NATIONAL RURAL HEALTH MISSION

Key Findings

SECOND COMMON REVIEW MISSION

November – December 2008

Theme – I – Assessment of the case load being handled by the system at all levels

	State	Key Findings
1.	Assam	NRHM a revolution in access to health services. It has made a huge difference. Significant increase in institutional births and outpatient visits. Significant increase in IPD cases as well. Evening OPD started in many places.
2	Bihar	The increased utilization of services is reflected in increased number of persons provided every type of service that is available – be it outpatient care, be it in patient care, be it institutional delivery services, be it emergency services, or surgical services, lab services, etc. Every Block has a 24X7 facility with at least 6 doctors and nurses. Close monitoring facilitates service guarantees. High case load in Block PHCs and District/Sub District Hospitals. Additional PHCs still to be made operational.
3.	Chhatisgarh	OPD services and normal deliveries show increasing trend in Health Sub Centres and CHCs. No increase in PHCs due to shortage of doctors and nurses. Well functioning CHCs with regular attendance of doctors has increasing indoor patients as well. District Hospitals have increasing case load. Uneven performance in family planning services.
4.	Jharkhand	Evidence of increased case load at the Block PHCs in spite of unsatisfactory basic infrastructure and hospital beds at that level. Increased in patient load in District Hopsitals. Slight fall in OPD in one District Hospital perhaps due to better functioning of Block PHCs and Sub Centres. Sahiyyas very active. Institutional deliveries yet to pick up on a very large scale. In patient care also picking up with more functional facilities.
5.	Karnataka	Institutional deliveries have increased from 60% in 2005 to 79% in the current year – perhaps on account of JSY and State Government initiatives like Madilu (post natal care kits for BPL), Prasuthi Ariake (ANC benefits for BPL), etc. Many NRHM initiatives are recent. OPD load suggests substantial increase in case load at PHCs. District and Taluka Hospitals have high case load. FRUs under utilized.
6.	Kerala	Outpatient case load is god in all hospitals, CHCs and PHCs. State wise data suggests that OP cases have shown increase in 2007-08. Inpatient cases are variable. Inpatient cases can increase if full range of services is provided. Not all CHCs providing 24X7 services. Wide variation among facilities and their load. Need to focus on life style diseases (diabetes, hypertension).

7.	Madhya Pradesh	NRHM represents a revolution. There is a significant increase in IPD and OPD case load at health facilities. JSY has increased the credibility and confidence of the people on the government health institutions. There are trained and skilled manpower to support health facilities at many institutions. Khargone, a tribal district, has reached 71% institutional deliveries. Increase in OPD and IPD has been so significant that a decision to increase bed strength by 6000 beds has been taken in the State.
8.	Maharashtra	Definite improvement seen in the outpatient load of Sub centres, PHCs and Rural Hospitals(CHCs). 24X7 Block PHCs are offering outpatient, emergency and institutional services. Sub Centres are regularly doing deliveries (labour room construction has increased numbers). Increase in in patient load due to JSY as also facility upgradation, clean toilets, water availability, inverter for alternate source of electricity, free meals and also due to feel good factor generated by the beautification of the centres with NRHM funds. Sub District Hospitals need improvement. .
9.	Mizoram	IPD/OPD attendance appears to be the same over the last three years. Presence of Regular Medical Officers has made positive impact on IPD/OPD in PHCs. Little Sub Centre delivery. ANM doing home delivery. Increase in institutional delivery at PHC/CHC after JSY. Utilization of delivery facility at District Hospital has gone up but up gradation is not commensurate with the increased load.
10.	Orissa	NRHM has transformed public health service delivery in the State. The decentralization, responsiveness to local needs, paradigm shift in health system management and availability of untied funds has improved the facilities and their credibility among members of the public. JSY, community mobilization by ASHAs, and proper referral transport have contributed to a large extent in increasing the case load. However, greater patient load has been noted in the district, sub district hospitals and CHCs as compared to PHCs and Sub Centres. Increased number of deliveries, OPDs and bed occupancy reported from the districts visited. Sub Centres weak, limited services.
11.	Rajasthan	Increase in institutional deliveries. Almost all PHCs reporting institutional deliveries. Some Sub Health Centres also conducting institutional deliveries. Well performing Health facilities attracting increased case load, cases of malnutrition and large number of non communicable disease cases as well.
12.	Tamil Nadu	Since the inception of NRHM, the PHC case load has increased remarkably – daily OPD by 17% and inpatients excluding deliveries by over 100%. The average Op attendance is 60 to 230 in the PHC. Discharge two ays' after

		deliveries and diet is supplied through SHGs. The SDHs and DHs are well equipped.
13.	Uttar Pradesh	NRHM has infused a new life into the flagging health sector in UP. Huge upsurge in institutional deliveries. Sub Centre has one ANM but active in most places. OPDS also show increasing trend because of better maintained facilities. District Hospitals very well maintained. Some CHCs have also started providing surgical services. Increase in 24X7 PHCs.

Theme – II – Preparedness of health facilities for patient care and utilization of services

	State	Key Findings
1.	Assam	While human resource has increased, there is a still a long way to go in fully preparing facilities for all kinds of morbidities. Physical infrastructure and availability of ambulances has improved. Blood storage arrangement not functional in many First Referral Units. Family Planning services need more attention. Basic diagnostic tests being done – need to provide for a larger range of test services. Need for better equipped emergency rooms. Shortage of drugs. Need to expand range of services in Village Health and Nutrition Day.
2	Bihar	Patient satisfaction was in almost all places very positive – the recent memory of a complete lack of services and the current changed situation being upper most in people's minds. Provider qualification was more qualified, but even then, on the whole, very positive. 'The workload has increased so much but there is little improvement in staff or facilities to manage the increased workload.' The system is in danger of stabilizing at a low level of expectations and outputs. Increase in services up to the Block PHC level. Additional PHCs still a big challenge – very poorly functional. APHC works like a Sub Centre with an outpatient dispensary.
3.	Chhatisgarh	Improvement has taken place in Health Sub Centres, CHCs and District Hospitals. PHCs are the weakest link. CHCs not providing First Referral Unit services in most places. Improvement with untied grants in infrastructure, equipments, drug supply, water supply, contractual staff etc. Unsatisfactory utilization of ambulance services. Lab facilities

		functional with minimal services. Large human resource shortages affecting preparedness, besides irrational placements.
4.	Jharkhand	Sahiyyas have been trained up to third module and have drug kits with them. ANMs are in place at the Sub Centre with basic facilities like BP equipment, stethoscope, etc. Immunization through VHNDs is a priority. Medicine availability at Block PHC and District Hospitals has improved leading to higher case load. Doctors on contract besides the regular doctors at PHCs and Additional PHCs. Many of them providing service 24X7 in spite of a various adverse housing facility in remote areas. Poor infrastructure is a serious concern. While large scale new construction has started under NRHM and the Finance Commission grants, it will take some time before they are all completed.
5.	Karnataka	Concerted efforts to improve the health facilities from funds from different sources. Availability of untied funds has made a significant difference in the preparedness of health facilities at all levels. While facilities are well equipped, utilization services is not very high in PHC/CHC.
6.	Kerala	Uneven preparedness of facilities leading to uneven utilization rates. Assured services can reduce congestion in higher order facilities.
7.	Madhya Pradesh	Facilities do not have staff as per Indian Public Health Standards norm. District Hospitals were adequately staffed. The Specialists at CHCs and blood storage facilities there need priority attention. Janani Express vehicles in all FRUs help in referral transport. Lab services available in all facilities. Keeping in view the sudden increase in patient load especially under JSY scheme, the infrastructure in terms of staff and other facilities are under a great strain which is affecting adversely the quality of service and has reduced attention to other programmes. Mobile Health Units doing well.
8.	Maharashtra	Extremely committed health functionaries in coordination with public representatives have been ale to deliver good quality services. 30% PHCs have reached IPH Standards. Nurses, doctors and Specialists have been appointed. Well stocked drugs and consumables, laboratory facilites for conducting diagnostic tests. Water quality checking at Sub Centres. Blood storage facility in IPHS PHC and CHC.
9.	Mizoram	Medicos and Para medics available at all levels – except Specialists. Young doctors in position, appear confident and capable of handling most conditions. Need to better utilize time of health workers at Sub Centres. District Hospitals better equipped. Some equipment not fully utilized. Lack of Specialist manpower at CHC. All PHCs well equipped in lab

