGO led interventions. Kerala, Tamil Nadu and West Bengal plan on leveraging community collectives of programmes in other sectors for MAS formation and ASHA selection. States such as Mizoram, Rajasthan, Punjab, Chandigarh, and UP are yet to initiate selection. States such as MP and Rajasthan have leveraged on the progress made by Health of the Urban Poor Program (HUP) in MAS formations and outreach. Most states are yet to open bank accounts for MAS and provide funds for their functioning. Training of urban ASHAs has begun in states such as Assam and Madhya Pradesh.

- ▶ Public Private Partnership strategy for service delivery is underway in some states such as Uttarakhand, Bihar and Telangana.

## RECOMMENDATIONS

- ▶ Implementation and roll out of components and activities under NUHM need to be expedited and strengthened in all states. States must leverage the flexibility in NUHM for implementing customized services through innovations, PPPs and collaborations with local stakeholders.
- ▶ States should expedite mapping of slums and appropriate ASHA selection in all cities under NUHM. Community processes interventions in NUHM as mandated in the guidelines must be managed by the same support staff that manages the ASHA for the NRHM. Partnerships with existing slum based NGOs would expedite the selection and training process.
- ▶ States should conduct a gap analysis of the existing infrastructure both human and other resources such as physical infrastructure and equipment for need based planning and implementation.
- ▶ In many states service delivery is required to be strengthened for outreach services, which is a key component to reach the vulnerable and marginalized.
- ▶ States are recommended to expedite recruitments. Recruitment of staff to the

management units at the state, districts and service delivery facilities including ASHAs, on the basis of the situation assessment and gap analysis, needs to be completed in many states.

- ▶ States are required to organize capacity building of recruited staff to enable them to carry out program activities and ASHA trainings on different issues pertaining to slum areas.
- ▶ States are recommended to expedite activity of baselines, vulnerability mapping of slums and slum like habitations, for effective outreach.
- ▶ States such as Kerala, where program is rolled out well, are recommended to create Hospital Development Committees (HDCs), ensure availability of all drugs (as per EDL in UPHCs) and essential equipment in all UPHCs.
- ▶ Convergence mechanisms with all related departments are required to be in place in all states, except in Kerala. Orientation and involvement of Urban Local Bodies (ULBs) and convergence with other non-health departments is recommended to be undertaken to facilitate comprehensive and participatory planning of urban health services. Institutional mechanism for coordination and convergence between ICDS, water and sanitation department, urban local bodies needs to be strengthened and structured.
- ▶ States presently employing the PPP mode for service delivery (Bihar, Uttarakhand and Telangana) are recommended to strengthen the models (including aligning the TORs with the GOI guidelines/framework, and performance), on the basis of experiences gained till date.

## FINDINGS FROM STATES

### ASSAM

- ▶ Officials of Tinsukia have little updates/information on NUHM and therefore, no institutional arrangement/ programme management was existing in the city.
- ▶ 1181 ASHAs for Urban areas have been selected, their trainings have started but not yet completed. 634 Mahila Arogya Samitis will be formed in the current year.
- ▶ The recruitments for programme management units is still to be completed and very little information was available regarding city level convergence to be taken up under NUHM
- ▶ Systematic mapping and up gradation of UPHCs is yet to take place in the state.

### BIHAR

- ▶ There are 15 cities in the state of Bihar covered under NUHM. Main components of NUHM programme implementation are Urban PHCs, ASHA & Mahila Arogya Samiti (MAS).
- ▶ The state has an existing urban health programme intervention supported by donor partners, which also has 400 MAS and 391 ASHAs in place and functional. This programme intervention is also being integrated under the planned NUHM interventions.
- ▶ 61 Urban Primary Health Centres have been sanctioned under NUHM. Of the total 61 UPHCs, 16 are in Patna district, and 15 of them are being started shortly, the location of these UPHCs has been identified.
- ▶ State has appointed Additional Executive Director, State Health Mission as Officer in Charge for NUHM. The technical support team that has been put in place as a collaborative support from donor partners led by DFID, is also supporting the NUHM programme planning and implementation processes.

## CHANDIGARH

- ▶ Mapping of Urban Slums data has been procured from the Department of Urban and Town Planning.
- ▶ The community processes activity is lagging. The Union Territory (UT) is facing challenges in the activities of MAS constitution (due to migrant population) and ASHA selection entrusted to ANMs, who find it difficult to motivate candidates in the face of alternate economic opportunities (and due to demand for fixed monthly income). As Chandigarh has been a non-ASHA state so far, identified ASHAs will be trained in collaboration with the neighbouring states of Punjab and Haryana.
- ▶ The already existing civil dispensaries are to be upgraded to UPHCs. RKS has not been constituted at these facilities, due to which untied funds cannot be disbursed to these facilities.

## CHHATTISGARH

- ▶ The number of facilities covered under NUHM is 28 UPHCs and 251 Sub Swasthaya Kendras (SSKs).
- ▶ Urban health cell has not been formed both at State and City level and additional Mission Director has not been appointed.
- ▶ There are 10 Urban Health Cells formed in the State covering 19 cities (8 Nagar palika, 1 nagar panchayat, 10 municipal corporations). Involvement of urban local bodies in NUHM implementation and facility strengthening is weak.
- ▶ The Mukhya Mantri Shahri Swasthaya Karyakram (MSSK) was already operationalized in the state earlier. The sub centres working under the same have been included under NUHM now. 3234 Mitanin and 3234 MAS have been functional for over a year, and are supported through the existing management structures as for the NRHM resulting in smooth implementation.
- ▶ There are 3234 (100.06 %) urban ASHAs (Mitanins) appointed. The UHNDs are held and cover mainly immunization sessions only.
- ▶ The bank accounts of MAS have been opened

## KERALA

- ▶ NUHM has been rolled out in the State in terms of activities such as strengthening Urban PHCs, outreach camps for urban slums and urban immunization programmes.
- ▶ The state has utilized the existing programme officers under NHM to roll out NUHM in the State. Existing clinical staff under urban RCH program has been absorbed under NUHM since 2013-14. Staff Nurses, pharmacists and laboratory technicians have been recruited through PSC.
- ▶ Services at UPHCs included daily general OPD, immunization services, limited lab facilities and pharmacy. Average monthly OPD per UPHC (as reported by the Ernakulam District) stands at 3648.
- ▶ In addition to the outreach services done by JPHNs, weekly NCD clinics are also found to be operational in all UPHCs with services of screening and treatment.
- ▶ Sound coordination was observed between NUHM program structures and ULBs. For example infrastructure such as buildings for UPHCs was given by Cochin Corporation.
- ▶ State has completed the mapping of all slum areas. State has also conducted one day orientation of corporation staff for NUHM programme.



- ▶ 1927 ASHAs have been selected based on mapping, but there is a shortfall. Existing groups in the state's Kudumbashree programme have been co-opted as MAS. Training of ASHA and MAS has yet to be initiated.

## **MADHYA PRADESH**

- ▶ MOU with MAP-IT for facility level mapping has been initiated. Expression of Interest (EOI) for baseline survey of 28 cities is being finalized.
- ▶ Population Foundation of India (PFI) is supporting the state team in NUHM roll out (through its USAID funded- Health of the Urban Poor -HUP Programme). PFI has also deputed a full-time consultant to support the SPMU, along with two full-time staff who are working under the HUP programme.
- ▶ Recruitment processes are complete in only 23 cities (out of 50). Three positions at the state level are still vacant- Consultant Community Processes, M&E Officer and Accountant. 3,876 ASHAs have been selected out of 4,200 ASHAs required. Out of selected 3,600 urban ASHAs, 3,000 have been oriented in the 5-day induction module through the NGO selected by the State. Total 80 social mobilizers are in place.
- ▶ MAS members are in place, but training is yet to begin. MAS members interact with community facilitated by social mobilizers and appear to be active.

## **MIZORAM**

- ▶ NUHM has been implemented in two cities i.e. Aizawl (East & West) and Lunglei Township. There are 6 UPHCs in Aizawl city and 2 UPHCs in Lunglei city, all the UPHCs are providing 24X7 services. There is strong involvement of Urban Local Bodies (ULBs) in the state.
- ▶ 10 outreach camps (out of 60 approved) have been conducted till date (8 in Aizawl and 2 in Lunglei). However no UHNDs have been organized till now.
- ▶ ASHAs working in urban areas have been subsumed into NUHM. There are total 29 Mahila Arogya Samitis (MAS) in place. It was observed that MAS do not have separate bank accounts. Trainings for ASHA & MAS were organized by the state in the month of May'14.
- ▶ Except for 2 medical officers, all other positions have been filled up through regular as well as contractual staff.

## **ODISHA**

- ▶ In the state a total of 36 cities and towns are planned to be covered under NUHM. Around 47.67 lakhs urban population will be covered out of which 13.55 lakhs will be of people living in 2236 urban slums in the state.
- ▶ The expansion of state health society, district health society has been carried out and city health society has also been created with ex-officio members of department of housing and urban development, municipal corporations etc.
- ▶ State has well placed the key ex-officio members of the ULBs in the City Health Society for example Mayor is the chairperson of the CHS.
- ▶ The ward councilors have been assigned the responsibility of President in Ward Kalyan Samiti (WKS) and Chairperson in Rogi Kalyan Samiti (RKS).

- ▶ The workforce for NUHM has been put in place at the state level and the urban health cell at the state is also functional with requisite personnel. Additional staff has been placed in five DPMUs and four CPMUs are functional with 8 program management personnel.
- ▶ The Additional Mission Director is placed as a nodal officer for NUHM.
- ▶ State is striving to build effective convergence mechanisms at the all levels to strengthen the state level coordination committee and city level coordination committee through meetings.
- ▶ In Behrampur city against 48 sanctioned positions of ASHA, 82 are in place and those are directly subsumed from NRHM.
- ▶ In Behrampur city, 82 Urban ASHAs are in place and 50 MAS has been formed out of the 143 approved for the Behrampur city. Training for the ASHA and MAS has yet to be initiated.

## PUNJAB

- ▶ Utilization rate of the last financial year was very poor i.e. 2% of the amount approved in FY 2013 – 14.
- ▶ Deployment of staff has been done at State level, but the posts are vacant at District and city level. Orientation and training of the Program Management Staff & Medical Officers have been done.
- ▶ Engagement of ASHAs & constitution of MAS is under process. State is yet to plan the UHNDs & Outreach camps focused for urban slums. Training is yet to begin.
- ▶ New constructions of building 23 UPHCs and 11 UCHCs have also been sanctioned which have not started yet as land transfer is in progress. Establishment of Urban Health Kiosk at Malerkotla, District Sangrur is in process.

## RAJASTHAN

- ▶ While the Urban Health Cell in the SPMU is functioning under the Additional MD, the state is yet to establish 30 DPMUs and 4 CPMUs for NUHM. Role of ULBs in implementation was not evident to the visiting team.
- ▶ The pre-existing Health of the Urban Poor Program (HUP) has been conducting NUHM related activities in the state, such as mapping, outreach and MAS establishment. The state plans to build on the progress already made by HUP on NUHM, by adopting the 53 existing MAS in Jaipur city from a previous urban health have been co-opted in NUHM.
- ▶ Urban ASHAs have not been selected yet. Outreach sessions are also yet to begin.
- ▶ The state is in process of establishing and upgrading UPHCs and recruiting Medical Officers (full time and part time), Pharmacists, Staff Nurses, Lab Technicians and ANMs for these urban health institutions.

## TAMIL NADU

- ▶ NUHM roll out is in nascent stage, as the government order is still awaited. However, the work has started with administrative order from the NRHM MD. Urban health cell has been formed within existing NRHM SPMU.
- ▶ 135 UPHCs have been created as per in 117 municipalities and 21 town panchayats. Funds for civil works (73 new constructions and 203 renovations) have been transferred to CPMUs and DPMUs, which will commence by February 2015 and be completed by August 2015. A separate bank account for NUHM has been opened in all the District Health Societies

- ▶ Training under NUHM has not started in both the districts visited for Medical, Paramedical staff and Urban Local bodies.
- ▶ Tamil Nadu Urban Livelihood Mission will be the partner agency in implementing Community process in urban slums. TNULHM will identify SHGs in all slum clusters, whose heads will be engaged as ASHA. No ASHA is appointed so far. MAS constitution and ASHA selection are underway.
- ▶ State has completed its HR gap analysis. All HR including Medical Officers, Staff Nurses, Lab Technicians, and Pharmacists will be recruited through Tamil Nadu Medical Service Recruitment Board. MOs competency Test had taken place and process of certificate verification is currently taking place. State has planned to recruit all HR by January 31, 2015.

## ■ TELANGANA

- ▶ The activities under the urban health mission are yet to be rolled out in Telangana state. Though the NUHM ROP for the year 2014-15 was sanctioned, the programme roll out is still at a slow pace in view of the recently completed bifurcation of the state.
- ▶ As per the new ROP 2014-15, the NUHM in Telangana would be covering 41 Urban Local Bodies (ULBs) with a total urban population of about 121.48 lakhs including the Greater Hyderabad Municipal Corporation (GHMC).
- ▶ The state has good urban health infrastructure with 16 urban family welfare centres (UFWCs) and 20 civil dispensaries under Municipal Corporation of Hyderabad. In 2011, the 20 civil dispensaries were upgraded as urban primary health centres (UPHCs) and the UFWCs re-designated as urban health posts (UHPs). In total, the GHMC now has 85 UPHCs divided into 14 clusters of 6 to 10 UPHCs.
- ▶ Presently, most of the UPHCs in Telangana are functioning with limited staff and lean outreach services.
- ▶ The process of constitution of MAS and selection of ASHA is yet to begin.

## ■ UTTARAKHAND

- ▶ 36 UPHC are approved by GOI for 06 cities (Dehradun 16, Haridwar 05, Roorkee 07, Haldwani 04, Rudrapur 03, Kotdwar 01) under National Health Mission and 36 UPHC will start in PPP mode from January, 2015 as per the ROP.
- ▶ At present 21 urban health centres are successfully running in the state (Dehradun 09, Haridwar 06, Roorkee 03 and Haldwani 03) in the PPP mode in Uttarakhand. Staff position per UHC is Doctor 01, ANM 03, Pharmacist 01, Ward Aya 01, Watchman 01 and Lab Technician 01 (01 per 03 UHC).
- ▶ Program Management staff is in place at the state level and the city level positions in the cities of Dehradun, Roorkee, Haridwar and Haldwani have been filled.
- ▶ There are existing ASHA and ASHA facilitators but they need re-orientation. There is no involvement of local urban bodies in NUHM.

