2010

Fourth Common Review Mission - Maharashtra

DRAFT REPORT - 4th Common Review Mission Maharashtra

Table of Contents

INTRODUCTION

Maharashtra is situated in the western part of India and as per the 2001 Census, Maharashtra is second largest state in India with population of 9.67 Crores after Uttar Pradesh having 9.42% population of the nation. With an area of 3.08 lakh Sq. Km, the state also ranks second in area after Uttar Pradesh. The state has the highest percentage of urban population i.e. 43.3%. According to 2001 census, spread over 15 districts, 8.9% of the state's population is tribal. The districts of Gadchiroli and Nandurbar have highest tribal population at 38% and 65% respectively.

A brief overview of the administrative units in the state;

- State has 35 districts -33 rural and 2 urban districts (of Mumbai), divided into 6 revenue divisions and eight health circles.
- There are 43711 villages and 27920 gram panchayats spread over 351 development blocks.
- There are 23 municipal corporations and 222 municipal councils along with 7 Cantonment boards, which have no organized health infrastructure.
- Thane district has registered the highest decadal growth rate (54.86%) and the lowest growth rate is found in Sindhudurg district (3.55%). The state average decadal growth rate is 22.57%.

The number of villages with less than 1000 population is another consideration for access to public health services in the State. About 67% of the population lives in 54.5% of such villages (with population <1000). Only 53% of the total villages in the state are connected by all-weather roads (compared to 100% in Kerala and 99% in Punjab).

4TH CRM TEAM (MAHARASHTRA)

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- ❖ Dr. Santhosh S., Public Health Expert
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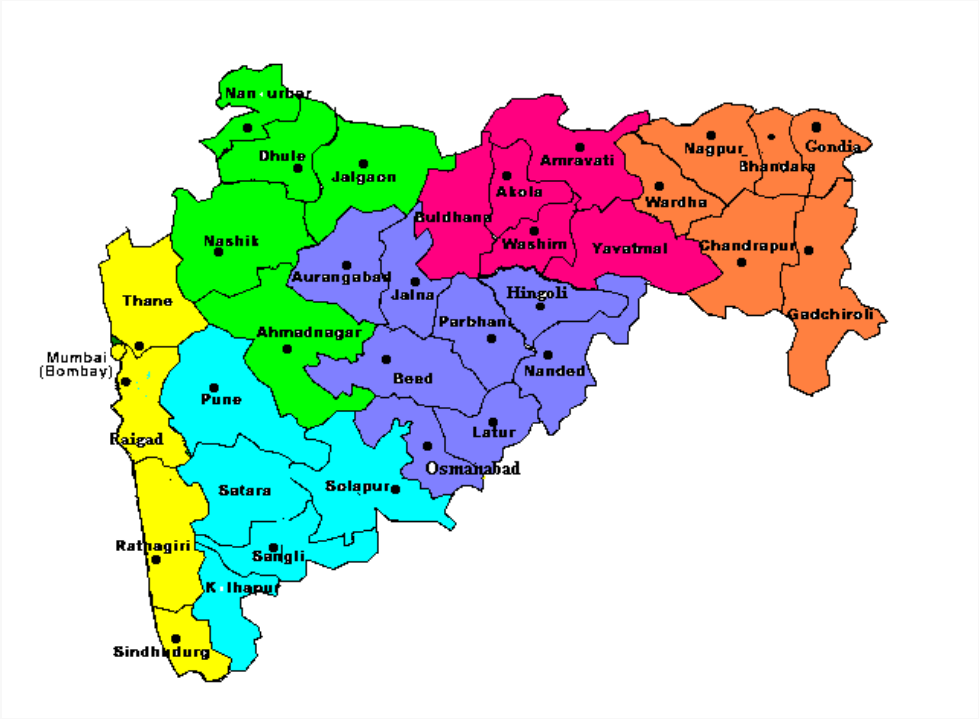
Facilities Visited