		facilities with regular tests being done. Rapid Diagnostic kits with ASHAs but not with health workers. All facilities well maintained with proper cleanliness, disposal pits constructed (using RKS funds) – paramedical and Group D staff trained in IMEP at District Hospital.
10.	Orissa	Urgent need to up grade infrastructure. Inadequate budget for drugs leading to out of pocket expenses. Utilization of untied funds, maintenance grants and RKS grants to improve preparedness of health facilities was very impressive in both districts. 1153 AYUSH doctors at PHCs and CHCs to provide OPD services. Substitution rather than co location in the absence of the MBBS doctor in PHC (N).
11.	Rajasthan	Sub Centres getting prepared for institutional deliveries with labour rooms. Good institutions attracting high load. Large number of surgeries in District and Sub District Hospitals. Significant number of non communicable diseases are being identified and treated at primary and referral levels. PHCs and CHCs handling larger case load and prepared to do so. All PHCs have an MBBS doctor and 40% have an AYUSH doctor as well.
12.	Tamil Nadu	The PHCs, Block PHCs, upgraded PHCs, Sub District Hospitals and District Hospitals are adequately equipped for the routine works and emergency situations. All the facilities are provided with adequate number of Specialists, Doctors, Nurses, VHNs, Pharmacists, Lab Technicians, and other support personnel on regular, service placement or contract basis. The PHCs, SDH, and DH are able to meet the requirements for lab investigations, x-ray, ECG, ultrasonogram, etc. All Sub Centres and PHCs are provided with requisite drugs and other supplies. Need to improve quarters at PHCs.
13.	Uttar Pradesh	While cleanliness has improved, shortages of Nurses, Doctors, Specialists hampers preparedness to deliver quality care. Rationalization of posting and stable tenures needed for preparedness to improve further. Need to focus on expansion of nursing services. Sub Centes and PHCs have started using untied grants. More than half the ASHAs are very active in the community. Village Health and Sanitation Committees have been set up though getting the cooperation of PRIs is proving difficult in many areas.

Theme – III – Quality of services provided

	State	Key Findings
1.	Assam	Substantial improvement in infrastructure. Need for further improvement of quality and range of services. Wards were patient friendly with clean linen, sufficient lighting and clean toilets. Segregation of waste with deep burial. Complaints about CHCs have reduced as they are functioning well.
2	Bihar	Over 100% Bed occupancy in District Hospitals. Lack of nurses and mid wives hampers quality of care. Mamta programme for women volunteers in hospitals is an innovation to meet the nursing shortages in hospitals. Additional of more trained and well supported nurses into the system would be the single most important step that could be done to improve quality. Lack of beds and nurses in Block PHCs. Excellent outsourced ambulance service helps in shifting patients. Conversion to 30 bed PHCs is needed on a priority wherever more than 5 deliveries take place every day. Standards of cleanliness would require substantial improvement. In all facilities visited there are efforts to improve amenities – lighting, wiring, water supply, patient waiting halls, toilets, drainage, etc. but these are rather sporadic. Need to use untied funds at all levels. There is a systematic effort to provide generator support, pathology diagnostics, x-ray and soon ultrasound as well, ambulance services, laundry services, diet services and cleanliness and sanitation services. Need to monitor outsourcing arrangements more effectively to ensure full compliance to agreements.
3.	Chhattisgarh	Health Sub Centres are giving better services than in the past, thanks to untied funds and their proper utilization. Functional telephones at all Health Sub Centres. Mitanin help desk in health facilities is a good initiative in bringing poor households to facilities. CHCs and District Hospitals provide bed nets to protect from mosquitoes. Infection control measures have started but pits are provided only in a few places.
4.	Jharkhand	Block PHCs are basically six bed hospitals with very modest basic features. New buildings will take a little time for completion. OP services have improved due to availability of medicines. Contract doctors have improved availability of human resources. Shortages of nurses. Sub Centres are quite well equipped though own building is a constraint. Sahiyyas are active though performance based payments are not timely.

5.	Karnataka	Staff Nurse and Medical Officer availability has increased. Drugs largely available. Quality Assurance thrust in Tumkur leading to efficient use of untied funds. Untied funds being used imaginatively for client convenience – TV, Plants, CD players, waiting halls, etc. More attention needed on toilets – not very clean. School Health programme improving access.
6.	Kerala	Wide variation in the quality of services between similar type of institution. Related to the motivation, commitment and skill of the head of the facility. PHC buildings have been renovated. TVs and DVD facilities in many hospitals in Wynad district. Display of list of medicines. Need to monitor services from the point of input versus services.
7.	Madhya Pradesh	NABH accreditation for District Hospitals is under way. Quality assurance is receiving attention in the system.
8.	Maharashtra	Sub Centres well equipped with infrastructure and equipments and untied funds. Hospitals have become women friendly. Clean and well equipped labour rooms. Waste management satisfactory. Panchayat representatives involved.
9.	Mizoram	PHCs and Sub Centres are well managed. Cleanliness is good. District Hospital needs improved facilities.
10.	Orissa	Overall some improvements have been made in the services like cleanliness, waste collection, electrification, water supply but are inadequate. While there were extra sweepers appointed from untied funds and maintenance grants, there is still scope for improvement in the cleanliness of toilets and availability of water supply in some hospitals.
11.	Rajasthan	Most institutions have received a face lift with the untied funds of NRHM. Toilets were clean and functional and many CHCs had functional power back ups. CHCs are still not able to provide Caesarean section service. Blood storage is an issue. No or limited surgeries at CHCs. Waste segregation and facility level disposal are being done at most institutions; pits were found to be constructed and in use; bio medial waste was being brought back from outreach sessions.
12.	Tamil Nadu	Almost all facilities are well maintained and upkeep of facilities is of satisfactory levels. Family Health Clinics in all 385 Basic Emergency Obstetric Centres thrice a week.
13.	Uttar Pradesh	Nursing cadre shortages hampers quality of care. Women not staying 48 hours after delivery. While cleanliness and basic infrastructure improvements have improved the quality of services, quality of care requires far greater thrust on nursing services.