## ■ UTTAR PRADESH

- ▶ In current phase, only Meerut city is covered under NUHM. In Meerut district, there are 41 urban health facilities which include 08 state UHPs, 11 NHM UHPs, 22 SCs. Also, there are 4 Nagar Nigam Centres.

- ▶ In Shrawasti district, NUHM is not being implemented because urban population is merely 34,449 which is scattered in 2-3 block headquarters. At present this population is being catered to by the district hospital and CHC of the respective block.
- ▶ Services were mainly confined to Immunization, Ante-natal and Contraceptive care. Antenatal services were compromised in some of the facilities due to the non-availability of diagnostic facilities and post of lab technicians being vacant.
- ▶ Urban ASHAs were yet to be selected in the district till date and Mahila Arogya Samitis were not constituted in the district. Slum areas have been mapped.
- ▶ Mapping of vulnerable population and gap analysis of health facilities have not been carried out.

## WEST BENGAL

- ▶ Urban Health cell is functional at State level. The Appointment of Additional Mission Director has been completed. Urban Health cells are functional in districts with the existing DPMU Human Resource, and in 6 City PMUs at Kolkata, Howrah, Chandannagar, Durgapur, Asansol and Siliguri. Additional Staff recruitment has not been done at any level.
- ▶ Planning has been done for all 67 Cities. GIS mapping has been done for 5 (out of 6) Municipal corporations and 7 Municipalities (out of total 26 Municipalities). Identification of Slums in selected cities has been completed whereas identification of Vulnerable population in the selected cities will be undertaken shortly.
- ▶ Integration of NUHM with pre-existing structures- The process has been initiated but not has been completed.
- ▶ ASHAs have not been recruited yet, although the process has begun. MAS have been identified from the existing Neighbourhood Group (NHG). Outreach services in Slum areas have not started under NUHM. Gap Analysis of public health infrastructure has also been completed.
- ▶ Funds have been disbursed to the selected cities under NUHM. The Modalities have been fixed about the construction and procurement of drugs and equipment. A total of 169 sites have been identified for the U-PHCs and U-CHCs strengthening. The identification of sites for outreach sessions is under process.





## TOR 11

# Governance and Management

### Guiding Principles/Strategies of the NHM

- i. Establish an Accountability and Governance Framework that would include social audits through people's bodies, community based monitoring and an effective mechanism of concurrent evaluation (2.3.15)
- ii. Rogi Kalyan Samitis (RKS) would be strengthened to oversee governance and serve as an effective Grievance Redressal Mechanism at the facility level, with active engagement of Panchayati Raj Institutions (PRIs)/Urban Local Bodies (ULBs) (Para 5.2.5)
- iii. Support the establishment and strengthening of State, District, City and Block Programme Management Units with suitably qualified and supported human resources and requisite infrastructure (5.9.2i)

## KEY FINDINGS

### Institutional Mechanisms

- ▶ Across all states State and District Health Societies have been established and notification for inclusion of the Urban Health Mission issued. However there are variations in terms of functionality, meeting regularity and programmatic review. Irregularity of state level meetings was reported from Uttar Pradesh, West Bengal, Assam, and Telengana.
- ▶ At the level of the District, there is better functionality, and meetings appear to be better organized, across most states. Exceptions appear to be Rajasthan, Madhya Pradesh and Shravasti in Uttar Pradesh. In Palakkad, Kerala, an active Executive Committee of the DHS took decisions related to differential financing of its facilities and modifying approved activities based on local context for Attapady block.
- ▶ Though RKSs have been formed across all states visited, their spread at different levels of facilities, functioning, meeting regularity, quality of minutes and levels of participation varies substantially. RKS are yet to be formed in some CHC and PHC, while they were in place in all DH in the districts visited.
- ▶ State reports highlight that members had limited awareness about the mandate of RKS and were not clear about the use of RKS funds. Instances of partial release of untied funds and other grants were also reported. The funds are primarily spent on infrastructural improvements and overall ambience/cleanliness. In Madhya Pradesh, decline in revenue generated was shared as a reason for RKS not functioning well, after the user charges being abolished in the state.

- ▶ While active public participation is reported from Kerala, Chhattisgarh, Mizoram, and Odisha, other states lag behind in involving elected representatives and other community members. In Tamil Nadu, the active role of PRIs is gradually getting weakened, and mainly it is the executive committee, comprising largely of facility's staff running the affairs of the RKS, with the community and patient concerns taking a back seat in the activities of RKS.

## **Planning**

- ▶ To a large extent, ready availability of data and the capacity to analyze and plan at local levels determines the extent to which data is used for identifying gaps and planning.
- ▶ This emerges as a gap in most states except in Tamil Nadu and Odisha, with ready access to the uploaded data. In Madhya Pradesh and Uttar Pradesh, district plans and block plans were available, but the basis of these is a mix of use of data and field observations. In West Bengal, planning teams at all levels, shared that the quality of data as a key area of concern. In Punjab also the team notes that district planning is a weak area. Even where planning does take place, there is little flexibility to address local issues and garner additional financing as reported from Medak in Telengana.

## **Programme Management**

- ▶ Programme Management Units (PMU) at state (SPMU), District (DPMU) and Block (BPMU) levels are in place in all states except Tamil Nadu, where the programme managers at each level are the designated officers of the existing public health cadre, indicating strong integration.
- ▶ Integration with Directorate appears as a problem, manifesting itself at state and district management, except in the states of Tamil Nadu, Odisha, Uttarakhand, and Kerala. Another related issue that emerges is the lack of integration between programme divisions seen in Madhya Pradesh and Uttarakhand.

- ▶ Functionality of DPMU and BPMU depends on the human resources allocated, a sound training and orientation programme, and regular supervision. In most states, this appears to be a serious lacuna. Many of the sanctioned positions are lying vacant. In Madhya Pradesh 39% of SPMU, 69% of DPMU and 23% of BPMU positions are vacant, with serious implications for implementation, monitoring and supervision.
- ▶ A larger concern is that even where there are adequate staff, monitoring is weak as seen in Mizoram.
- ▶ In Odisha, Uttar Pradesh and Bihar, the reports make reference to the role played by Development Partners in monitoring and programme support. In Odisha and Uttar Pradesh there are concerns about effectiveness and duplication respectively, and in Bihar it appears that monitoring at the level of ASHA and ANM is being undertaken by staff of development partners.
- ▶ From a few states, (Uttar Pradesh, Madhya Pradesh, Assam,) reports make highlight the lack of guidelines issued by the state for the national programmes, at the peripheral levels, leading to lack of understanding and poor implementation of programmes for which funds are available and which remains underutilized.
- ▶ Apart from the state of Tamil Nadu which has a public health cadre in place, there were no reports from any of the states visited of instituting such a cadre.

## **Supervision and Monitoring**

- ▶ Overall monitoring and supportive supervision are weak across states, including the non high focus states.
- ▶ Supervisory checklists are not being used, nor are community interactions being undertaken to validate data on services. This was seen in Madhya Pradesh, Odisha, In Uttar Pradesh, plans were signed and checklists were being used, but in the absence of

review and feedback, there is little value to the process.

- ▶ In Bihar and Chattisgarh, ranking of blocks and districts using performance monitoring data indicates effective supervision.
- ▶ One factor that hinders supportive supervision was identified in Telengana as being due to lack of mobility support.
- ▶ Another issue is a progressive reduction in support to the lower levels of implementation – namely from state to district, district to block and thence to the village/city/slum. This was noted in the reports from Madhya Pradesh, Rajasthan, and Punjab.
- ▶ In Telengana, high levels of absenteeism is being addressed through a mechanism of skype attendance.

### Accountability

- ▶ District/City Level Vigilance & Monitoring Committees (D/CLVMCs) have not been constituted in most states. DLVMCs are yet to be established in Ganjam, in 16 out of the 38 districts in Bihar, in Shravasti, Uttar Pradesh, and in Sri Ganga Nagar in Rajasthan. Even where they are in place, they are not yet effective.
- ▶ Community accountability has been discussed in TOR 5.



### Regulations- For Clinical Establishments Act (CEA)

- ▶ Mizoram and Chandigarh are implementing the CEA. In Orissa, the process has been initiated to include all the private hospitals to be registered under Clinical Establishment Act while in Tamil Nadu, the state is awaiting the clearance from Law department to revive the Tamil Nadu Private Clinical Act 1997, with modifications in the Act and Rules. In Rajasthan and Kerala, the CEA is not in place yet, a critical gap, given the high OOPE in the private sector.

## RECOMMENDATIONS

- ▶ There is an urgent need to address the strengthening of the programme management units including creating TORs, filling up vacancies, ensuring orientation to roles and responsibilities and creating systems for performance appraisal.
- ▶ Hurdles to field supervision be they related to mobility, checklists, formats and registers need to be addressed. States must put in place mechanisms for review and feedback to ensure the complete supervisory cycle to improve programme implementation.
- ▶ The planning process at block and district levels needs to be taken seriously by making available high quality data in a timely fashion to enable context specific planning, accompanied by capacity building of staff to undertake such planning.
- ▶ Capacity building of Rogi Kalyan Samiti members needs to be undertaken to equip them to perform their roles with support and monitoring from the state and district levels to district and sub district facilities.
- ▶ States should create a plan to disseminate guidelines- at the monthly review meetings with the CMHO/DPM and those at district levels, and/or by uploading them on websites and sending reminders and alerts.
- ▶ National and state level advocacy meetings to expedite the process of CEA and the creation of a public health cadre in states are urgently required.

## FINDINGS FROM STATES

### ASSAM

- ▶ Governing Body (GB) and Executive Committee (EC) of the State Health Mission, have been reconstituted to include Ministers of Education, Minister of Welfare of Minority, Labour Minister etc. according to the revised guidelines.
- ▶ The last meeting of State Health Mission was held on 8, July 2013.
- ▶ The structures for monitoring and supervision are weak. The awareness amongst official about guidelines and programmatic activities was lacking.
- ▶ The District level Vigilance and Monitoring Committee are not active and no structured mechanism for facility monitoring is found in place.
- ▶ 1123 RKS formed up to PHC level, but awareness on fund utilization varies across RKS.

### BIHAR

- ▶ The meeting of State Health Mission is regularly organized once in 6 months.
- ▶ DPM has weekly meetings with BPMs where grievances, program running and performance reports across the blocks are discussed.
- ▶ Ranking of Blocks is based on performance, and non-monetary incentives provided such as certificate of appreciation and felicitation.
- ▶ RKS in place in all facilities visited, with regular meetings, albeit poor meeting records. RKS role in monitoring state level PPPs for facility level service contracts found to be limited.
- ▶ Only 16 District/City Level Vigilance & Monitoring Committees (D/CLVMCs) have been reconstituted out of 38 Districts of Bihar.

### CHANDIGARH

- ▶ State Health Mission, Governing Body (GB) and Executive Committee (EC) meetings are held regularly.
- ▶ Effective integration among the various NHM programmes and between Programme Management Unit and Directorate of Health and Family Welfare was noted.
- ▶ U.T. has not uploaded its supportive supervision plan and visit reports on State NHM website, as part of Mandatory Disclosures. Supervision by programme officers at field level (especially the role of LHVs) needs to be strengthened.
- ▶ One meeting was held regarding District Vigilance and Monitoring Committee (DVMC) under the Chairmanship of Secretary Health in the last year.
- ▶ No RKS have been constituted in any of the facilities, but PRI members were oriented on utilizing RKS funds.
- ▶ Clinical Establishment Act is applicable in the UT and is being implemented



## CHATTISGARH

- ▶ Meetings of State Health Mission and State Health Society are periodically being conducted in the state. District Health Societies and Jeevan Deep Samitis (Rogi Kalyan Samitis) meet regularly.
- ▶ District planning process is in place and all district PIPs are forwarded to the State. The disease control programmes are being implemented by nodal officers under the overall supervision and control of CMO and the DHS.
- ▶ Regular reporting of NHM activities is occurring at all levels. Monitoring meetings are being undertaken at various levels based on analysis of data received from field.
- ▶ Jeevan Deep Samities (state nomenclature for RKS) have been established across all levels and appear to be functional. User fees from patients serve as a revenue source, although Students, APL & BPL card holders are exempted.
- ▶ HMIS/MCTS data is being used for planning and monitoring purposes. A monthly analysis of HMIS data is done every month. A district wise comparison is done and rankings are generated. This analysis is then sent to District Collector, CMHO and Health Secretary, forming a feedback loop.
- ▶ Low levels of community awareness about NHM facilities/services result in limited capacity to demand services or undertake social audit.

## KERALA

- ▶ Local government bodies including Panchayati Raj, Member of Parliament and Member of Legislative Assembly allocate substantial proportion of their resources towards strengthening and scaling up of public health services.
- ▶ Even state of the art blood banks, Hemophilia and Renal dialysis centers are being run by civil society with funds generated locally.
- ▶ The state also engages woman- self-help group (Kudumbhasree) volunteers towards community mobilization, health screening, source reduction activities, and in provision of health services. Furthermore, PRIs are the common link for all health and health related initiatives of various departments.
- ▶ Sulekha - A plan monitoring software developed by Information Kerala Mission for the formulation and monitoring of plan projects of Local Governments is a good model.
- ▶ The State's approach discourages parallel systems of service provision and program management. This is reflected across all levels with increased integration and ownership of NHM initiatives within the health department/directorate of the state.
- ▶ RKS meet once a quarter and minutes were found to be maintained. As members of RKS it was observed that PRI representatives and representatives of different political parties are actively involved in decision making as well as mobilization of funds.
- ▶ At certain health facilities (esp. at PHC level) HMC funds have been merged with AMG and Untied Fund. This results in better utilization and monitoring of funds.
- ▶ District Level Vigilance and Monitoring Committees are in the process of re-constitution.
- ▶ Clinical Establishment Act is passed by the assembly but the rules are yet to be passed. An unregulated private sector with compromised quality of care at high costs remains a concern.