Theme – IV – Utilization of diagnostic facilities and their effectiveness

	State	Key Findings
1.	Assam	Range of diagnostic services available at various levels has improved substantially. Much more needs to be done to improve the technical skills of the Lab. Technicians.
2	Bihar	Diagnostic services through PPPs. Outsourcing by contracting in private providers. Private partner not showing that much interest at operating it at the Block level.Non availability of regular Lab technicians. Inadequate attention to quality and biomedical waste management.
3.	Chhatisgarh	District Hospitals and CHCs have functional laboratory facilities. Not functional in PHCs due to lack of manpower. Pregnancy testing kits and rapid diagnostic kits are available in most facilities. Convergence of lab services of RNTCP, general health services and vector borne diseases.
4.	Jharkhand	TB Programme Lab Technicians at a nu,ber of Block PHCs. Integration of lab services is taking a little time. Diagnostic centres being established in District Hospitals. Modern equipments procured or in the process of being procured.
5.	Karnataka	7 Regional diagnostic labs under the Karnataka Health System Development project. Lab Technicians are largely in place with adequate equipments and reagents. X- ray and ultra sound at Taluk Hospital. Water testing facilites. Lab investigations for ANC not available at PHC. No RTI/STI testing. Utilization of diagnostic equipments by ANMs at Sub Centre is low.
6.	Kerala	State has appointed Bio Medical Engineers to ensure that the equipments are in working condition. Overall the equipments are good.
7.	Madhya Pradesh	In most of the facilities one Lab Technician is available for doing all the investigations for all the programmes.
8.	Maharashtra	All 24X7 PHCs are provided with lab providing basic facilities. Semi auto analyzer, ECG, X ray facilities. Services at reasonable user cost. 30 Public Health Lab services for water quality monitoring, industrial waste/effluents examination, etc.
9.	Mizoram	Diagnostic facilities available but not as per Indian Public Health Standards. Need for proper maintenance strategy for equipments. Need to build strong accountability of suppliers at purchase stage
10.	Orissa	There was an effective pooling of Lab Technicians from malaria, TB, NIV/AIDS for efficient handling of investigations and diagnostic workload in the

		DH/SDH/CHC level. Lab facilities are not available in PHC (N).
11.	Rajasthan	Lab services suffer from staff shortages. Rapid Diagnostic Kits for malaria, IDD kits and haemoglobin kits available with ANMs. Pregnancy testing kits available with ANMs and ASHAs.
12.	Tamil Nadu	The essential investigations are available in all PHCs, Sub District Hospitals and District Hospitals. The Block PHCs are provided with scan and all the 235 upgraded PHCs are provided with ultrasonogram, x-ray, ECG and semi auto analyzer. Blood storage facility in 20 PHCs by TANSACS.
13.	Uttar Pradesh	Lab Technicians are available for basic tests. Need for better coordination and convergence among all the programmes.

Theme – V – Drugs and supplies

	State	Key Findings
1.	Assam	Less than satisfactory in 2008-09. Medicine availability in 2006-07 an 07-08 was better. Supplies expected to improve December 2008 onwards.
2	Bihar	Improved supply of essential drugs is the most notable achievement by the State and this has significantly contributed to the increased use of public facilities noted during the past few years. The new rate contracting system and enforcing presence the presence of distribution depots of the suppliers within the State through which the districts place orders, has tremendously improved the availability of essential drugs at public facilities. At least 15 drugs were available in most PHCs. Sub Centres without drugs. Local procurement to meet stockouts. Per capita expenditure on drugs is Rupees 8 after steep increase. Needs to substantially increased with improved availability of drugs at Sub Centres as well. Logistic systems need to be fully operationalized.
3.	Chhatisgarh	State level e- procurement is in place. Some delays in supplies. Proper mechanism for receipt, storage and indenting of drugs. Need for warehouses at district level. Availability of drugs is satisfactory. Occasional replenishment by Jeevan Deep Samiti is made. Mitanins got drugs but delays in replenishment. Recent efforts at streamlining equipment management.
4.	Jharkhand	Rate contract system with funds being released to PHCs. Availability has improved considerably at all levels. Sahiyyas have also been given medicine kits but arrangements for replenishment is not in place. Essential drug list and standard

		treatment protocols has been prepared for the state.
5.	Karnataka	A State Drugs, Logistics and Warehousing Society has been established that acts as an official procurement agency to meet all requirements pf health and family welfare department. Indents collected at the beginning of year. Rate contracts after call for tenders. 14 Drug warehouses in the State. 14 more taken up for construction. Use of untied funds to procure drugs in case of shortage has helped. A very sound procurement system with very few stock outs. Need for review of drug list to make it more rational. ASHA drug kit replenishment needs attention.
6.	Kerala	Setting up of the Kerala Medical Services Corporation is a major step. Operation from April 2008. process of procurement and distribution of medicines and supplies has been streamlined. Computerization, pass book system and essential drug list has been established. Systematic and regular testing of all batches of medicines. Need to standardize the indenting procedure. Need to increase storage space.
7.	Madhya Pradesh	The State has developed a drug policy. TNMSC model is being implemented in the State. Separate drug cell has been formed and Laghu Udyog Nigam has been appointed as procurement support agency. Procurement through e – tendering has reduced cost of supplies and improved quality. Distribution of procured medicines and materials is done through outsourced warehouses. 21 warehouses are under construction under NRHM funds.
8.	Maharashtra	Drugs and supplies are in abundance in the Sub Centres, PHCs and in CHCs. They are well stocked in newly made racks and cupboards with proper marking for easy retrieval. Vaccines are also available (except measles) and in proper condition stored in IPL and deep freezer.
9.	Mizoram	Medicines are centrally procured and distributed based on indents. There are shortages. Need for effective inventory management.
10.	Orissa	Most of the health facilities had drugs and pharmaceuticals available as per allocations but the budget per facility is inadequate and needs to be enhanced. A State Drug Management Unit has been set up for procurement of medicines and this has improved timely procurement and availability. However, mechanism for transparency and need basd distribution of drugs to districts/facilities is yet to be put in place. Emergency drug tray was found to be adequately stocked in most facilities.
11.	Rajasthan	Generic drugs available in Hospitals and facilites at 30-50% lower than MRP through cooperative stores. List and price of generic drugs displayed in all facilities. ASHAs provided

		drug kit. Replenishment from Sub Centre. Indenting needs to be more timely to prevent stock out situations. Shortage of high cost antibiotics for weeks. Injectibles and fluids show no stock out.
12.	Tamil Nadu	Role model supply system of TNMSC. It is very effective in ensuring adequate supplies of drugs and other routine supplies of all health facilities. EC Pills and IUDs are not available.
13.	Uttar Pradesh	While drugs are available, the allocation of drugs is very less compared to the need on a per capita basis. There is a need to increase the drug budget and develop sound system of logistics, inventory management and forecasting. Preparation of essential drug lists and use of generic drugs needs to be encouraged alongside efforts to set up TNMSC like corporation for procurement and logistics of drugs and equipments.

Theme VI – Health human resource planning

	State	Key Findings
1.	Assam	There are shortages of doctors and para medics and efforts have been made to rationalize through regular posting and by contractual appointments. Incentives have worked for the contractual but there is resentment among the regular doctors – need for incentives for regular staff and for career progression. Need to rationalize placement of ANMs. Many ANMs at higher level institutions. Need for cadre review of doctors and paramedics to retain good human resource.
2	Bihar	The availability of human resources has increased substantially in Health Sub Centres, PHCs, DHs and Medical Colleges. Shortage of Specialists, Nurses and Lab Technicians still exist. Very innovative new cadre ruels have been approved for doctors with well defined career progression. Contractual appointment policy is in place. Need to improve and expand nursing education as a top most priority.
3.	Chhatisgarh	Chhatisgarh ahs seriour human resource shortages. Lack of rational and transparent transfer and posting further aggravate the problem. Recent effort to post Rural Medical Assistants in difficult areas from the 3 year course students. Large scale shortages of Nurses, Lab Technicians Para medics, Specialists.

4.	Jharkhand	Large scale shortages of Specialists and Nurses. Efforts have been made to rationalize postings of Specialists at Block, Sub District and District Hospitals. Need to create Specialist cadre and undertake rational and transparent policy of transfers and postings. Gradation list not yet prepared in Jharkhand state leading to lack of transparent criteria in key postings of doctors. State needs to look at Bihar's new cadre rules and create a similar system. ANM School and Nursing schools need further strengthening with increase in intake. Jharkhand has a tradition of nursing services and women workers migrating in search of work. Nursing will improve skill levels of migrant women workers. 1200 doctors being recruited through the Jharkhand Public Service Commission. Appointment in final stage.
5.	Karnataka	Medical doctors, para medics, nurses reasonable available in facilities visited. Contract appointment of Specialists, Doctors, staff nurses, ANMs and Lab Technicians has been made to meet shortfall. In sourcing in FRUs. MBBS doctors trained in Emergency Obstetric care and life saving anaesthetic skills have been posted to designated FRUs. Signs of improvement in availability of HR. ANM Training Centre needs attention. Cadre management and service conditions of doctors is an issue.
6.	Kerala	Various category of human resources have been added on contract under NRHM and this has added to services. Medical Officers as DPM working well. Compulsory Rural Service for MBBS and Specialists is a good step. NRHM Coordinators not integrated into health system. More rational systems of deployment needed.
7.	Madhya Pradesh	There are large scale shortages of Specialsts and Nurses in the State. Contractual support structures for programme management are in place at the State and the district level. The block level structure is being put in place.
8.	Maharashtra	Several steps to improve availability of Nurses. Second ANMs provided. MPW Male already there. Shortage of Anaesthetists. Need to rationalize posting of Specialists to ensure service guarantees. Capacity of government nursing schools has been developed. Decentralized appointment on contract. Multi speciality training on priority for nurses posted in tribal and extremist affected pockets. Higher payments in tribal and naxal areas.
9.	Mizoram	Availability of doctors and nurses has increased due to contractual appointment in NRHM. Specialist shortages persist. 2 ANMs in Sub Centres. Need for in service nursing education. Need to invest in mobility of non doctor supervisors as well. Increased staffing of Lab technicians leading to increase in service availability.

10.	Orissa	Shortage of MBBS doctors, Staff Nurses, Specialists and Lab Technicians plague ublic health services. The State has taken several immediate and long term initiatives to meet this HR crisis in the State. 3 new Medical Colleges have been set up in the private sector. Cadre reforms and up gradation of entry level post of doctors as Junior Class –I plus allowances in difficult areas likely to attract more doctors. Cadre restructuring under active consideration. Multi skilling going on. Proposal for 8 GNM Schools and 13 ANM Training Centres.
11.	Rajasthan	Shortage of Specialist at FRU/CHC. The Rural Medical Officer cadre has greatly increased availability of MOs at PHC level. Shortage of Lady MOs. Multi skilling under progress – needs to be utilized better. 2 ANM in tribal areas is a very good development. Very few refresher courses for ANMs. Need for synergy among training institutions.
12.	Tamil Nadu	During the last two years 4263 nurses were appointed on contract basis in the rural health centres. Life saving Anaesthesia skills imparted to 106 MBBS doctors who are posted back to Block PHCs. All VHNs given Mobile Phones. Cadre reforms to promote posting in rural areas. Satisfactory HR position.
13.	Uttar Pradesh	Human resource is the real challenge in UP. Huge shortage of Nurses and Specialists. Some rationalization is improving availability of services of Anaesthetists and Gynaecologists. This alone will not be enough. Need to expand nursing and medical education sevices on a large scale. Some District Hospitals could be considered for up gradation in to Medical Colleges in a time bound manner. Three year courses as in Assam and Chhatisgarh could be considered.

Theme VII - Infrastructure

	State	Key Findings
1.	Assam	While lot of buildings have been constructed or are under construction, there is a need for greater rationalization of capital investments in order to ensure full utilization. While facility surveys have been completed, the up gradation is often not based on felt-needs.
2	Bihar	Infrastructure wing under the State Health Society has been created. Progress on construction is tardy. State exploring options for faster pace of construction and maintenance. Quality supervision of construction is weak.
3.	Chhatisgarh	Unsatisfactory infrastructure. PWD and Chhatisgarh Infrastructure Development Corporation doing buildings. Lot to be done. Many Sub Centres in rented buildings. Many new construction works are under progress.
4.	Jharkhand	A very unsatisfactory infrastructure. Large scale construction has been taken up in the last six months which will take a few more months for completion. It is likely to improve the position for infrastructure. Block level PHCs need up gradation into 30 bedded CHCs on a priority. Accommodation for doctors and nurses also needs priority attention.
5.	Karnataka	State is pooling infrastructure resources from different sources. Impressive physical lay out of PHCs/Taluka Hospitals, and newly constructed Sub Centres. Need to focus on quality of construction in a few places. Facility Surveys undertaken and gaps identified. Engineering Cell of Health Department doing the construction.
6.	Kerala	Building and equipment infrastructure coming from many sources. Engineering wing of NRHM Kerala for planning and monitoring. Equipment bought should be audited for their utilization. A State wide emergency ambulance system needs to be established.
7.	Madhya Pradesh	Infrastructure Wing has been established under the Health Department and large scale construction works have been undertaken. 1747 Sub Centre buildings, 193 PHC buildings, 101 CHC buildings, and 7 District Hospital buildings are under construction at present.
8.	Maharashtra	Excellent construction of new infrastructure and repair/upgradation of the existing infrastructure. Gardens and landscaping. Staff Quarters in good condition.
9.	Mizoram	Construction cell in NRHM Directorate is over stretched due to the volume of work. Need for assessing need for engineers. Local people's committees may be involved.

10.	Orissa	Huge backlog of construction activities un der NRHM and State funds. A separate engineering unit set up last year. Work allotted to 8 Governement PSUs. Progress unsatisfactory. Need to prioritize Health Sub Centre construction along with ANM's residential quarter.
11.	Rajasthan	Good progress in construction. Emphasis to construction of residential quarters at PHCs/CHCs is a positive step. Out of pocket expense for referral transport.
12.	Tamil Nadu	All the PHC premises have a new look as most of the civil works have been completed. Need to improve residential quarters. Need for an infrastructure division within the health department as PWD has many other responsibilities.
13.	Uttar Pradesh	Infrastructure in District Hospitals, CHCs and OHCs has vastly improved in the last few years. There is a lot more to be done. Construction is going on at many places. A large number of Health Sub Centres need new buildings or repair. Site selection for PHCs must be near habitation for their optimal use. Large gaps in infrastructure need to be addressed on a priority.

Theme VIII – Empowerment for effective decentralization and flexibility for local action

	State	Key Findings
1.	Assam	20,309 VHSCs formed. Started late due to PRI elections. Need for capacity building. Rogi Kalyan Samitis in most places. Good community participation in programmes. Village Health and Nutrition Days have attracted community participation.
2	Bihar	Panchayats are represented in the RKSs and the District Health Society. Involvement of Panchayats in NRHM is still not a priority. RKSs have been formed and are functional. VHSCs not formed as yet. Block Health Manager and Data Assistant working under the RKS. District Health Society meets regularly and proceedings are well maintained.
3.	Chhatisgarh	Good participation of Panchayati Raj Institutions in the decentralization agenda. VHSCs constituted under the umbrella of the PRIs. Jeevan Deep Samitis in facilties. Good use of untied grants in 2008-09. PRIs need to be made more active in Jeeevan Deep Samitis.
4.	Jharkhand	Panchayat elections have ot been held in Jharkhand since 1978. There are no elected PRIs. Therefore NGOs have been enlisted in selection of Sahiyyas and in the constitution of the