## MADHYA PRADESH

- ▶ State Health Society (SHS) meetings are being held regularly, while meetings of the District Health Society (DHS) are irregular.
- ▶ State level Programme Management Unit is functional, but 39% of the sanctioned positions are vacant, including the State Programme Manager and State Finance Manager.
- ▶ The PMUs are functional at all levels and integrated with the Directorate. However, integration among different programme divisions needs to be improved.
- ▶ Use of data from various sources and gap analysis as per local requirement is not reflected in preparation of DHAPs.
- ▶ Rogi Kalyan Samitis have been constituted in all the visited facilities, but General body meetings are irregular. While meeting records are maintained, follow up of action taken appears poor.
- ▶ State and District officials reported loss of interest from PRI members on account of decline in revenue generation due to elimination of user charges, and there is little effort on reviewing use of existing funds or generating alternative resources.
- ▶ State has established mechanism of supportive supervision and monitoring of all health programs and schemes, by senior officials of the Directorate of Health Services (DHS) and National Health Mission (NHM) and weekly meetings with directors and state program officers are held, using 'e-health' software.
- ▶ Policies, guidelines and tools have been put in place, e.g. rational drug use, EDL, treatment protocols, grievance redressal committees, etc. However, awareness and ownership on most of these policies and guidelines are poor in DPMU/BPMU teams and amongst district and block officials.
- ▶ Social audit and community accountability mechanisms including District level vigilance & Monitoring Committee, IEC Committee, ASHA Grievance mechanism, were not in place.

## MIZORAM

- ▶ The State Health Mission, State Health Society, Governing Body and Executive Committee are all in place and functional. The state has a Joint Mission Director position also.
- ▶ District Vigilance and Monitoring Committees are formed and meetings have been held.
- ▶ The State has in place the Clinical Establishments Act 2007, which has been amended to adopt the features of central regulations. The state is also focusing on implementation of Food and Safety Standards Act, 2006. A State has drafted a State Drug Policy, based on the previous policy of 2003, specifying directions regarding generic prescriptions, open tender procurement, pharmaco-vigilance, consultations committees etc. The finalization of this policy as well as the Essential Drugs List is in process.
- ▶ Although RKS is in place at PHC and CHC level, with active involvement of civil society and PRIs in monitoring of the programme implementation, but involvement in planning process is weak, reflecting the need for capacity building. RKS meetings are not held regularly.
- ▶ The program staff at SPMU and DPMUs is adequate, but structured supervision and monitoring plan was found lacking.
- ▶ It was also observed that HMIS, IDSP, FMR data is not used in PIP preparation.

## ODISHA

- ▶ There is effective convergence between the Health Directorate and the Programme management Unit.
- ▶ The DLVMC in the process of being reconstituted.
- ▶ HMIS data is being used for planning purposes. At facility level, internet connectivity remains an issue leading to delay in feeding data.
- ▶ As part of implementing Clinical Establishments Act data relating to private Hospitals registered under the act is being uploaded to GOI portal.
- ▶ Rogi Kalyan Samitis are formed and are functional.
- ▶ Although complaint and grievance boxes were installed in many facilities, there was no Grievance Redressal Mechanism in place.
- ▶ The District Level Vigilance and Monitoring Committees (DLVMC) are in the process of formation.
- ▶ Most of the resources (GOI and DP support) are not utilized effectively as funds are diverted towards administrative expenses. An effective system may be devised for optimal utilization of funds/resources by adopting a Hospital/facility by development partners for parity with international/GRIHA standard.

## PUNJAB

- ▶ State Health Mission was formed in October 26, 2005 later amended in 2013 to incorporate NUHM.
- ▶ RKS is established at District hospital and at few CHCs. However, there is no participation of Zila Parishad and community in functioning of RKS. Documentation of meeting minutes e.g RKS, accounting not maintained properly. RKS meetings are irregular with low participation of PRI and members have not been trained.
- ▶ Health Planning and Monitoring Committees for Block and PHC have been constituted at different levels.

## RAJASTHAN

- ▶ State and District Health Societies are functional and are well coordinated. Meetings of the District Health Society are not being held regularly. During the meeting of DHS, data/information provided through PCTS is reviewed.
- ▶ The role of PRI at Sub-Centres(SCs) and Public Health Centres (PHCs) are very limited. In Rajasthan Medicare Relief Society (RMRS), Collector of the District is the Chairman and Chief of Zila Parishad is the village Vice-Chairman.
- ▶ Supervisory visits carried out by officers from time to time are being discussed and decisions taken thereon are being sent to all concerned for compliance. About 11 supervisory visits i.e. 5 CHC, 15 PHC and 20 Sub-Centres are to be organized during a month which include 6 night stays at the peripheral facilities to understand the problems faced by staff as well as communities accessing services there from.
- ▶ District Vigilance and Monitoring Committees (DVMC) are only now being formed.
- ▶ Clinical Establishment Act has been adopted by the state but the rules are yet to be passed.

## TAMIL NADU

- ▶ NHM is integrated with the Directorate of Public Health & Preventive Medicine and Directorate of Medical & Rural Services.
- ▶ There is no separate staff recruited for State Program Management Unit and from the regular service; program officers are managing the components of the NRHM.
- ▶ State Health Society meetings are being held regularly while meeting of State Health Mission is not held since 2012.
- ▶ RKS have been formed in 2172 facilities from Medical Colleges to PHCs. Meetings are reported to be regular. There is no representation of general community or users in the RKS.
- ▶ Even though structured system of Supportive Supervision is in place, many districts are yet to implement them effectively.
- ▶ District Level Vigilance & Monitoring Committee are formed.
- ▶ For Clinical Establishment Act the State is awaiting clearance from the Law Department and after approval, will revive the Tamil Nadu Act.

## TELANGANA

- ▶ The State is in the process of reconstituting the State Health Mission and all the district level Vigilance and Monitoring committees. The new members need to be inducted after the bifurcation of the State and fresh elections.
- ▶ Coordination between numerous directorates and institutions is a major challenge at the State as well as district level.
- ▶ Convergence between DPH, TSVVP and NHM is poor and intra- departmental exchange of information is also low.
- ▶ In the absence of full time Mission Director with stability of tenure, the Principal Secretary (Health) takes interest in all the directorates and spares time for important events. However, it is neither sustainable nor recommended in the long-term to do so.
- ▶ Pace of programme implementation is very slow. Overall expenditure is below 25%.
- ▶ Most programme management positions in SPMU are vacant. District Health Society is functioning well. The district planning process is in place but DPMU staff need to coordinate with the two directorates (DC-HS and DM-HO).
- ▶ PIPs do not reflect district needs and priorities.
- ▶ RKS or Hospital Development Society was constituted in all the visited blocks but functionality was limited.
- ▶ United funds were used for infrastructure improvements and cleanliness. There was limited public participation of community or of elected representatives.
- ▶ Use of evidence in planning seemed to be weak. There is greater scope of integrating survey data as well as HMIS/MCTS and Supportive supervision findings in plans.
- ▶ The supervision and monitoring of NHM activities in the State was found to be very weak.



- ▶ Given serious concerns about chronic absenteeism of health staff in the Districts, the DHS is considering the piloting of biometric attendance measures for gathering information on attendance by linking to salary.

## UTTARAKHAND

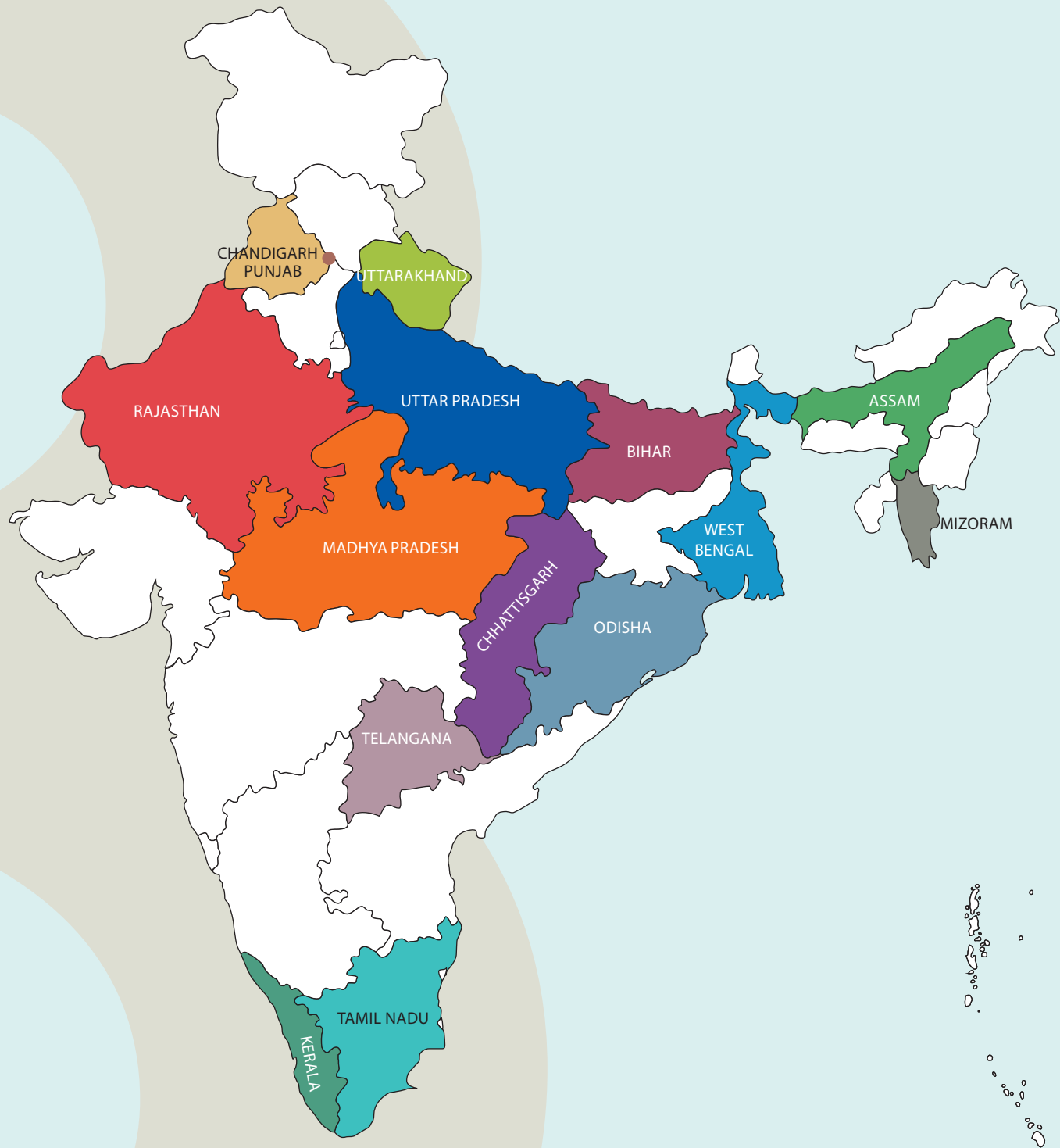
- ▶ There is effective integration of the Program Management Unit with the Directorate of Health Services.
- ▶ Recruitment of HR for program management has been delegated to State Administrative Officer. Task Groups for Selected Tasks (time-bound) are formed for effective implementation of programs.
- ▶ With the lack of dedicated program officers, Medical officers are being given additional charge.
- ▶ The lack of coordination between contractual and regular staff further makes it difficult for personnel from BPMU and DPMU to discharge their duties.
- ▶ Supportive supervision and monitoring visits being undertaken by management unit at all level are sub optimal. Follow up on the monitoring and field visit reports of the BPMU by the DPMU and SPMU is weak.
- ▶ District vigilance and Monitoring Committee needs to strengthen its activities and provide suitable recommendations/feedback for program refinements.

## UTTAR PRADESH

- ▶ The State Health Mission meetings are not held regularly
- ▶ At state level the Programme Management unit under each cell is headed by regular staff on deputation from the Health system supported with additional Consultant who has been recruited under NHM.
- ▶ RKS has not yet been constituted in many facilities, although it is reported that the DH is getting regular funding of annual maintenance grant and untied fund under NHM.
- ▶ Ownership of programs at district and block level is an issue. The District Medical Officers and (particularly) the Block medical officers are not actively involved in the management of various national programmes.
- ▶ The implementation of the programme is left to the field level workers and the data is being routinely collected and transmitted by the data operators or a set of officers called Assistant Research Officers.
- ▶ There is lack of clarity amongst the Chief Medical Officer, DPM and DAM on the financial power of the District Health Society.
- ▶ State has taken positive initiatives to improve supportive supervision. District Officers, especially contractual officers, undertake field visits, using check list and upload them on the state NHM website.
- ▶ While officers do inspect blocks and PHCs this is seen as a routine exercise, not yielding much by way of analysis and review of implementation. Sub centre and village visits by medical officers do not take place.
- ▶ It is also seen that all the national programs clubbed together present a very complicated picture at the field level, particularly in sub-centres.
- ▶ It has been observed that there is duplication of roles and responsibilities between the staff under NHM and TSU.
- ▶ The District Vigilance and Monitoring Committee is in the process of formation.

## WEST BENGAL

- ▶ The State Health Mission is formed but the meetings are infrequently held. At the district level, the District Health Mission is not formed.
- ▶ Given shortage of subordinate staff (CMOH – I, II, III etc.) the CMHO holds additional charge for several programmes, including for NUHM.
- ▶ De-centralised planning is in place and all districts have planned for NHM. However, the block planning and village planning were sporadic and the enthusiasm for district planning is low. This was largely due to the lack of district participation in preparation of district PIPs.
- ▶ Limited use of HMIS data for planning appears to be on account of poor data quality.
- ▶ The shortage of PMU at block level is the most acute with all the positions of BPMs (341 blocks) vacant.
- ▶ RKS have been constituted across all facilities with bimonthly meetings being held. Most facilities use untied funds for diagnostic services, cleanliness services and BMW.
- ▶ There has been no capacity building initiatives and trainings programme on planning and management areas, conducted for the DPMU staffs.
- ▶ Regular review meetings of SHS and DHS are being conducted.
- ▶ State level support supervisory teams for the Districts were in place for various programmes, and District officials were aware of monitoring visits formats shared by the state headquarters.
- ▶ The State is yet to establish a systematic supportive supervision, review and follow up mechanism.
- ▶ There appears to be an absence of supervision and monitoring at District level. No regular visits were conducted by the District Officials to the block level. There is no grievance redressal cell established for DPMU.
- ▶ The State has a regulation in place for Clinical Establishments but the Central Act or its ambit has not been adapted by the State. But the details of private hospitals registered are available on the website.



# State Positives and Challenges

# ASSAM



## DISTRICTS/INSTITUTIONS VISITED

### District Karimganj

Civil Hospital Karimganj, Makunda Christian Leprosy & Genral Hospital, Isabel T. E. Hospital  
Durlabhchera Model CHC  
R.K. Nagar BPHC, Nivia PHC, Cheragi PHC, Chargula Mini PHC, Bazarichera Subsidiary Health Center, Patharkandi BPHC, Nilambazar PHC  
Dohalai State Dispensary & SC, Bazarghat Medighat, Tillibhumi, Bazarichera, Puraharia  
Hamindpur AWC, Khukhichera AWC, Ranu prabha Upper primary School, Kalacherra

### District Tinsukhia

Civil Hospital Tinsukia  
Margherita CHC FRU, Digboi CHC  
Ledo-MPHC, Ketetong BPHC, Na-Sadia BPHC, Hapjan BPHC, Bordirak MPHC, Kakopather BPHC  
Alubari SC, Makumkilla SC, Islambari SC, Kailaspur SC, Naupanitulla SC, Rumaighabharu SC  
Sankardev Vidyapeeth High School, Kailaspur AWC, Margherita Tea Estate Hospital, Boat Clinic, MMU

## REVIEW TEAM

- ◆ Dr. S. Sikdar, DC, MoHFW
- ◆ Ms. Bindu Sharma, Dir. (IFD)
- ◆ Ms. Deepti Srivastava, Dir (Stats)
- ◆ Dr. Parthajyoti Gogoi, RD (Gol)
- ◆ Dr. Madhulika Bhattacharya, Prof. (NIHFW)
- ◆ Dr. L. Ramakrishnan, SAATHI
- ◆ Dr. Nayan Chakraborty, PHFI
- ◆ Dr. Manika Sharma, Sr. Consultant
- ◆ Dr. H. Sudarshan, Dir. (Karuna trust)
- ◆ Ms. Jhimli Barua, IHBP (FHI 360)
- ◆ Dr. Parminder Gautam, NHSRC
- ◆ Ms. Rachna Singh, DFID
- ◆ Mr. Sumanta Kar, FMG-MoHFW
- ◆ Dr. Arpana Kullu, NHM-MoHFW
- ◆ Dr. Shikha Yadav, NHSRC
- ◆ Dr. Poonam Mishra, Consultant (NVBDCP)
- ◆ Mr. R. K. Upamanyu, Sr. Consultant NRHM 1
- ◆ Mr. Tarkeshwar Rao, MMPC



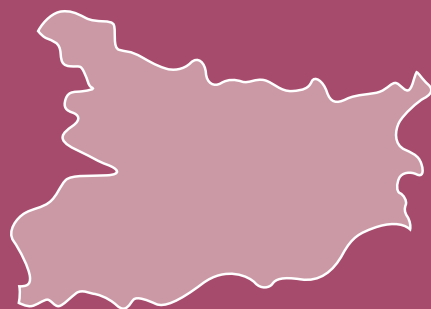
## POSITIVES

- ◆ A substantial increase in OPD and IPD footfall has been seen throughout the state.
- ◆ Quality of infrastructure was good in most facilities across both the districts, with adequate space for wards, labour rooms and laboratories.
- ◆ State has adequate infrastructure as per population norms, with a range of levels of facilities such as Sub-centre, Mini-PHC, PHC, Block PHC, CHC, Civil Hospital and Medical College associated hospital.
- ◆ Well functioning SCs with dedicated frontline workers (ANM/MPWs). State has a pool of enthusiastic and skilled ASHAs.
- ◆ The program management staff at DPMU and BPMU is dedicated and have high morale (in both districts). The DPMU and BPMU staff has good coordination between themselves.
- ◆ EDL (Essential Drugs List) for different level of facilities is available and drugs are being procured by generic names.

## CHALLENGES

- ◆ The delivery points in both the districts visited were not planned and mapped adequately.
- ◆ The state has a wide variety and nomenclature of health institutions, but their differentiation in terms of infrastructure, human resources and functionality is not clearly demarcated.
- ◆ The state is yet to develop a systematic 'Road-map' for Quality. The functioning of State Quality Assurance Units is not yet established.
- ◆ JSSK services are not being implemented as per guidelines. Interaction with beneficiaries revealed huge out of pocket expenditures on diet, referral transport and drugs.
- ◆ The JSY payments to beneficiaries are irregular and varied in all blocks of both Districts.
- ◆ The convergence between facility and community MDR and IDR is weak and the findings/analysis of maternal death review is not reflected in planning strategies to combat the issue.
- ◆ The performance of the EMRI has deteriorated in the last few years, with call drops reported from the districts. MMU services are highly underutilized, with most of them stationed near the health facilities.
- ◆ Mapping of trained HR is unavailable thus influencing rational deployment.
- ◆ The state lacks a well planned supportive supervision mechanism.
- ◆ In the absence of a centralized procurement system, there is duplication of procurement by both DHS & NHM.





## BIHAR



### DISTRICTS/INSTITUTIONS VISITED

#### District Patna

SDH Danapur, Guru Govind Singh  
BPHC Maner, Fatuha, Bakhtiyarpur, Phulwarisharif, Danapur, Sampatchak, Dhanarua  
APHC Sherpur  
HSC Jethuli, Rukunpura, Potahi, Taneri, Aurangpur  
PMCH, NRC Guru Govind Singh, Regional Drug Warehouse Fatuha, BMSICL  
VHNDs-Jethuli, Aurangpur, Taneri Madhya, Taneri

#### District Madhubani

DH Madhubani  
SDH Jhanjharpur  
BPHC Rajnagar, Laukahi BPHC, Jhanjharpur, Benipatti  
APHC Mahadev Math, Benipatti  
HSC Sarv Seema, Uchhat, Bankatta, Anganwadi Centre Laukahi, Benipatti  
ANM training centre, Madhubani, Blood Bank Madhubani, Blood Storage Unit Jhanjharpur  
VHNDs-Sarv Seema, Paitghat  
AWW Lohan, Shahpur  
Village Baswaria Kachra (Bankatta), Behta (Behtta)

### REVIEW TEAM

- ◆ Shri B. K. Pandey, Advisor (SP)-Planning Commission
- ◆ Dr. Pradeep Halder, DC (Imm)
- ◆ Mr. Amal Pusp, Dir. (IH/IC/Tobacco)
- ◆ Dr. R K Das Gupta, JD, NVBDCP
- ◆ Mr. Kedar Nath Verma, DD (NRHM-II)
- ◆ Dr. Amit Katewa, Con (D&C), NVBDCP
- ◆ Ms. Pallavi Kumar, UNFPA
- ◆ Ms. Pinky Bulchandani, NRHM-I
- ◆ Dr. Sharad Iyengar, AGCA Member
- ◆ Dr. Sheenu Chaudhary, MMPC
- ◆ Dr. Charu Garg, Advisor Health Care financing, NHSRC
- ◆ Dr. Alia Kauser
- ◆ Mr. Ratish, Adolescent Health
- ◆ Dr. A. Kadu, RNTCP-WHO Consultant Bihar
- ◆ Dr. Jyoti Joshi Jain CH&I, Public Health Foundation of India
- ◆ Dr. Arun Srivastav, Consultant NHSRC
- ◆ Mr. Pradeep Kumar Choudhry, NIPI
- ◆ Mr. Dharmendra Kumar, NHM-Finance

## POSITIVES

- ◆ Regular meetings of State Health Mission, State Health Society and District Health Society as per the norms are convened.
- ◆ A good supply chain for drugs and consumables is in place, ensuring the availability of free drugs at all public health facilities.
- ◆ The state has ensured availability of free diagnostic services, by providing free X-Ray/Ultrasound & pathology services at 60 USG centres and 369 X-Ray centres throughout the state. 33 units of Pathology Laboratories and 252 units of pathology sample collection centres are also operational in the state.
- ◆ Differential fund allocation to HPDs is provided.
- ◆ A well functioning ASHA support structure is in place at state, district, block and cluster levels.
- ◆ The PPP model adopted by the state for running the NRCs has been successful in implementing malnutrition combat strategies. Interestingly, sixty percent of those admitted are girls, which is contrary to the trend seen in SNCU admissions.
- ◆ The rate of completed immunization has risen from 70% as per AHS 2012-13 to 73% in 2013-14 as per the HMIS.
- ◆ The state has taken proactive role in 2014 to come closer to the Kala Azar elimination target by 2015. The state has started single day treatment with Liposomal Amphoterecin B (free supply by WHO) in 4 districts and shall expand this in a phased manner in all the 33 endemic districts.
- ◆ The state has undertaken QI intervention during 2014 in 36 DH, 30 FRUs, 35 L2 PHCs & 2 maternal units of medical colleges under National Quality Assurance Standards Guidelines (NQAS) guidelines.

## CHALLENGES

- ◆ The post of Director Finance and State Account Manager (at the state level) and several positions at block level have been vacant for over a year, adversely affecting financial management.
- ◆ The state has an uncommitted unspent balance (Rs. 199.52 crores) and committed unspent balance (Rs. 621.81 crores), but districts have no clear understanding about the activity wise committed and uncommitted unspent balance.
- ◆ There is a wide gap between sanctioned and existing staff; the majority of clinical staff are on deputation.
- ◆ There is lack of trained manpower. Refresher trainings for existing staff and induction training for new staff are required.
- ◆ There are inordinate delays in JSY payments to both beneficiaries and ASHAs. No concrete actions have been taken to address this.
- ◆ There is no structured system for maintaining records/reports of physical and financial progress at State or District level.
- ◆ Systems for grievance redressal are weak.
- ◆ There is absence of an active role for urban local bodies in the NUHM programme.
- ◆ The population: ambulance ratio is fairly inadequate; only one ambulance is available in Madhubani district for a population of 48 lakhs. Ambulance telephone numbers are not integrated creating a lot of confusion.
- ◆ Unavailability of a systematically managed supply chain mechanism was evident via a huge mismatch in demand and supply of vaccines at VHND sessions.





## CHANDIGARH



### DISTRICTS/INSTITUTIONS VISITED

#### Chandigarh

District Hospital: Sector 16

MCH Polyclinic 22, Civil Hospital Manimajra, Poly clinic 45 (under construction)

Civil dispensary-Citco, 37 B, Dhanas, Resettlement colony, Attawa, Mauli Jagaran

Ayush Dispensary-Mauli Jagaran, 47, 37 B

AMU-Khuda Jassu, Khuda Lahora

SCs-Raipur Kalan, KishanGarh, Mali Jagran, Khuda Jassu, Khuda Ali Sher, Sharangpur, sector 47, Dhanas, Sector 45, Sec 44, Palsora, Behlana, Raipur Khurd, Kishan Garh

AWCs-Raipur Kalan, Indra Colony

UHTC 44, UHTC Indira Colony

RHTC-Sector 54

MC-GMCH 32, PGI Chandigarh

### REVIEW TEAM

- ◆ Dr. Bamin Tada, Advisor Health, Ministry of Development of NE Region
- ◆ Mr. R.C. Danday, Director NHM & RCH Donor Coordination, MoHFW
- ◆ Dr. Tarsem Chand, Director, MoHFW
- ◆ Mr. Suresh Chand Rajeev, Director, CGHS-Admin, Gol
- ◆ Dr. Amarjit Kaur, CMO, ROHFW, Chandigarh, Gol
- ◆ Dr. D.N. Nayak, Publiv Health Expert, DFID
- ◆ Ms. Asmita Jyoti Singh, Senior Consultant, NHM, MoHFW
- ◆ Dr. Priyanka Agarwal, Consultant RNTCP
- ◆ Dr. Anubhav Srivastava, Consultant CH&I, RBSK, MoHFW
- ◆ Ms. Abhilasha Sahay, Consultant, TSA
- ◆ Mr. Puneet Jain, Consultant FMG, MoHFW
- ◆ Mr. Mohammad Ameer, Consultant, NHSRC



## POSITIVES

- ◆ Integration between NHM and Directorate of Health Services in the State is effective.
- ◆ Partnerships with PRIs, Medical College and NGOs, enable convergence resulting in better outcomes.
- ◆ The overall infrastructure of the facilities was well maintained and disabled friendly.
- ◆ District Hospitals are being utilized as nursing schools, thus providing an opportunity for skill based training.
- ◆ In Mani Majra, an excellent Psychiatric OPD and Helpline being run as an ASHA initiative.
- ◆ State has a well designed IEC strategy on Cancer Awareness which is being implemented.

## CHALLENGES

- ◆ JSSK has yet not been implemented as per guidelines.
- ◆ The UT has not yet formulated or implemented Free Drug Policy/Diagnostics Scheme. There is no facility wise EDL in place. UT does not have any IT enabled supply chain management.
- ◆ The sex ratio in the UT is a concern (818). Despite initiatives such as the Beti Bachao initiative, the increased number of second trimester abortions needs attention.
- ◆ There are no patient grievance redressal mechanisms in place.