		Viigae Health Committees. Wherever the NGO selection has been a good one, the performance of the Sahiyyas and the Village Health Committees has been good. In other places, selection of NGO has hampered local processes. Procurement of drugs, untied grants to local institutions, has helped in the process of decentralization.
5.	Karnataka	PRIs are on board. Members of Panchayats as members of Arogya Samitis. CEO of Zila Parishad in District Health Society. All facilities from the Taluka downwards are funded thorugh the Panchayat system. Indifference to health among Panchayat members perceived by doctors, leading to delayed decision making. Good use of untied funds at all levels. District Health Society meets regularly.
6.	Kerala	Ward Health and Sanitation Committees have been operationalized. Untied, annual maintenance grants and RKS funds being regularly used to upgrade facilities and services. PRIs are part of RKS and are involved. Panchayats are involved in the running of Sub Centres.
7.	Madhya Pradesh	VHSCs being formed and accounts being opened. Not fully operational as yet. RKS in all facilities. Untied funds being used under direction of ANM. Need to improve the involvement of the Sarpanch.
8.	Maharashtra	Excellent involvement and cooperation of PRIs. VHSCs are fully functional. Untied funds used for cleanliness and beautification. SHGs involved in providing meals in PHCs. ANM providing meals to delivery cases at Sub centre. RKS meetings are held regularly. Sarpanch, members of VHSC, Gramsabha, and employees of health panchayat and ICDS involved. In preparation of Village Health Plans.
9.	Mizoram	Village Health and Sanitation Committees operationalized in all villages. Active involvement of youth, women and senior citizen groups in activities such a s awareness for malaria, improved sanitation, etc. Need for regular meeting and monitoring of financial progress. RKS operational with active involvement of Village Council members. Good use of untied funds. District Health Society meetings not regular.
10.	Orissa	Untied funds at different levels have contributed significantly to addressing local needs effectively and towards empowerment of local action and convergence. 11774 VHSCs set up (Gaon Kalyan Samiti). NGOs supporting the process. PRIs, women's SHGs and ICDS AWWs are being involved in the functioning of RKS, GKS and in the health system.
11.	Rajasthan	Untied funds being utilized at all levels – the pace of utilization needs to increase. MRS formed at all levels. VHSCs formed but their money is still with the Sub health Centre. Need to make VHSCs more active.

12.	Tamil Nadu	VHSCs established for 12,618 villages and 2540 town panchayats. VHSCs meeting regularly and the record of discussions are maintained. Untied funds well utilized. Patient Welfare Societies in PHCs. Active District Health Missions. Need for empowerment of DMHOs. Community monitoring in a few facilities.
13.	Uttar Pradesh	PRI sa re involved but health functionaries complain of non – cooperation in many places. Village Health and Sanitation Committees have been set up under the umbrella of PRI. Sub Centres have joint accounts.

Theme IX - ASHA

	State	Key Findings
1.	Assam	26,225 ASHAS have completed Module IV training. ASHA programme has created a groundswell for NRHM and ASHAs are the visible and audible presence. JSY work popular. Most of them earned less than Rs. 10,000 in one year. Medicine kits provided but no arrangement for replenishment. Popular weekly radio programme.
2	Bihar	ASHA programme is in place and the ASHAs are almost without exception, enthusiastic and functional. In most facilities they were seen in the labour rooms and maternity wards with the patients they had accompanied. Delays in performance based payments. Training for 2-4th module is delayed. ASHA programme is doing well in spite of the constraints. Succeeding due to local innovations. The Muskaan programme and the JBSY provide specific task for ASHAs.
3.	Chhatisgarh	60,000 Mitanins in Chhatisgarh. Trained and deployed in every hamlet. Active in the field. Wide appreciation of Mitanins role in society. Comprehensive support structures. Mitanin help desks in all CHCs and District Hospitals. High degree of skills and competence among Mitanins. Irregular replenishment of drugs. Competition with ANMs for family planning incentives.
4.	Jharkhand	The Sahiyyas of Jharkhand have been selected by NGOs, through Village Health Committees. They have done threee modules of training. Good modules have been developed in the local contexts. Medicine kits have been made available to them. Sahiyyas see themselves as a representative of the local community and not as an administrative assistant of the ANM. This has helped in keeping their community links strong. Performance based payment processes need

		streamlining.
5.	Karnataka	2150 ASHAs are in place in C category districts. Well designed training programme for ASHAs. ASHAs have ID cards. Need to create support systems for ASHAs. More communication material needed for ASHAs.
6.	Kerala	8435 ASHAs in place. Selected by Panchayats. ASHAs confident and aware of the NRHM programme. Performance basd payment made regularly. Need to increase performance based payment criteria. Regular drug kits still to be provided.
7.	Madhya Pradesh	ASHAs are effective and knowledgeable. Accompanies JSY cases. Reource Persons at the District level for training. ASHAs involved in making blood smear slides in fever cases. Incentives not worked out formalarai work. Some issues of relationaship of ASHAs/AWWs/ANMs. Need for more NGO involvement in the ASHA programme.
8.	Maharashtra	ASHAs working in tribal areas. Third module training going on. ASHAs are well motivated and enjoy the confidence of the community. Block level ASHA libraries established in three Blocks.
9.	Mizoram	ASHAs are active. Rapid Diagnostic kits for malaria provided to them. Facilitate community leadership.
10.	Orissa	34,252 ASHAs selected. Induction training completed for all. 48% ASHAS have comleted up to fourth module. ASHAs provided with drug kits. Posters providing details f ASHAs payments displayed in all facilities. ASHAs weer found to be rooted in the community, highly motivated, and the comp[etnecies and skills were good. Good team work with women SHGs and AWWs. Role in nutrition and women's empowerment.
11.	Rajasthan	ASHA Sahyoginis are of the ICDS programme and their involvement in institutional deliveries, etc. is low. Closely linked to Aanganwadi Workers. The involvement of ANMs with ASHAs need strengthening. 15 day training for ASHA Sahyogini – State may like to assess need for change.
12.	Tamil Nadu	Not implemented in Tamil Nadu as yet.
13.	Uttar Pradesh	More than half the ASHAs are very active in the field. The community knows them and uses their support in seeking health services. Two rounds of training has been completed. Performance based payment criteria needs to be widened to include a larger number of activities for performance based payments. Training needs to be speeded up. Role clarity vis-a-sis ANM and AWW will help. ASHA is a key person in the Village Health and Sanitation Committee.

Theme – X – Systems of financial management

	State	Key Findings
1.	Assam	The capacity of the State to utilize funds made available to it under various components of NRHM has consistently increased. Good State level leadership and active role of District Health Missions. Need to improve financial record keeping. District PMUs have good data. Need to strengthen capacity at State level. Civil works and tender process take a little time and that is fund utilization takes a little time.
2	Bihar	
3.	Chhatisgarh	Though State Health Society account is opened, many disease control programmes still operating through old accounts. State share process initiated but not transferred to State Health Society as yet. Audit of 2007-08 completed. Core banking from District to Block level. Slow progress on approved activities in 2008-09.
4.	Jharkhand	Vacancies at the Block and district levels have al been filled up Efforts to strengthen the state level set up has also been made. Financial performance has improved and levels of expenditure has picked up with large scale construction activity.
5.	Karnataka	Delegation of administrative and financial powers in February 2008. Accounts with SBI and SBM. FMG constituted. Electronic transfer of funds from State to district. Single audit report in the State. Concurrent audit in place in 6 districts.
6.	Kerala	E banking facility across the State. The facility is operational, and allows for transparency, audit and speed of operations. ASHAs given electronic cards for financial transactions.
7.	Madhya Pradesh	Expenditure reporting found to be satisfactory. Monthly Audit of District Accounts and reporting by e-mail has helped. Use of computers in PHCs. Substantial increase in utilization of funds.
8.	Maharashtra	Societies have merged. SPMU and DPMUs are functional. Block Monitoring Committee in place. FMG at State level providing guidance to field units. Timely reporting of financial statements.
9.	Mizoram	System of financial management in place with specific personnel at various facilities. Delays in JSY payments.
10.	Orissa	Increased pace of utilization of funds. Financial reporting is timely. Transfer of funds through e-banking. Financial guidelines under NRHM disseminated to all districts.
11.	Rajasthan	Finance team strengthened at all levels. Electronic transfer of

		funds up to Block levels. Monthly financial reporting from Blocks to districts, districts to States has been initiated. Tally software has been introduced but use is at nascent stage.
12.	Tamil Nadu	E transfer of funds to districts. Untied grants released to all. VHSC members need to be trained regarding accounting procedures.
13.	Uttar Pradesh	DPMUs have been established recently. Block and PHC level staff strengthening needed for better financial management. E – transfers to districts with the support of SBI. Need to further streamline processes of reporting and their timeliness.