## CHHATTISGARH



### DISTRICTS/INSTITUTIONS VISITED

#### District Jashpur

DH, Jashpur

CHC Bagicha, CHC Kunkuri, CHC Manora, CHC Kansabel

PHC Narayanpur, PHC Aastha, PHC Bagiya

Health Sub Centre: Lora, Bandarchuan, Rupsera, Charaid and, Chatakpur, Cheraghogra, Beldih

Schools-Prathamik Shala, Bagiya (RBSK Team), Prathamik Shala and Madhyamik Shala Chatakpur, Prathamik Vidyalaya, Lota

Aanganwadi Lota (VHND) and Chatakpur

Focus Group Discussion- 4 (Mitani), 1 (AWW), 1 (School Teacher), 4 (Adolescents Girls and Boys), 1 (PW and Mothers), 1 (Village Chatakpur)

ANMTC, Jashpur Nagar

Empanelled Hospital- Holy Cross Hospital

#### District Korba

DH, Korba

CHC Kathghora, CHC Pali

PHC Korba (Urban PHC), Churi, Dhodi Para, Jatga, Chaitma

Health Sub Centre, Rajkamma, Bandhkhar, Binjra, Churi, Kohadiyacharpara

Schools- Pali Primary Residential School, Jagraha Primary School

Anganwadi Lalghat, Jagraha, Purenakhar, Dhawaipur

Focus Group Discussion- 20

### REVIEW TEAM

- ◆ Capt. Kapil Chaudhary DS (NHM-II)
- ◆ Dr. Sukhveer Singh, JD (NVBDCP)
- ◆ Ms. P. Padmavati (Astt. Dir-NRHM-II)
- ◆ Mr. Sanyasi Pradhan, (AEA)
- ◆ Dr. Bhuputra Panda (PHFI)
- ◆ Dr. Inderjeet Singh (DFID)
- ◆ Ms. Snigdha Sen, Senior Project Manager (SAATHII)
- ◆ Dr. Pushkar Kumar (MH)
- ◆ Dr. Praful Bharadwaj (MH)

- ◆ Dr. Faisal Shaikh (NRHM-I)
- ◆ Ms. Bharti Dangwal (PFI)
- ◆ Mr. Rajeev Ahuja (BMGF)
- ◆ Mr. Rajeev Prasad (NHM-Finance)
- ◆ Dr. Kshitij Khaparde (RNTCP)
- ◆ Dr. Richa Kandpal (NHSRC)
- ◆ Ms. Aastha Ummat (YP-PAMD)
- ◆ Ms. Avi Saini, (NUHM)



## POSITIVES

- ◆ The availability of infrastructure of health facilities conforms to population norms.
- ◆ The utilization of OPD, IPD and delivery services was good, with an increasing trend observed in the last three years.
- ◆ State has enabled career opportunities present for different cadre of workers like Mitadin, ANM, and RMP.
- ◆ State has created a strong non monetary incentives for Mitadin- such as preferential admission in ANM courses, benefits like life insurance for self and spouse; maternity benefits, education grants and scholarships for children.
- ◆ The overall awareness and utilization of RSBY/ MSBY among target beneficiaries is high.
- ◆ State has a number of functional IT based systems functional - e-Mahtari, State Health Human Resource MIS, Daily reporting system, Online Epidemic Reporting System (Sachet) etc.
- ◆ State Health Systems Resource Center, an autonomous agency, is actively engaged in the design, implementation and monitoring of health system led programs like the Mitadin program, RMP refresher training, research projects etc.
- ◆ State has notified the policy of Free Generic Medicines in August 2013 in all the public health facilities and the procurement process for drugs, diagnostics and equipments is being done centrally through CGMSC.
- ◆ The per capita allocation for drugs in Chhattisgarh is higher than Tamil Nadu and Rajasthan.

## CHALLENGES

- ◆ There is a severe shortage of specialists in the state. In Jashpur, there is no Paediatrician available at Government health facilities in the whole district. Ultrasound facility not available at any public facility in the districts visited.
- ◆ The availability of MTP services is limited to district level only, indicating.
- ◆ Availability of drugs for MTP, EC Pill and contraceptives was found to be irregular across facilities.
- ◆ Untrained and poorly trained staff is another area of concern and requires immediate attention.
- ◆ Capacity of sub district staff in financing and accounting is weak.



# KERALA



## DISTRICTS/INSTITUTIONS VISITED

### District Palakkad

District Hospital  
W&C Hospital  
THQH Ottappalam  
TSH Kottathara  
CHC - Agali, Kongad  
PHC: Puthuppariyaram, Kalladikode, Mankara, Sholayur, Kanjirapuzha  
UPHC Dayara Street  
SHC - Kalladikode, Gonchiyur, Thuppanad  
JPHN Training Centre  
Anganwadis, Patients' Houses  
Homeo Dispensary, Kottaya  
Ayurveda Dispensary, Kannadi

### District Ernakulum

General Hospital  
DH - Aluva, Muvattupuzha  
THQH North parur  
CHC -Pandappally, Kalady  
PHC - Malayattur, Valakam, Edavanakad  
UPHC - Chambakkara, Thammanam  
SHC - Thazhuvankunnu & South Panangad  
Floating Dispensary Chathamma  
Anganwadis  
TI Vytila  
NGO VIHAN  
Don Bosco (Private Hospital)

## REVIEW TEAM

- ◆ Dr. Sushma Dureja (DC, AH, MoHFW)
- ◆ Dr. C.V. Dharma Rao (Director, NVBDCP, MoHFW)
- ◆ Dr. Muhammed Aslam (RD, H&FW)
- ◆ Mr. Sanjay Wadhawan ( US-MoHFW)
- ◆ Mr. Manoj Kumar Jha (US-MoHFW)
- ◆ Dr. Antony, Public Health Expert
- ◆ Ms. Neha Kashyap ( Consultant-MoHFW)
- ◆ Dr. MadhusudanYadav (Consultant-NHSRC)
- ◆ Ms. Sucheta ( Consultant-NHSRC)

- ◆ Mr. Jayant Mondal ( NHM- Finance, MoHFW)
- ◆ Dr. AshalataPati ( Consultant-MoHFW)
- ◆ Dr. Meena Som (Health Officer, UNICEF)
- ◆ Mr. Rajneesh Ranjan (State Program Officer, UNFPA)
- ◆ Dr. Shibu Balakrishnan (WHO Consultant RNTCP)
- ◆ Dr. Sai Subha Sree Raghavan (President, SAATHI)
- ◆ Mr. Vipin Joseph (Consultant RCH, MoHFW)
- ◆ Ms. Jyoti Khattar (RO, Planning Commission)
- ◆ Ms. Chaya Pachauli (PRAYAS)



## POSITIVES

- ◆ State is implementing programmes for care of NCD, home based palliative care, and mental health, with high levels of community involvement and acceptance.
- ◆ Effective convergence was observed between health institutions and local governance structures (PRI/ULBs), as seen in the palliative care programmes.
- ◆ Convergence extends beyond programmatic efforts to additional financing- state funds to PRI are equivalent to the untied funds provided through the NHM.
- ◆ Convergence between Directorate of Health Services and the State Health Mission is also commendable. District Programme Managers (for NHM) are selected from Kerala Medical Services.
- ◆ Well trained and motivated Junior Public Health Nurse (JPHN) are active in programme implementation, including community components.
- ◆ In urban areas, state has leveraged land for UPHCs from the Municipal Corporations, indicating ownership by the Urban Local Bodies.
- ◆ The State uses IT in several initiatives -Jatak and Janani Software for community based management of SAM children, HR Apps to manage employee leave status at District level and Digital Document Filing System.

## CHALLENGES

- ◆ There appears to be a dilution of efforts in provision of RCH services. The quality of delivery services in public health facilities, including at PHCs and CHCs was low.
- ◆ No framework exists for regulating the unorganized private sector, despite a significant number of deliveries are being conducted by this sector.
- ◆ A dedicated ASHA support structure (especially at sub-district levels) is lacking in the State. JPHNs are responsible for guiding ASHA on her day to day work. A formal ASHA grievance redressal mechanism is also not in place. ASHA payments show long pendency and in many cases ASHAs have not been paid incentives in the last year. ASHAs also reported non availability of drug kits. These findings imply a lack of adequate institutional support to the ASHA, and the state must examine the utility of this cadre in its present context.
- ◆ Supportive supervision mechanism is weak in the State. Integrated monitoring plans are not in place. Most visits are sporadic and a very vertical structure of monitoring is being followed by various program divisions.
- ◆ The Emergency Response System (ERS) continues to be weak. 6th CRM had also made this observation, and little progress was visible.
- ◆ The State has a dedicated corporation for procurement of drugs. However, stock-outs of few drugs, including Zinc and Vitamin K, was observed. State does not have online stock indenting mechanism/ drug vaccine distribution management system in place. A prescription audit mechanism needs to be instituted.





## MIZORAM



### DISTRICTS/INSTITUTIONS VISITED

#### District Aizawl West

Civil Hospital (Aizawl)  
SDH, Kulikawn  
PHC Sairang  
PHC Lengpui  
PHC Aibawk  
Urban PHC (ITI)  
SC Sairang  
SC Lengpui  
SC Tachhip  
SC Lengte  
Ambulance Call Center  
Central Medical Stores

#### District Lunglei

District Hospital (Lunglei)  
1 CHC  
PHC Tawipui (S)  
PHC Buarpui  
SC Hnahtial  
SC Serte  
SC Leite  
SC Thualthu  
SC Muathuam,  
SC Tawipui (S)  
Ramlaituianganwadi center,  
Thualthuangwanwadi center  
TB Hospital

### REVIEW TEAM

- ◆ Dr. M. K. Aggarwal (Team Leader), DC (UIP), MoHFW
- ◆ Dr. Shailendra Singh, Director (Drugs), MoHFW
- ◆ Ms. Renu Sobti, Jt. Adv. (HRD)-Planning Commission
- ◆ Dr. S. N. Sharma, Jt. Director (NVBDCP)
- ◆ Dr. Singh, Regional Director, DGHS
- ◆ Dr. Pushpanjali Swain, Faculty, NIHF
- ◆ Ms. Shalini Rao, Deloitte, Technical Support Agency
- ◆ Dr. Sheema Chowdhary, Consultant, Immunization Division
- ◆ Mr. Satyajit Sahoo, Consultant, NHM-Finance
- ◆ Ms. Aastha Sharma, Consultant NHSRC
- ◆ Dr. Shahab Ali Siddiqui, Consultant, NRHM-I
- ◆ Dr. Ravinder Kaur, Consultant, MH Division, MoHFW
- ◆ Mr. Ajit Kumar Singh, Consultant, NHSRC
- ◆ Prof. Sandra Albert, PHFI
- ◆ Shri Parijat Mishra, YP(SP)-Planning Commission
- ◆ Ms. Supriya Pattanayak, DFID
- ◆ Dr. Tulika Singh, SAATHI
- ◆ Dr. Gautam Borgohain, RNTCP
- ◆ Mr. RLM Kima, North East Regional Resource Center

## POSITIVES

- ◆ State has an adequate number of and distribution of health facilities.
- ◆ The rate of institutional deliveries is very high in the state (90%), and most deliveries take place in public institutions (82%).
- ◆ Infrastructure at health facilities was found to be good with well maintained, clean and hygienic facilities with safe drinking water and functional toilets.
- ◆ Sub Center Clinic concept as per time to care approach for scattered population is a commendable innovation by the state. The SCCs are set up on need basis through alternative funding (from the state and the Planning Commission) enhance accessibility to the health centers.
- ◆ The District Hospital (Aizawl) is an ISO certified hospital with eye bank and Cornea Transplantation Facility, tobacco cessation clinic, cancer registry and Electronic Medical Record System and the psychiatry unit at SDH (Kulikawn) providing exemplary mental health services.
- ◆ State has introduced motorcycle ambulance which reaches patients before the ambulance (which takes more time in the difficult terrain) and provides first aid and any other support needed.
- ◆ Strong community involvement in health activities was noted. Many NGOs, philanthropic or Christian Charitable Organizations help in improving amenities at hospitals like donating benches for patients' waiting area.

## CHALLENGES

- ◆ Immunization services (OPV, Hepatitis birth dose and BCG) at birth were lacking in the state, even for institutional deliveries. Storage of vaccines was also not as per guidelines.
- ◆ Irrational deployment of staff is a major issue.
- ◆ Utilization of National Ambulance Service is very limited, with most ambulances being used for patient drop back and inter-facility transfers, and few pick ups.
- ◆ Functionality of MMU was poor as very few outreach clinics were organized by MMUs in a month (2-5 per month per district). MMUs were not adhering to the National Guidelines.
- ◆ Standard Treatment Protocols in labour room and ICUs were not displayed.
- ◆ Availability of drugs and essential commodities such as IFA, Mag. Sulf., Misoprotol, Oxytocin and Zinc tablets was found to be poor, due to unavailability of a structured supply chain management system.
- ◆ Fixe day services for family planning are not provided at facilities below District Hospital level. Poor quality of Cu (380 A) has affected the adoption of IUCD services.
- ◆ Delay in payment of JSY incentives to ASHAs and beneficiaries was reported since May 2014 because of lack of funds.
- ◆ Huge HR shortage in NVBDCP.







## MADHYA PRADESH



### DISTRICTS/INSTITUTIONS VISITED

#### District Panna

DH Panna  
CHC Amanganj, Powai, Shahnagar  
PHC Mahendru, Suleh, Raipura  
Village & HSC Mehwa, Sathaniya  
HSC Pahadi Khera  
GAK Naya Bara, Beli Hinoti  
Tribal Village Umaria, Tulla  
VHND Village Lorehai  
Village Vutaria Pati, Diya  
Village & Primary School Hinoti  
Sentinel Site, DH Panna

#### District Katni

DH Katni  
SDH Vijayraghgarh  
CHC Rithi, Barhi  
PHC Slimnabad, Teori, Bilhari  
HSC Devgaon (also GAK), Kaudia (also GAK),  
Kua (L1), Sansarpur (also GAK), Gulwara (also  
GAK), Badagaon, GAK Bichpura  
High School Badwara  
Primary School Bilhari  
Primary School Badagaon  
District Warehouse  
Urban Slum Baghseoni, Bhopal

### REVIEW TEAM

- ◆ Dr. Dinesh Baswal, Dy. Commissioner (MH),  
Gol – Team Leader
- ◆ Dr. Nikhilesh Chandra, Sr. Regional Director
- ◆ Dr. Sher Singh Kashotiya, Asst. Dir (NVBDCP), Gol
- ◆ Mr. D K Pandey, Dir. (OL), Gol
- ◆ Dr. Preeti Kumar, PHFI
- ◆ Dr. Lalit Mahendru, RNTCP, Gol
- ◆ Dr. Sandhya Ahuja, NHSRC
- ◆ Mr. Sanjiv Gupta, FC (FMG), Gol
- ◆ Mr. Lalit Makwana, EO (Health), Planning Commission
- ◆ Dr. Raghunath Saini, RCH, Gol
- ◆ Dr. Apurva Chaturvedi, Unicef
- ◆ Dr. Sri Priya, SAATHI
- ◆ Mr. Bijit Roy, PFI
- ◆ Dr. Ravish Behal, NHM TSA – Deloitte
- ◆ Dr. Rattan Kumar, NIPI
- ◆ Ms. Neha Agarwal, NRHM, Gol
- ◆ Mr. Syed Abbas, NHSRC
- ◆ Ms. Risha, Adolescent Health, Gol
- ◆ Mr. Perwaiz Alam, HMIS, Gol
- ◆ Mr. Ritesh Aeron, MCTS, Gol



## POSITIVES

- ◆ Infrastructure for facility based newborn care is good - 30 out of 53 functional SNCUs have been accredited by National Neonatology Forum (NNF). State about 88% functional NBCC and 91% functional NBSUs.
- ◆ State has initiated certification of Model Maternity Wing (MMW) based on 37 criteria identified, this is under process in 25 districts.
- ◆ An online portal, 'CM online', has been set up for grievance redressal.
- ◆ To facilitate rational postings, list of all ANMTC graduates is put up on the web-site with domicile details and district may select candidates with preference to candidates from that district or division.
- ◆ State has developed annual performance appraisal system for service delivery and PMU staff.
- ◆ District MDR committee have been constituted and MDR is discussed on regular basis in DHS meetings. State has set up coordination with Medical colleges which provide regular feedback on the cases referred to Medical colleges with cause of deaths and level of delays.
- ◆ State has made efforts in provision of IUCD and PPIUCD services as a result uptake of PPIUCD services has also increased. Trained PPIUCD providers are available at all 51 DH, 63 SDH, 284 CHC and 54 PHCs. All 8764 SHCs provide fixed day interval IUCD services.
- ◆ "Mamta Abhiyan" launched by state is a good initiative to ensure quality of services.
- ◆ Gram Arogaya Kendras set up at AWC which provide 16 types of drugs and 5 diagnostic test at village level emerges as good practice of bringing essential primary care services at the door step up of community.

## CHALLENGES

- ◆ Inadequate and inequitably distributed delivery points and FRUs with concentration in certain areas.
- ◆ Skill based assessment and rational deployment of HR needs to be done at the facilities in Sub districts level.
- ◆ Though there is availability of trained staff at the health facility, poor adherence to GoI guidelines/ protocols for and service delivery esp. for MCH.
- ◆ Poor field level implementation of RBSK at the Districts. No systematic record keeping found at the districts.
- ◆ State needs to revisit the protocols being followed for Anemia Management which is not in concurrence with the protocols.
- ◆ HMIS data is not utilized for planning and monitoring the various initiatives / programmes / Schemes, and for preparing District health action plans.
- ◆ Shortage of Human resource needs to be addressed at the state and District level for NVBDCP.
- ◆ Need to establish an inventory and supply chain management system to ensure regular drug supply at all levels. Birth dose of OPV, Hep B and BCG were not being provided at any of health facilities.
- ◆ Handholding support needed by the CPMUs from the state for effective implementation of NUHM.

**सरदार बल्लभ भाई पटेल**  
**निःशुल्क औषधि वितरण केन्द्र**

SR NO	OPD MEDICINE		
1	Tab-ARTESUNATE	43	Tab-Paracetamol 500mg
2	TAB-Acetazolamide-250mg	44	Tab-Phenytoin sodium 100mg
3	Tab-Alprazolam 0-25mg	45	Tab-Primaquin 15mg
4	Tab-Amlodipine 10mg	46	Tab-Pantoprazole 40mg
5	Cap-Amoxicillin 500mg	47	Tab-Phenobarbitone 60mg-30mg
6	Cap-Amoxicillin 250mg	48	Tab-Quinine Sulphate 300mg
	Tab-Sulfamethoxazole 800mg+Trimethoprim 160mg	49	

माता से राख,  
यो जेने वाड

मुख्य शिक्षता एवं स्वास्थ्य अधिकारी,  
जिला कटनी (म.प्र.)

Comparative Block wise Dashboard  
RMNCH + A Indicators Based of HMIS data  
(April - September 2014 Vs April - June 2014)

Registered maternal & new born care

Reproductive age

Pregnancy Care					Child Births					Postnatal maternal & new born care					Reproductive age				
% Registered Pregnancies	% Registered Pregnancies with ANC	% Registered Pregnancies with ANC	% Registered Pregnancies with ANC	% Registered Pregnancies with ANC	% SBA attended deliveries	% Institutional deliveries	% Institutional deliveries	% Institutional deliveries	% Institutional deliveries	% Newborns having weight less than 3.5 kg	% Newborns having weight less than 3.5 kg	% Newborns having weight less than 3.5 kg	% Newborns having weight less than 3.5 kg	% Women 15 years and above	% Women 15 years and above	% Women 15 years and above	% Women 15 years and above		
Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14	Apr-14		
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78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1		
78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1	78.1			



## ODISHA



**DIET CHART FOR THE YEAR 2014-15 OF CHC KESINGA**

SL NO	NAME OF DIET	QUANTITY	TIME
01	BANANA(BHUSABALI)	1 Piece	BREAKFAST
02	APPLE	50 gm	BREAKFAST
03	BREAD	250 gm	LUNCH
04	HEN EGG	1 Piece	LUNCH
05	MILK (OMFED)	500 ml	LUNCH
06	SUGAR	26 gm	LUNCH
07	BISCUIT (ANMOL)	1 Packet	DINNER

Sd/-  
Medical Officer I/C  
CHC Kesinga



### DISTRICTS/INSTITUTIONS VISITED

#### District Kalahandi

DH Bhawanipatna  
SDH Dharmagarh  
CHC- Kesinga (FRU), Kalampur, Lanjigarh, Biswanathpur, Junagarh, T. Rampur, M. Rampur  
PHC- Utkela, Bara Bhanda,  
SC- Utkela, Kutrukhamar, Bara Bhanda, shergad, Bali Sarai, Gopalpur, T rampur, Daspur,  
Villages/Community Interaction- Kiding, Balabhadrapur, Trilochanpur, Kutrukhumar, Kanagown UGHS, T. Rampur, Lanjigarh, Bankapala  
Maternity Waiting Rooms: Lanjigarh & Burrat  
NRC: DH Bhawanipatna, Dharmagarh SDH  
SNCU: DH Bhawanipatna  
AWC: Kumari, Shripalli, Gunapur, Pulingpada  
Schools: Udaypur, Deypur, Shripalli

#### District Ganjam

DH City Hospital, Berhampur  
SDH: Bhanjanagar, Chattarpur  
CHC- Khallikote, Kudrakhandi, Girisola, Hinjlicut, Buguda, Belgaon  
PHC- Ganjam, Baragaon, Manitar (PPP)  
SC- Bendalia, Baragaon, Baghala,  
VHND- Sunadhara, Pochlima, Sapuapalli, Kanchioru, Baghala, Punitola Cultural Bhawan (Immunization Site), Palibandh Sub-center, Belpada  
AWC, Subhalaya Sub-center, Belpada  
Village: Govindpur  
Academic: MKCG Medical College, Nursing College  
NRC: CHC Bhanjanagar  
SNCU: MKCG College  
NBSU: CHC Bhanjanagar  
School: Sapuapalli

### REVIEW TEAM

- ◆ Ms. Limatula Yaden, Dir. (NHM-III), MoHFW, Gol
- ◆ Mr. G. Narayan, Dir (BOP), Gol
- ◆ Dr. J. N. Srivastava, Advisor-QI, NHSRC
- ◆ Dr. S. C. Agrawal, AD, BoP, Gol
- ◆ Dr. R. Panigrahi, RNTCP, WHO
- ◆ Dr. S. N. Pati, Sr. Regional Director, Bhubaneswar
- ◆ Dr. Suresh Thakur, Health Officer, UNICEF
- ◆ Dr. Aboli Gore, DFID
- ◆ Dr. Sangamitra Pati, PHFI
- ◆ Mr. Kumar Manish, UNFPA
- ◆ Ms. Amita Chauhan, Consultant NHSRC

- ◆ Mr. Ashish Sarin, SSO-Stats
- ◆ Mr. Bhaswat K. Das, Consultant-NE-RRC
- ◆ Dr. Nikhil P. Utture, Consultant-NHM
- ◆ Ms. Umra Liaqat, MCTS
- ◆ Mr. Rahul Govila, Consultant, NHM-Finance
- ◆ Dr. Manorama Bakshi, NRU
- ◆ Mr. Nabeel Ahmed, Consultant-NHM
- ◆ Mr. B. B. Pattanayak, SAATHI
- ◆ Ms. Anjana Rajagopalan, YP (PPD)-Planning Commission
- ◆ Ms. Preetu Mishra, CH & I, NIPI

## POSITIVES

- ◆ Center of Excellence for Communication, CoE has been established in the state with “Integrated approach for IEC”.
- ◆ In each MCP card JSSK entitlements, high risk mothers identification symbol, JSY voucher was found printed which is a good initiative with targeted approach for generating awareness. GKS formed and information displayed about activities of GKS in Health Wall.
- ◆ AYUSH strengthening is effectively done in the state and their capabilities are being utilized.
- ◆ Separate VHND and Immunization Day in the state for ensuring effective delivery of services.
- ◆ At all the delivery points visited, SBA trained personnel were available. Lab Technicians are trained on all programmes and there is an integrated lab at the facility level.
- ◆ One of the Good Practice of Odisha is “Pass book for Vaccines and Immunization Logistics for Sub-centers”. RHCLMIS – ICT enabled contraceptive logistic supply chain management is in place up to the ANM level.
- ◆ MO-MOSHARI initiative for pregnant women and tribal residential school for LLIN distribution is a good example of convergence.
- ◆ For MDA, Drug administrators were engaged in place of Drug distributors.
- ◆ ASHAs were found to be extremely happy and satisfied with their work. There were no delays in payment and payments were e-transferred to their respective accounts.
- ◆ HMIS personnel are placed up to Block Level. Validation committee have been formed at district and block level and validation checks are done on monthly basis.
- ◆ District Headquarters Hospitals (DHHs) and Sub-district Hospitals (SDHs) have Hospital Managers, who are also nodal persons for Quality Assurance.

## CHALLENGES

- ◆ Rational deployment of HR as well material resources must be initiated to increase the performance of Public Health facilities in terms of increased utilization.
- ◆ Referral linkages for transferring patients from primary to secondary to tertiary level need to be established to avoid over-burdening of tertiary level facilities and to optimally utilize the resources of lower level health facilities.
- ◆ Facility wise EDIs need to be put in place. The presence of private drugs stores within public health facilities run counter to the policy articulation by the Government to provide free drugs. This needs to be addressed.
- ◆ Inadequate Sanitation and hygiene in facilities, open defecation was prevalent. ASHAs were not aware of the incentive for motivating household to build toilets.
- ◆ No monitoring mechanism for follow up of SNCU discharged or referred children. SNCU Reporting Software not being used.
- ◆ ASHA is not the member secretary of GKS and ANM is not the holder of joint account of GKS. Both these roles being done by AWW.
- ◆ Non-Compliance with the Biomedical Waste Management Handling Act, Radiation safety measures and Standard infection control practices were found.
- ◆ Standard Treatment Guidelines & drug formulary are not available at desired locations.





## PUNJAB



### DISTRICTS/INSTITUTIONS VISITED

#### District Sangrur

DH, Sangrur  
SDH, Malerkotla  
SDH, Sunam  
CHC, Lehar Gaga  
CHC, Koriya  
CHC, Amargarh  
PHC, Chajli  
Urban Slum Dispensary, Malerkotla  
24x7 PHC, Cheema  
24x7 PHC, Manvi  
Mini PHC, Jakhepal  
Sub-centre, Beerkalan  
SC, Chonda  
Mamta Divas at Badla, Chonda, Cheema & Beerkalan

#### District SBS Nagar

DH, Nawanshahar  
SDH, Balachaur  
CHC, Mukandpur  
CHC, Saroya  
Mini PHC, Paniali  
PHC, Aur  
PHC, Khakhatkalam  
SC, Mukandpur  
SC, Gunachar  
Sub Center, Saroya  
AWC, Paniali  
Two VHNDs / AWCs in Balachaur Block

### REVIEW TEAM

- ◆ Ms. Preeti Pant, Director (NHM) MoHFW
- ◆ Mr. Mahendra Singh, Director (Welfare & PG) MoHFW
- ◆ Dr. Nishant Kumar, Assistant Director (IDSP)- NCDC
- ◆ Dr. Rajesh Kumar, Assistant Professor NIHF
- ◆ Ms. Rita Pradhan, Consultant (NE-RRC)
- ◆ Mr. Sahil Chopra, Consultant NHM MoHFW
- ◆ Mr. Anil Kumar Gupta, Consultant NHSRC
- ◆ Dr. Jatin Dhingra, Consultant NUHM MoHFW
- ◆ Mr. Deepak, Consultant Adolescent Health MoHFW
- ◆ Mr. Ritesh Laddha, PRAYAS
- ◆ Dr. B R Thapar, Consultant NVBDCP
- ◆ Dr. Saurabh Gupta, PHFI
- ◆ Dr. Amod Kumar, St. Stephen's Hospital
- ◆ Mr. Daman Ahuja, Programme Manager-PFI
- ◆ Mr. Subhash Chandra Satyam, NHM-Finance MoHFW
- ◆ Ms. Tanvi Jain, BMGF



## POSITIVES

- ◆ Utilization of services shows an increasing trend in all areas, especially at the delivery points.
- ◆ State has adequate infrastructure and has made good progress in completing projects with the support of Punjab Health Systems Corporation.
- ◆ Overall sufficient availability of medicines was observed at all the facilities.
- ◆ Home Delivery of contraceptives was ensured through ASHA in both the Districts.
- ◆ Vaccines, diluents and syringes were available as per load at RI session.
- ◆ Malaria and dengue cases are showing declining trend, throughout the State.
- ◆ All ASHAs trained in Module 6 & 7 (Completed upto round 2) and ASHAs have good knowledge about HBNC.
- ◆ Grievance Redressal Committee constituted till block level.
- ◆ District level data regularly uploaded on the NRHM portal and birth registration is being done online.
- ◆ 96% of the agencies registered on Public Management Financial System (PFMS) portal.
- ◆ 100 facilities identified for E-Aushadhi to establish online procurement system to be made functional by November, 2014.
- ◆ Transparent system: List of essential list, procurement guidelines and instruction, rate contracts, black listed firms etc. are available in public domain. ([www.punjabhealth.co.in](http://www.punjabhealth.co.in)).