Theme – XI – HMIS and its effectiveness

	State	Key Findings
1.	Assam	Data system is weak. Information is collected but rarely analyzed. State has partially operationalized the web based district data system. Post 2005 the Data Manager at the district has a lot of data.
2	Bihar	Data Centres at State,, district and Block level. Outsourced system. Daily information is available. Cellphone connectivity has also been established. Holds everyone in the system responsible. A little over intrusive but then it serves the purpose.
3.	Chhatisgarh	Data generation through Block level, bypassing PHCs. New formats being used in State level reporting. Most programmes retaining vertical reporting formats. Feedback mechanism not in place to improve the MIS process. Sub Centres have up to date records.
4.	Jharkhand	While basic data is being collected manually, its analysis and utilization varies. Need to create a strong HMIS for monitoring performance of facilities, especially surgical procedures at Block level facilities.
5.	Karnataka	Detailed State proforma. Web based system introduced in one district. HMIS needs to be harmonized with NRHM needs. Need for training staff.
6.	Kerala	The current manual HMIS is not meeting the need. The State in process of developing new HMIS. Need for Nodal information officers at each level. CHCs and PHCs have computers.
7.	Madhya Pradesh	HMIS operational. Need to make it more effective with capacity building at all levels.
8.	Maharashtra	Very well functioning web based HMIS formats, user friendly software for data entry, analysis and report

		generation at different levels and trained health staff in use of software database are the features of the State HMIS.
9.	Mizoram	HMIS data being collected. Not stable as yet. New staff deployed.
10.	Orissa	Comprehensive HMIS reporting formats have been introduced since April 2007. Need to improve quality of data. Feedback to PHC and Sub Centre needs to be strengthened.
11.	Rajasthan	Integrated HMIS is in pilot phase covering RCH, IDSP and NDCPs. Data validation build into the system. Testing phase is over. To be expanded State wide in 2009-10.
12.	Tamil Nadu	Has good MIS. Computers in PHCs.
13.	Uttar Pradesh	Weak area in UP. Data is collected but not adequately analysed at the right level. Efforts needed to ensure that the new web based HMIS takes deep roots early and facilitates analysis at each level.

Theme – XII – Community processes under NRHM

	State	Key Findings
1.	Assam	Need greater support and capacity building. RKS functional. VHSCs constituted. PRIS involved at each stage but greater efforts at capacity building is needed.. NGO sector needs to be involved more.
2	Bihar	While access to services at Block PHC has considerably increased, the formation of community process institutions like the Village Health and Sanitation Committees, Sub Centre level committees, etc, is still pending. Rogi Kalyan Samitis have been formed in most health facilities.
3.	Chhatisgarh	92% VHSCs already constituted and accounts in the joint signature of Mitanin and Panchayat Secretary has been opened. Low utilization of funds so far. Monthly Village Health and Nutrition Melas being held. Mitanins working in tandem with ANM, AWW, SHGs, etc. Community monitoring has been initiated.
4.	Jharkhand	Largely led by the NGOs through the Sahiyya programme. Large presence of NGOs has helped. Rogi Kalyan Samitis have been formed. Sub Centres are utilizing their untied grants.
5.	Karnataka	Community monitoring through VHSCs in four districts, with support from Karuna Trust. Need for more effective systems of monitoring. Simplify village report card. Evidence of PRI members say in use of untied funds.

6.	Kerala	Ward health and Sanitation Committees meet regularly and maintain minutes. Panchayats provide fund for electricity, medicines and glucometer. Need to orient Panchayat members about NRHM.
7.	Madhya Pradesh	Satisfactory involvement of the local communities and PRIs in RKS and other institutions. ASHAs are effective. Indicates useful selection criteria.
8.	Maharashtra	7887 ASHAs in tribal areas. ASHA selection in other areas has started. Support mechanism for ASHAs in place. VHSCs established in 82 % villages. Maximum utilization of village health funds is on providing safe water supply and thereafter on Village health and Nutrition Day.
9.	Mizoram	ASHA in place everywhere. 7 day training. Need for refresher training. ASHA mentoring group has met only once. Needs to meet more often. VHSC operational in every village. Need to involve other than health department functionaries.
10.	Orissa	Community processes are strong. ASHA selection, role of PRIs in GKS and RKS, Village Health and nutrition Days have all created platforms for community action.
11.	Rajasthan	Begun involving VHSCs in microplanning. Involvement of community representatives in management structures needs to be further increased. NGO programme is weak.
12.	Tamil Nadu	Strong community participation through VHSC, RKS, etc.
13.	Uttar Pradesh	PRIs are involved. RKSs have been set up. VHSCs have been set up. Need for training of PRI/community leaders to improve their contribution in decentralized management of health system.

Theme – XIII – Assessment of non – governmental partnerships for public health goals

	State	Key Findings
1.	Assam	NGOs involved in Boat Clinics – doing very well. NGOs in community monitoring programme. There could be greater involvement.
2	Bihar	The mother NGO programme is not operational. The State has a number of PPPs. It has very little Ngo involvement at pr3esent. Efforts to run APHCs through NGOs has not been very successful so far.
3.	Chhatisgarh	State Health Resource Centre playing a key role in community based health sector reforms. Playing a creative capacity building role in many areas. Large scale NGO partnerships in the Mitanin programme, blindness control programme, MNGOs and FNGOs for RCH. NGO Jana Swasthya Sahyog running very good hospital in Bilaspur district.
4.	Jharkhand	Sahiya programme and Mobile Medical Units have made use NGO presence. MMUs are run by Vikas Bharati. Doing very well with wide coverage.
5.	Karnataka	Large scale involvement of NGOs. 49 PHCs outsourced to NGOs.
6.	Kerala	Few NGOs involved. Community monitoring is not formally introduced.
7.	Madhya Pradesh	Need to further increase NGO involvement.
8.	Maharashtra	Large scale involvement of NGOs in programme. MMUs by NGOs. Training and capacity development through NGOs. Community monitoring through NGOs. NGOs working for TB/ HIV/AIDS.
9.	Mizoram	Active village level involvement of youth, women and senior citizens through VHSC. MMUs proided to some NGOs. Mother Ngo scheme to strengthen government efforts. Yong Mizos Asociation and Mizo Women's Association are active.
10.	Orissa	Good NGO participation in NRHM activities. NGOs involved in ASHA training, community processes for setting up of GKS in a campaign mode, referral transport and management of a few PHC(N) as a PPP arrangement, PRI sensitization, organizing health melas, etc. 17 MNGOs and 88 FNGOs cover 2891 villages in 22 districts under the MNGO programme.
11.	Rajasthan	Clearly spelt out NGO and PPP policy in the State. EMRI ambulance service, MMUs, social marketing of sanitary products as examples.
12.	Tamil Nadu	Donations to hospitals as PPP. Many local initiatives.

13.	Uttar Pradesh	Very few partnerships. Need for building detailed criteria that facilitates NGO involvement. PPPs being proposed for Medical Colleges.

Theme – XIV – Systems in place for outreach activities of Sub Centre

	State	Key Findings
1.	Assam	Some of the Sub Centres in the State were found to be functioning very well with a resident ANM, high quality buildings and good use of untied funds. Variation across centres. Many Sub Centres in rented buildings. Non resident ANM in many places. Need to speed up Sub Centre construction. 108 Ambulance system operationalized in a few districts. The Male Worker is needed at the Sub centre level.
2	Bihar	ANMs in place in Sub Centres. Untied funds given but not yet utilized. Need more confidence to spend. Engaged in the Muskan programme.
3.	Chhatisgarh	Besides VHNDs, biannual child health months has led to significant increase in coverage of outreach services. While ambulances are available, their utilization for referral cases was low.
4.	Jharkhand	Sub Centres are doing better than in the past. VHCs are getting active and funds have started reaching them. Mobile Medical Unit has expanded access in remote areas.
5.	Karnataka	Streamlined outreach through fixed monthly putreach plans. VHNDs getting institutionalized. Mobile Health Units operational in KHSDP. EMRI planned for emergency ambulance service across the State. Health Workers (Male) being trained..
6.	Kerala	WHNDs are regularly observed. IEC materials are innovative and well displayed. Sub Centre kit supply needs to be regular. EC pills not available. JPHNs need periodic training to cover all aspects.
7.	Madhya Pradesh	Village Health and Nutriton Days effective. Sub Centres doing outreach services. Need to widen land include larger public health challenges as well.
8.	Maharashtra	Fixed day services in village for iummunization. Village Health and Nutrition Days.

9.	Mizoram	VHNDs held regularly – more educational rather than service function. MMU operational under District Hospital.
10.	Orissa	Fixed Village Health and Nutrition Days are increasing ANC registrations, immunization, growth monitoring and nutrition counseling activities. Mobile Units are in place. Second ANMs have been provided for outreach activities in remote areas. Absence of MPW Male limits the actities.
11.	Rajasthan	Coordination with AWW is god as Sahayogini is a ICDS functionary. VHNDs held regularly.
12.	Tamil Nadu	100 Mobile Medical Units with 100 doctors on contract. 63,715 camps in 2007-8. Effective school health programme.
13.	Uttar Pradesh	Sub Centres need the MPW Male and the second ANM. The load on a single ANM is heavy. Fixed day services have started with good results. Mobile Medical Units to improve outreach services yet to begin.

Theme – XV – Thrust on difficult areas and vulnerable social groups

	State	Key Findings
1.	Assam	Special efforts are being made to address health needs of tea estate workers and people living in tribal and char areas. Need for a robust plan. There is the challenge of attracting good human resource in remote areas.
2	Bihar	Exemption from user fee needed for the poor.
3.	Chhatisgarh	Chhatisgarh has difficult areas. Proposal for creation of Rural Medical Corps with special pay to address remote area needs, waiting for Cabinet approval. Rural Medical Assistants have already been posted in tribal areas.
4.	Jharkhand	Tribal areas with large area with active Naxal issues. Difficult working conditions for doctors and apra medics. Many of them are providing service in these difficult areas. Untied funds has helped them to activate the health facility and make it clean. VHC and Sahiyyas have helped in improving the outreach of services.
5.	Karnataka	219 PHCs identified as remote. Additional financial incentives to doctors and staff nurses. Priority to C category and tribal districts is commendable.
6.	Kerala	Tribals form 1.14% of State's population. ASHAs in tribal areas. Sickle cell anaemia project targeted at tribal population. Comprehensive Health Care Scheme for tribals provides for full reimbursement.

7.	Madhya Pradesh	Mobile Health Units in tribal areas has helped. Need for more focused attention. More direct publicity of free services for the BPL/SC/ST needs to be highlighted.
8.	Maharashtra	Tribal area focus in ASHA programme. Additional financial incentives for tribal and naxal areas. MMUs in difficult areas.
9.	Mizoram	Mizoram has difficult and remote areas that need special initiatives. Perhaps efforts like NGOs managing remote PHCs (as tried out in Arunachal Pradesh) could be tried out in Mizoram.
10.	Orissa	Needs to be more pro- actively sought and encouraged.. Special provisions for KBK districts.
11.	Rajasthan	Tribal Sub Plan provides for additional funding in diffuclt areas. 2 ANMs in difficult areas.
12.	Tamil Nadu	Accessibility and availability of services is very good. Good outreach through MMUs.
13.	Uttar Pradesh	Need to expand outreach services through camps. More nurses and Male Health Workers needed in the field.

Theme – XVI – The preventive and promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health

	State	Key Findings
1.	Assam	Newly elected Panchayat members an opportunity for convergence. Road map for their capacity building is needed. Need for more involvement of health department functionaries in inter sectoral convergence.
2	Bihar	Nutrition rehabilitation programmes have begun. Emphasis on the Vitamin A campaign.
3.	Chhatisgarh	AYUSH co – location has not happened as yet. Intra health sector convergence is also an issue in Chhatisgarh.
4.	Jharkhand	VHNDs arer popular. Rapid Diagnostic kit for malaria has helped. ANMs have these kits.
5.	Karnataka	Good convergence with NACP – III and ICDS in VHND. Water quality monitoring being undertaken. PPP for vector surveillance.
6.	Kerala	WHNDs are regularly observed. United funds of WHSC used for source reduction and vector control. The absence of malaria, filarial, dengue and Chikanguniya this year may indicate success of such activities.
7.	Madhya Pradesh	Greater community led action needed for preventive and promotive health.

8.	Maharashtra	School Health Programme (353 teams at Taluka level) in coordination with education department, geriatric schme implemented in cooperation with volunteers from Kishori Shakti Yojana and senior citizens attending the sessions at Aanganwadis and doing exercise, constitution of VHSCs in partnership with the water and sanitation committees, VHSC funds for improvement of amenities in Aanganwadi Centres, safe water supply, RKS funds utilized for drinking water facility, viable partnership with ICDS through ASHAs in tribal areas, 438 Child Development Centres to treat Grade – III and Grade IV malnutrition, partnership with Public Health Labs for water quality testing, are all an affirmation of the convergence in the State.
9.	Mizoram	Measures of vector control are good with involvement of VHSCs. Convergent efforts in the VHNDs. Need for dental services.
10.	Orissa	NRHM implementation has clearly contributed to better linkages of health staff with ICDS, Total Sanitation Campaigns and Self Help Groups. The team work of ASHAs, AWWs and ANMs in organizing the Village Health and Nutrition Day is a good platform for convergence.
11.	Rajasthan	Need for greater coordination.
12.	Tamil Nadu	Good coordination at the field level.
13.	Uttar Pradesh	School Health Programme and Saloni programme for adolescent girls has been started. The Village health and Sanitation Committee can also greatly enlarge preventive health thrust. Need for systematic capacity building.

Theme – XVII – Effectiveness of the disease control programmes including vector control programmes

	State	Key Findings
1.	Assam	Thrust is on RCH. Gains in disease control programmes are incidental. Malaria cases and deaths have reduced mainly due to use of rapid diagnostic kits and insecticide treated bed nets. ASHAS are trained in use of Rapid Diagnostic Kit and in blood slide making. TB abd leprosy programme reported to be doing well. No district tlevel laboratory under IDSP.
2	Bihar	Disease control programmes now with the Directorate. In the absence of adequate financial delegation the programme has slowed down. Technical protocols need to be more widely discussed. Supply of anti kalazar drugs has improved.