## CHALLENGES

- ◆ Most of the institutions are being upgraded to higher level without commensurate upgradation of related services e.g. part time MOs attached to two facilities.
- ◆ General cleanliness and toilet facilities were compromised, especially in labour room.
- ◆ Availability of home to facility transfer was poor (out of 15 pregnant women interviewed; only 2 had used Dial 108 services).
- ◆ Bio Medical Waste Management protocols were not followed at most of the facilities visited, with disposal outsourced to SPCB. No feedback mechanism in place.
- ◆ Overall facility based newborn care services very poor in both the Districts. SNCU & NBSU not functional in both Districts. Moreover, NBCC unit and NBSU are being treated evenly, and do not provide demarcated services as per guidelines.
- ◆ New born resuscitation skills poor in Staff Nurses/ ANMs. Staff Nurses were not trained in NSSK, IMNCI in Sangrur District.
- ◆ District Early Intervention Centers (DEIC) were not established in both Districts.
- ◆ Poor Implementation of Adolescent health programs (RKSK, WIFS, National Iron + initiative).
- ◆ Training on RKSK was not initiated in both Districts and WIFS training to school teachers was also inadequate.
- ◆ Data generated from IDSP network was not being utilized in preparation of District Health Action Plan.
- ◆ Training needs assessment and post training follow up was not done at any levels.
- ◆ Micro planning and mapping of infrastructure was not done.
- ◆ Blindness registers were not maintained and irrational deployment of eye specialist (CHC, Ahmednagar - Sangrur).
- ◆ State needs to expedite the process for filling the vacant regular positions of specialists.
- ◆ State share of Rs. 101.12 Crore to be settled at the earliest.
- ◆ Statutory Audit for the F.Y-2013-14 still pending.



## RAJASTHAN



### DISTRICTS/INSTITUTIONS VISITED

#### District Rajsamand

DH Rajsamand  
SDH Nathdwara  
CHC/BPHC Khamnor, Relmagra  
PHC Shishoda, Khuraj, Dariba  
Urban PHC Rajsamand  
SC Sema, Kesuli, Rajpura, Madara, Niroli, Khakroli  
Villages Sema, Kesuli, Madara, Chokdi  
Barai Telibera, Sakravas, Ooda, Bhoorwada, Rajpura, Dhariba  
Central Drug Store Rajsamand  
AWC Sema, Chokdi  
School Dhariba  
FGD with ASHAs and Community

#### District Sri Ganga Nagar

DH Sri Ganga Nagar  
CHC/BPHC Sadulshehar, Anoopgarh  
PHC Hindumalkot, Marjandakhari, Raisinghpur, Lalgah, 365 RD  
Urban PHC Sri Ganganagar  
SC Kalia, 56 GB, 61 GB, Bukharwali, Dudha Khichad, 9 LM, 13 MD, 12 KND, Dharamsinghwala, Kerachak  
Villages Hindumal Kot, Raisinghpur, 61 GB, 56 GB, Dudha Khichad  
District Drug Warehouse Sri Ganganagar  
AWC 61 GB  
School Raisinghpur  
FGDs with ASHAs, Community, Adolescent School Children (boys and girls)

### REVIEW TEAM

- ◆ Dr. Damodar Bachani, DC-NCD, State team leader, MoHFW
- ◆ Dr. Sanjiv Kumar, Executive Director District Team Leader, NHSRC
- ◆ Mr. Alok Kumar Verma, Director, Statistics District team leader, MoFHW
- ◆ Ms. C.H. Honey Director (Stats), Ministry of Tribal Affairs
- ◆ Mr. A. D. Bawari US(CCD/VBD) MoHFW
- ◆ Dr. Tarun Chaudhary, PD (MH)
- ◆ Dr. Vinod Chomal SMO (FW)
- ◆ Dr. Aruna Rastogi, Consultant, NVBDCP, MoHFW
- ◆ Ms. Girija Devi C4D Specialist UNICEF
- ◆ Dr. Sanjay Sinha RNTCP, WHO
- ◆ Mr. Vijay Jamwal, Team Leader PFI

## REVIEW TEAM

- ◆ Dr. Sharmila Neogi Maternal Health Specialist USAID
- ◆ Ms. Shraddha Masih, Consultant, NHM, MoHFW
- ◆ Mr. Anil Garg, Finance, MoHFW
- ◆ Ms. Aparna Addala, Sr. Program Manager, SAATHI
- ◆ Ms. Rupa Prasad Regional Program Manager PHFI
- ◆ Ms. Deepika Karotia, YP, Health Division, Planning Commission
- ◆ Dr. Kopa Imathur, Consultant, NHSRC

## POSITIVES

- ◆ About 400 essential medicines are supplied free of cost by the Rajasthan Medical Services Corporation (RMSC) to patients using public health facilities.
- ◆ Good quality essential diagnostic services are provided for free at all government health care institutions for early detection of disease.
- ◆ Well developed software for online management up to block level of drug supplies, monitoring PCPNDT Act, mother and child tracking, eligible couple tracking, Janani Suraksha Yojana, birth of girl child, birth and death registration immunization schedule reminders at public health facilities.
- ◆ IEC/BCC activities have been implemented extensively at key public areas for various programs
- and general awareness of the community; optimal utilization and reporting of referral transport.
- ◆ Coordination among parastatal bodies, NHM and DHS results in effective implementation.
- ◆ Timely and adequately trainings are being conducted for all service providers.
- ◆ Tanks built at various health facilities for breeding larvivorous Gambusia fish.
- ◆ Women from local community placed at district hospitals for providing psychological support to mothers in post-partum period and care for newborns.

## CHALLENGES

- ◆ Shortage of human resources of health across the state, lack of rational deployment of specialists, differential remuneration within cadres across districts and delayed remuneration.
- ◆ Absence of ASHA facilitator with limited non-monetary recognition or appreciation for ASHAs.
- ◆ Delay in creation of Quality Assurance Cell at state and district level for quality improvement, grievance redressal etc.
- ◆ Delay in updating information online in the various ICT software for management.
- ◆ Poor involvement of Panchayati Raj Institutions in public health systems, especially VHSNCs.
- ◆ Convergence between various disease control programs and NHM is minimal and needs to be strengthened.
- ◆ Activities to be undertaken under Untied Funds/ AMG should be treated as ongoing activity and should not be discontinued.
- ◆ Plans for establishment of urban health centers and other activities under NUHM have not yet been undertaken even after approval of budget.
- ◆ Clinical Establishment Act not yet implemented and District Vigilance and Monitoring Committee was not established in all districts.
- ◆ Action in relation to PIP conditionalities has not been adequately implemented.
- ◆ Under utilization of monitoring data and non-functional MMUs in Rajsamand.



## TAMIL NADU



### DISTRICTS/INSTITUTIONS VISITED

#### District Kancheepuram

DH Kancheepuram  
CHC Nandhivaran, Kundrathur, Thiruppukizhi  
PHC/APHC Salavakka, Sollavallam, Kunnavakam  
SC Kilambi, Thamal, Ammanambakkam,  
Karanaipuduchery, Madhuranthagam, Irumbedu  
PHC Sevilimendu, Urban Health Post Pilliarpallyam  
AWC Keelambi  
SIHFW Chennai  
Call Centres of 108 and 104  
Royapettah General Hospital, Chennai

#### District Madurai

District Health Society, Madurai  
DH, Usilampatti  
SDH Govt Hospital T. Vaadipatti, Tirumangalam  
CHC Samayanallur 24x7, Kallandiri  
PHC/APHC Thummakundu, Chakkanoorani, Vallalur  
SC Paravai, Kauppa Yurani  
Urban PHC/ Sub-center Health Post Anaiyur,  
Pattakurichu, Pothumbu, Pappakudi  
Panchayat/AWC/ Villages Alanganuller, Karupa  
Yurani, Paravai, Kutty Meikapatto  
Health and Family Welfare Regional Training Centre  
and ANMTC Samayanallur  
Madurai Medical College  
TNMC, Madurai

### REVIEW TEAM

- ◆ Ms. Kavita Singh Director (Finance) MoH & FW
- ◆ Dr. Zoya Ali Rizvi Asst. Commissioner (AH & MH) MoH & FW
- ◆ Mr. Sanjay Kumar Deputy Director (MCTS) MoH & FW
- ◆ Mr. Amrit Lal Jangid Asst. Director (NRHM II) MoH & FW, New Delhi
- ◆ Mr. Kaushlendra Kaushal NHM-Finance MoH & FW
- ◆ Dr. Nitasha Manpreet Kaur Sr. Consultant (NRHM-I) MoH & FW
- ◆ Dr. Manoj Kumar Singh Consultant, Community Processes, NHSRC
- ◆ Mr. Nishant Sharma Consultant, Human Resources for Health, NHSRC
- ◆ Ms. Sahita Sagir BMGF
- ◆ Ms. Sudha Balakrishnan UNICEF



## REVIEW TEAM

- ◆ Dr. Sarit Kumar Rout Public Health Foundation of India
- ◆ Dr. Shazia Anjum WHO Consultant, RNTCP State HQ, Chennai
- ◆ Dr. Akash Malik Child Health and Immunization, MoH & FW,
- ◆ Mr. Ajay Mishra Programme Manager Population Foundation of India
- ◆ Mr. Mohit Sharma Deputy Regional Coordinator, National RMNCH Unit, IPE Global, New Delhi
- ◆ Ms. Renuka Patnaik Consultant, Family Planning Division, MoH & FW
- ◆ Mr. Bilson Joseph SAATHI

## POSITIVES

- ◆ Round the clock (24 x7) '104' Health help line is functional for providing free access to Health information, Health Guidance and Grievance Redressal facility.
- ◆ Drugs including Siddha medicine and equipment are supplied by Tamil Nadu Medical Services Corporation (TNMSC) and were found to be adequate at all facilities.
- ◆ High Risk pregnancy tracking and management is very efficient in both the districts.
- ◆ All labor rooms are equipped with functional New Born Care Corner, emergency drug trays, sterilized instruments etc. Separate delivery trays with sterilized instruments for each delivery were available.
- ◆ RNTCP treatment cards are well maintained and DOTS is being given as per guidelines. Laboratory diagnosis services are sufficiently placed in the districts visited.
- ◆ The State has six regional training institutes in the State. Each of the six Regional Training institutes is attached with 3-4 Health Unit Districts to cater to their training needs. Skill laboratories have also been established in all these institutes.
- ◆ A well established mentoring and handholding system for training Staff Nurses and ANMs.
- ◆ A training school to train selected AWWs for two years to create a pool of future VHNs, is being conducted in a BPHC premise in Madurai currently. The AWWs stay in a residential setup and are trained on multiple health related issues during the 2 years.
- ◆ There is strong convergence between Government functionaries, NGO and Community for Behavior Change Communication programme for Adolescent girls and pregnant women in State.
- ◆ Web portals are developed and used for data management at various levels. All the PHCs are provided with computers & internet connectivity. All VHNs are provided with laptop and data card.
- ◆ The State has registered more than 90% agencies in PFMS.

## CHALLENGES

- ◆ Regardless of population size, all 8706 Health Sub-centers are functioning with 1 VHN only (ANM).
- ◆ The uptake of IUD and Spacing is very low. None of the service providers were aware of the PPIUCD incentive as per GOI norms.
- ◆ Birth dose of Hep-B, BCG and OPV are not being given at the SDH and DH level; and staff untrained for maintenance of cold chain. Poor convergence between Directorate of Health Services and Directorate of Public Health.
- ◆ Overall IEC, BCC and IPC at community level are weak which is affecting the utilization of certain services like 108 Ambulance, Spacing methods, JSSK privileges etc.
- ◆ No Bio-medical waste management place for District Public Health Laboratory. An effective Bio-medical waste management system can be ensured through outsourcing.