		Inconsistency in treatment protocols. Need for doctors' orientation on programme treatment guidelines. One round of spray for vector control. Social mobilization of communities needs to be speeded up. Case detection less than 50% for TB. Cataract surgeries are not being regularly undertaken in District Hospitals. No shortage of leprosy drugs reported. IDSP is just starting.
3.	Chhatisgarh	Section wise GIS mapping for malaria. 1,55,620 bednets distributed in 2007. Rapid Diagnostic Kits distributed in Bilaspur and Dhamtari. Mitanins trained in using Rapid Diagnostic Kits and in making blood slides. Vacancy of MPW Male affecting Malaria surveillance. Though malaria infected, District Malaria Officers and Inspectors are not there. Poor monitoring of NLEP. Inequitable and insufficient distribution of eye surgeons.
4.	Jharkhand	TB programme has picked up and services are available. Rapid Diagnostic kits have helped in timely detection of falciparum cases. In patient cases of malaria seen.
5.	Karnataka	Good progress on the disease control programmes. API has reduced and deaths are low. Convergence of NVBDCP, TB and HIV/AIDS noticed at PHC/CHC level. Vision centres are functional. IDSP working very well.
6.	Kerala	Commendable that State has set up innovative programme for the community to manage terminal illness. Use of NGOs/Volunteers for pain and palliative care is commendable.
7.	Madhya Pradesh	Thrust on RCH activities. Need for wider public health focus to cover all disease control programmes as well.
8.	Maharashtra	Well run. Good coordination with NRHM. Rapid diagnostic kits and other testing facilities available. ASHAs in tribal areas taking blood slides of malaria. RNTCP has linkages with all ICTC and ART centres.
9.	Mizoram	Malaria control programme is effective. Fevour and malaria cases have come fdown. RNTCP doing well. Blindness programme is less active because of lower awareness.
10.	Orissa	High incidence of malaria but no District Malaria Officers. Absence of MPW Male makes it difficult. MPW being appointed on contract. Time take for reporting cases by laboratory is three weeks to one month. Insecticide treated bed net useful but in short supply. GKS needs to be involved in the vector control activities actively.
11.	Rajasthan	Malaria areas well provided with active search and malaria drugs. Rapid Diagnostic Kits being used in PHCs but not by ANM/ASHA. TB detection and cure rates above the targeted levels. IDSP formats at District/CHC/FRU levels.
12.	Tamil Nadu	Working very well.

13.	Uttar Pradesh	Still functioning separately. Need for integration. Need for improvement in the Malaria control programme.

Theme – XVIII – Performance of maternal health, child health, and family planning activities seen in terms of availability of quality services at various levels

	State	Key Findings
1.	Assam	Large number of new born care centres at PHCs. Utilization still low. Institutional births up to 60% from 37% before NRHM started. Home births need attention as well. Full coverage of immunization has improved.
2	Bihar	Access to maternal, child and family planning services has expanded. However, unmet need remains high. The Muskan Abhiyan for immunization and institutional deliveries seems to have worked well.
3.	Chhatisgarh	Institutional deliveries yet to catch up. More needed to be done on child health. Nutrition not a priority as yet.
4.	Jharkhand	JSY yet to pick up. Institutional deliveries are slow to pick up even though ANC registration has increased. More confidence needed in the health facility and its service guarantee. Sub Centre deliveries are taking place.
5.	Karnataka	PHC Taluka Hpsitals have shown improvement in physical infrastructure to deliver RCH services. New born care needs attention. SBA training, MTP and LSAS needs quality assurance. Training of EmOC and LSAS for Medical Officers has shown good progress though coverage needs to be widened. Special efforts to simplify BPL certification has helped. E banking has improved efficiency of JSY payments. Improvement in immunization coverage is visible. Maternal deaths are being investigated.
6.	Kerala	PHCs, CHCs, Taluka Hospitals providing services for family planning. Only few CHCs providing 24X7 delivery services. Public awareness of JSY and immunization is satisfactory.
7.	Madhya Pradesh	Substantial increase in institutional deliveries. Efforts made in child health as well. . Improvement in family planning services.
8.	Maharashtra	Significant increase in institutional deliveries, good quality facilities and cleanliness contributes to popularity of the public system. Simultaneous attention to maternal and child health needs as also malnutrition. Pregnancy testing kits are available in Sub Centres.
9.	Mizoram	ANC done regularly at all facilities. Incidence of low birth

		weight is very low. Need to improve new born care facilties in CHCs and PHCs. Regular immunization at all centres. High offtake of oral pill for family planning. EC pills not available. Young doctors trained in minilap providing services at PHC/CHC. Quality of IUD services could be improved. .
10.	Orissa	PHC strengthening needs to be emphasized for preventive and curative services. Thrust on CHCs/SDH and DHs. 61% of all institutional deliveries in 2007-08 were JSY supported. Major gains made. Quality of maternal care needs immediate attention. Discharge within few hours of the delivery. 341 institutions that have been selected for 24X7 services need to be operationalized on a priority basis. FRU operationalization needs to be given priority. Childhood illness care at primary level needs strengthening. Nutrition Rehabilitation Centres in two districts. Contraception performance has improved marginally. NSV achievements are impressive. Increase in incomplete abortions coming for referral.
11.	Rajasthan	While maternal health has received attention, child health needs more focused attention, especially neo natal mortality. Need for birthing kit in JSY delivery centres. Shortage of vaccines this year.
12.	Tamil Nadu	Excellent MCH services. Pending JSY payments. Increase in family planning services at PHC level.
13.	Uttar Pradesh	Upsurge in institutional deliveries. Thrust on Child Care programmes. Family Planning services need improvement, especially IUDs and emergency oral pill availability.

Theme – XIX – Assessment of programme management structure at district and state level

	State	Key Findings
1.	Assam	149 BPMs, 149 BAMs, 454 PHC Accountants in place. Need for coordination between NRHM and the Directorate of Health. PMUs at all levels playing a significant role in planning and monitoring. Most of them are young and enthusiastic. The regular cadre of health personnel still not fully involved. Cleavages between public health system and NRHM.
2	Bihar	Programme management units at State, district and Block levels. These units are functioning well. Need to expand supportive supervision.
3.	Chhatisgarh	SPMU/DPMU in place. Need for more coordination with the

		Directorates in an effective and efficient way. Block level Programme Management teams being put in place.
4.	Jharkhand	SPMU, DPMU and BPMU has helped the programme in developing a system at the field level. Need for closer integration with the mainstream health administration.
5.	Karnataka	SPMU/DPMU is in position. BPM appointments in process. Merger of NRHM and KHSDP enhances efficiency.
6.	Kerala	SPMU and DPMU functional. Block Coordinators in each Block. More integration of Directorate may help.
7.	Madhya Pradesh	State and District Health Societies established and functioning with management skills.
8.	Maharashtra	SPMUs and DPMUs ae fully functional. Taluka Health Offices strengthened with additional human resources. Directorate staff fully involved in programme implementation.
9.	Mizoram	SPMU and DPMUs inplace. State Programme Manager to join shortly. Presence is a strong support to the district health administration.
10.	Orissa	SPMU strong. Good working ethos. DPMUs active, professional and vibrant. Good team work with district and block medical teams exist in the State. The professionalization of health systems management inNRHM in Orissa has been a major factor in enabling the paradigm shift and effective decentralization of health management. District Health Action Plans prepared by the district teams.
11.	Rajasthan	SPMU DPMU structure is well established and provides useful support to the programme. Need for closer integration of the Directorate of Health activities.
12.	Tamil Nadu	Implementation of the programme in the State is exemplary. The District Health Mission meetings are not being held as envisaged under NRHM. There is no DPMU and BPMU as yet. Block PHC has an Offfice Superintendent. DMHO from the public hea;th cadre.
13.	Uttar Pradesh	SPMU is active. DPMU and BPMU being set up. These skills are acutely needed. Divisional PMUs have been set with SIFPSA support.