## TELANGANA



### DISTRICTS/INSTITUTIONS VISITED

#### District Adilabad

Medical College, Adilabad  
 Training Centre Chincholi  
 Area Hospital, Nirmal  
 Maternity and Child Hospital Nirmal  
 CHNC Boath, Utnoor  
 PHC Basra, Indra Valley, Gudihatnoor, Wankeidi, Ichoda  
 UHC Shantinagar, Bangalphet, Putli Bowli  
 SC Chanda (T), Manoor, Patnapur, Dhani  
 AW & VHND Chanda, Manoor, Jodenghat, Dhani  
 Ashram School Hathi  
 104 Vehicle Chanda Village

#### District Medak

Gandhi Hospital  
 District Hospital, Sangareddy  
 Area Hospital Siddipet, Zaheerabad, Medak  
 Maternity and Child Hospital, Siddipet  
 PHC Kowdipally, Digwal, Jarasangham, Kangti, Thimmapur, Mulugu, Umaddalla, Reddypalli  
 SC Kalapagoor, Ramancha, Mulugu, Shivampet, Choutkur, Sultanpur  
 FGD- Manoor, Sultanpur  
 Primary School- Sultanpur, KGV School Chitkul  
 104 Vehicle Ponnala Village

### REVIEW TEAM

- ◆ Dr. Teja Ram, DC(FP), MoHFW
- ◆ Dr. Jupaka Mahesh, Senior Regional Director, RoHFW
- ◆ Mr. G L Gupta, SRO (Health), Planning Commission
- ◆ Dr. Shailesh Bhaskar Jagtap, JSI
- ◆ Mr. Narender Kande, BMGF
- ◆ Dr. Chakrapani Chatla, Consultant, WHO, RNTCP
- ◆ Dr. Mukta Tyagi (PT), Consultant, NHSRC
- ◆ Dr. Ajit Sudke, UNICEF
- ◆ Sanjeev Rathore, NHM-Finance, NHM
- ◆ Mr. Rajesh Nallamothe, NHSRC
- ◆ Mrs. Bharti Sharma, Project Assistant, M/o Tribal Affairs
- ◆ Dr. S. S. Das, CH&I, MoHFW
- ◆ Mr. Krishna Gopal, NRHM-II, NHM
- ◆ Ms. Mona Gupta, TSA, Deloitte
- ◆ Mr. N. Srinivas, PHFI
- ◆ Mr. Sunny, MMPC, Deloitte

## POSITIVES

- ◆ State has adequate number of health facilities staffed by young and enthusiastic medical officers.
- ◆ Initiative of 104 Vehicle and Referral transport through ITDA has contributed to timely care and referral of delivery cases across the districts. The ITDA Call Centre is functional 24 hours and follows up pregnant women based on their EDD as per data received from MCTS.
- ◆ State has functional IT infrastructure at all levels with availability of laptops with internet connectivity till PHCs and higher level.
- ◆ TB-HIV collaboration is well established and more than 98% of the registered TB patients are tested for HIV.
- ◆ Community based and surveys among school students are done as part of National Programme for Prevention and Control of Fluorosis leading to better implementation of the programme.
- ◆ The State nodal institution for training Indian Institute of Health and Family welfare (IIHFW) is a centre of excellence.
- ◆ ASHAs are seen as a catalyst in supporting beneficiaries for achieving health services and community had a very positive outlook towards ASHAs.
- ◆ ASHA payments are regular and are paid incentives through direct transfer to their respective bank accounts.

## CHALLENGES

- ◆ Service delivery through AYUSH remains unutilized optimally as medical officers are not involved in PHC planning process and supportive supervision of field staff.
- ◆ Maternal death review was evident at few places, however, community based maternal death review is yet to be initiated.
- ◆ The line listing of high risk pregnant women is not uniform. No efforts are visible at facility level for follow-up of severely anemic pregnant women and their treatment outcomes.
- ◆ The infrastructure, human resources and availability of commodities and various services was not as per the guidelines given in the MNH tool kit. These guidelines were not disseminated in both the districts.
- ◆ High training backlog, with very few SBA and NSSK trained Staff Nurses and ANM in position.
- ◆ ASHAs did not have necessary skills on new born care due to lack of support structures and well planned training.
- ◆ Monitoring and supportive supervision for HBNC is done purely on the basis of incentive payments and expenditures related to HBNC. The State has not yet disseminated revised HBNC guidelines and forms to the field.
- ◆ Hospital Development Society meetings are not held on a regular basis. They do not have an active involvement of all stakeholders/ members of the RKS.
- ◆ Supportive supervision and monitoring for financial review and management was very poor which may be attributed to vacant positions of Regional Audit & Account Managers, Assistant Accounts Manager and one Accountant at State level.
- ◆ Administrative processes are weak and at times unclear delaying approval at State level, leading to poor implementation lower down.
- ◆ Coordination between numerous directorates and institutions is a major challenge at the State as well as district level.



## UTTAR PRADESH



### DISTRICTS/INSTITUTIONS VISITED

#### District Meerut

LLRM Medical College  
District Main Hospital & District Women Hospital  
CHC Mawna, CHC Kharkhoda, CHC Daurala, CHC Sardhana  
PHC Hastinapur, PHC Falawda,  
APHC Lawad, APHC Kheda  
SC Jalanpur, SC Tigadi, SC Ganespur,  
SC Mahadeo, SC Naidu  
2 Schools in Tigadi  
1 VHNDJalanpur  
1 AWC, Sandesh Vahini Saraswa  
UHP Shalimar Garden, Health Post - Meerut Nagar,  
Urban Health Training Centre-Medical College, HP  
Nagla Battu

#### District Shravasti

District Combined Hospital  
CHC Ikona, CHC Gilola, CHC Sirsia  
PHC Sonva, PHC Harharpur-rani, PHC Lakshmanpur  
SC Katra, SC Takiya, SC Motipur, SC Sonva,  
SC Harharpur-rani, SC Patijiya  
Teeka Express  
RBSK-Masakalal  
RBSK – Amarebhairiya, 2 VHND, 1 School  
104 Vehicle Ponnala Village

### REVIEW TEAM

- ◆ Dr. R.P. Meena Director, MoHFW – Team Leader
- ◆ Dr. Satish Kumar, NHSRC
- ◆ Dr. Chhavi Pant, Assistant Director, MoHFW
- ◆ Mr. Ankit Mishra, Assistant Director, MoHFW
- ◆ Dr. Umesh Tripathi, RNTCP
- ◆ Dr. Malalay Ahmadzai, UNICEF
- ◆ Ms. Moni Sinha Sagar, USAID
- ◆ Dr. Goverdhan, JSI
- ◆ Dr. Joydeep Das, NE-RRC

- ◆ Dr. Jai Kishun, NIHF
- ◆ Ms. Sonia Luna, NHSRC
- ◆ Mr. Ravi Siriki SAATHI
- ◆ Dr. Salima Bhatia, MoHFW
- ◆ Sh. Rakesh Shokeen, MoHFW
- ◆ Dr. Prayas Joshi, MoHFW
- ◆ Ms. Isha Rastogi, MoHFW
- ◆ Sh. Vindesh Kumar Singh, MoHFW



## POSITIVES

- ◆ TSU supported initiative to implement in-service mentoring by way of appointment of nurse mentors at block level.
- ◆ Online drug procurement and inventory control system initiated.
- ◆ PYARI BITIYA website launched for implementation of PCPNDT and control of sex selective abortion.
- ◆ State Nutrition Mission has been set up to enable reduction in the high under nutrition rates in the state.
- ◆ 120,000 mobile phones have been distributed to ASHAs and M-Kunji initiated.
- ◆ Awareness and utilization of 102/108 ambulance services is high. The performance per ambulance is around 5 cases/ ambulance/ day.
- ◆ Centralized Call Centre for Grievance Redressal in place.

## CHALLENGES

- ◆ Shrawasti, an HPD does not have a single fully functional FRU in place. DH had huge specialist cadre shortage.
- ◆ Out of 360 facilities in Meerut, only 25 facilities (7%) are delivery points. In Shrawasti, none of the PHCs are delivery points.
- ◆ SNCU not yet functional in Shrawasti and not as per Gol Guidelines in Meerut. Radiant warmers not available at Delivery point sub centres in Shrawasti.
- ◆ Zero dose of BCG not given before discharge. There is lack of follow up of drop out cases and micro plans are not prepared in most cases.
- ◆ At the VHND nutrition counselling is not a priority and focus is entirely on immunization.
- ◆ Medical officers do not prescribe generic drugs. Also, antibiotics are not prescribed for full regime.
- ◆ Procurement of Drugs: approx 35% to 40% of the items remained unsupplied without any written communication by the suppliers.
- ◆ Accounting/ Book Keeping was weak and needs significant improvement.
- ◆ Differential financial for the high priority districts i.e. 30% in comparison to other districts is not being implemented by the state.



# UTTARAKHAND



## DISTRICTS/INSTITUTIONS VISITED

### District Tehri

DH Baurari  
SDH Narendranagar  
CHC Beleshwar, Thatyur  
PHC Nandgaon, Philki, Nainbag  
SC Gaja, Chowpadiyalgaon, Magron, Fakot, Almas  
Chowpadiyal AWC  
Govt. Intermediate College, Naulbasar  
Villages Chowpadiyal, Jajal, Aam Pataa, Almas, Kathud

### District Almora

DH Male & Female  
SDH Base Hospital, Almora & Ranikhet  
CHC Dwarhat  
PHC Dhauladevi, Panvanaula, Barachina  
SC Panvanaula, Darmar, Barachina  
Municipality Office Almora  
Gargoot Mini AWC  
Village Gargoot

## REVIEW TEAM

- ◆ Mr. B. Sriramachandran Murthy, Director, Gol
- ◆ Mr. K.C. Meena, Dy. Asst. Director-NVBDCP
- ◆ Dr. Ravinder Kumar, RNTCP
- ◆ Dr. Neeta Rao, USAID
- ◆ Mr. Ashish Kumar, Project Director-PFI
- ◆ Dr. Prem Singh, Associate Advisor, ITSU
- ◆ Dr. Jyoti Sharma, PHFI, MoHFW

- ◆ Mr. Daya Shankar Singh, IHBP-USAID
- ◆ Mr. Vikas Sheemar, Adolescent Health, MoHFW
- ◆ Dr. Abhishek Gupta, NRHM-III, MoHFW
- ◆ Ms. Shilpa John, NHSRC
- ◆ Dr. Anamika Saxena, Training, MoHFW
- ◆ Mr. Prabhash Jha, NHM-Finance, MoHFW

## POSITIVES

- ◆ On-site and mobile trainings of ANMs at Tehri, Haridwar and Dehradun is an excellent initiative by the state.
- ◆ Strengthening of pre-service nursing and midwifery through setting up of state nodal centre is noteworthy.
- ◆ Referral transport initiatives such as Khushiyon ki Sawari and Doli to carry patients and pregnant women from remote areas to 108 EMRI ambulances and the boat ambulance accessible areas in Tehri district.
- ◆ Regular monthly block level review meetings are used as an important platform for improving the quality of HMIS and MCTS data.
- ◆ Effective leadership demonstrated by BMO and ANM, resulting in optimally functioning facilities PHC Philki and SC Darmar, in difficult and hard to reach areas.
- ◆ E-transfer of funds is present up to the Block level.
- ◆ Timely fund disbursement from State Health Society to the District Health Society .
- ◆ Excellent coverage and follow up of the ABD project under RBSK is for thalassemia and anaemic patients.

## CHALLENGES

- ◆ Service utilization is sub-optimal especially at DH & SDH level, which needs improvement.
- ◆ Absence of comprehensive IEC materials for the key schemes and programmes operational in the state.
- ◆ Poor supply chain management resulting in unavailability of IFA tablets – either for ANC or for the WIFS programme in the last one year.
- ◆ State and District Quality Assurance mechanisms are yet to be established.
- ◆ No plan of rational deployment of trained human resources.
- ◆ No HR policy for all the contractual staff, addressing all aspects of their service such as TORs, appraisal, leaves etc.
- ◆ Orientation of PRIs and functioning of VHSNCs requires attention in the districts.
- ◆ ASHAs and ANMs are not actively engaged in the VHSNC activities.
- ◆ Sub-optimal utilization of MMUs, with most of them stationed at District levels.







## WEST BENGAL



### DISTRICTS/INSTITUTIONS VISITED

#### District Bankura

Bankura Medical College  
 Khaatra – SDH  
 Indpur – BPHC  
 Simla – BPHC  
 Simlapal BPHC (NRC included)  
 Taldangra BPHC  
 Onda BPHC  
 Sarenga BPHC  
 Chattna BPHC  
 Jorhira BPHC (NRC included)  
 Amarkanan – Rural Hospital  
 Krishnapur PHC  
 Leprosy Hospital – Gauripur  
 Telijaat MMU  
 Sub-centres – Telijat, Krishnapur, Ukhradihi, Simla, Banpushra  
 AWC – Vikhana, Kadra  
 Schools – Ukhradihi, Nagardanga  
 Villages (FGD) – Saranga, Ukhradihi

#### District Uttar Dinajpur

Rajganj DH  
 State General Hospital Kaliyaganj working as BPHC  
 Maharaja BPHC  
 Hematabad BPHC  
 Itahar BPHC  
 Islampur Hospital (FRU)  
 Karandighi Rural hospital (CHC)  
 Bangalbari PHC  
 Baharail PHC  
 Dalkhola PHC  
 Ayushmati PPP – Rogmukti Nursing home (Maharajganj)  
 Surun PHC  
 Sub centres – Chainagar, Jalalpur, Surun, Bangalbari, Naoda, Kasbah, Halapur, Daspara  
 AWC- Islampur, Ghughudanga,  
 Schools – Naoda, Durgapur Balika Vidyalaya  
 Villages (FGD) – Belthoni, Aampadi



## REVIEW TEAM

- ◆ Dr. Sila Deb DC(CH & I) - MoHFW
- ◆ Mr. Amrit Lal Dir (ME-I,II,III) MoHFW
- ◆ Dr. Biswajit Das, MoHFW
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- ◆ Mr. Moni Mohan Manna Consultant Finance (NHM), MoHFW

## POSITIVES

- ◆ Effective cold chain, ensuring round the clock availability of all vaccines.
- ◆ A team of active and skilled frontline workers (ANM, LHV, AWW and ASHA).
- ◆ E-procurement system formulated by the state to be a vital force taking up the management of procurement services.
- ◆ Institutions at all levels reported good administrative support for all programmes from authorities at all levels (State/District/Block).
- ◆ Good implementation of school health programme. The RBSK teams and trained teachers are coordinating screening of children and follow up actions are supported through public health institutions.
- ◆ The counseling sessions under ARSH programme are effective.
- ◆ TB detection and case management/treatment is done as per RNTCP guidelines, with drugs available at all levels and deaths are audited by STS.
- ◆ Total NHM fund utilization consistently more than 100% of the releases made in the last 5 years and e-transfer (RTGS) system is in place.
- ◆ Strengthening of field level functions of ANM with focus on Falciparum Malaria and Kala Azar .

## CHALLENGES

- ◆ No concrete action plan for IEC activities exists.
- ◆ Staff are yet to be trained on procurement and SCM.
- ◆ Informal payments being made by beneficiaries at various levels – ambulance, institutional care.
- ◆ Weak HMIS reporting system with significant under reporting.
- ◆ Staff (esp. delivering services at CEmONC Centres) yet to be trained on clinical protocols.
- ◆ Assessment of down time of equipments and expediting services under AMC across all institutions needs strengthening.
- ◆ Convergence to be strengthened to address issues of malnutrition. Community action to be initiated through revitalization of VHSNCs and multi-stakeholder engagement at all levels.







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