Kolhapur Team	**Gondia Team**
• HFWTC, Nagpur • Public Health Laboratory, Nagpur • CPR District Hospital & Medical College,Kolhapur • District Hospital, Satara • District TB Centre, Satara • Sub-district Hospital, Gadhinglaj • Sub-district Hospital, Kodoli • Rural Hospital, Ajara • Rural Hospital, Panhala • PHC, Kargaon • PHC, Chikhali • PHC Maligre • PHC, Shiroli (Pulachi) • PHC Wagholi (Pune)	• Daga Women Hospital • District Hospital Gondia • Gadchiroli DH • SDH Tiroha • Navegaon bandh RH (not FRU) • Goregaon RH • Deori RH • Akody PHC • Bangaon PHC • Kawrabandh PHC • Mullah PHC • Sondad PHC • Mahagaon PHC • Kumbhtola (SC) • Sub Centre Dandegaon • Jhaliya SubCentre and VHND

• Sub-Centre, Belewadi Masa • Sub-Centre, Kini • AWC, Shiroli • Village Linganur	• Chichtola AWC

MAHARASHTRA STATE



Trend of selected indicators (DLHS)

Indicator	DLHS – 2 2002-04	DLHS – 3 2007-08	Trend
Mother with 3+ ANC%	69.2	74.5	+
Institutional deliveries	57.9	63.6	+
Children 12-23 fully immunized	70.9	74.0	+
Children under three years breast fed within one hour after birth	44.3	53.3	+
Mean age at marriage	19.1	19.4	+
Girls marrying below 18 years	21.1	18.5	+
Any FP method	63.3	63.8	+
Female sterilization	48.3	51.5	+
Male sterilization	2.0	2.5	+

Sr	Indicator	NRHM Goal (2012)	Status of Maharashtra	Source
1	IMR	30	33	SRS (2008)
2	MMR	<100	130	RGI (2004-06)
3	TFR	2.1	2.0	SRS (2008)

INFRASTRUCTURE

	ITEM	NUMBER
	Public Health Infrastructure	
1	Super-speciality hospitals	2
2	District hospitals	23
3	Sub-district hospital (200 Beds)	3
4	Sub district hospitals (100 Beds)	23
5	Sub district hospitals (50 Beds)	56
6	Rural hospitals	365
7	Primary Health Centers	1816
8	Sub Centers	10580

NRHM has made significant contribution to infrastructure improvement in the State. Many Health Facilities have been provided with labs, OPDs, wards, new PHCs and Sub-Centres have been created. Considering the importance of this aspect, Maharashtra has established Infrastructure Development Wing in 2007-08. The Infrastructure Development Wing (IDW) is headed by Superintending Engineer who is regular government employee on deputation from Public Works Department, Government of Maharashtra. Four Executive Engineers have been appointed at 4 Mumbai, Pune, Aurangabad and Nagpur to supervise the IDW works. At district level one Deputy Engineer is appointed at each district HQ (33) and at block level 93 Junior Engineers are appointed. From April 2008, IDW has taken 5293 works in hand out of which it has completed 4368 (83%) works with the expenditure of Rs. 240.32 Crores. Facility wise detailed information is mentioned in table below:

Facility wise detailed information of Civil Works carried out by IDW 2008-09 to 2010-11 (up to October 2010)

Sr	Type of facility	Total works taken up	Total completed	Expenditure (in lakhs)
A	New Construction			
1	Sub-Center	476	277	3711.98
2	PHC	34	3	544.34
3	Rural Hospital (CHC)	12	5	1306.1
4	Sub-Dist Hospital	1	0	0
5	District Hospital	16	6	72.52
	Total	539	291	5634.94
B	Partly new Construction			
1	Sub-Center	303	205	427.28
2	PHC	323	225	670.12
3	Rural Hospital (CHC)	21	10	139.92
4	Sub-Dist Hospital	3	3	12.74
5	District Hospital	14	12	144.19
	Total	664	455	1394.25
C	Repairs			
1	Sub-Center	2145	1935	1894.4
2	PHC	1672	1415	13744.35
3	Rural Hospital (CHC)	129	129	698.68
4	Sub-Dist Hospital	26	25	286.85
5	District Hospital	118	118	379.46
	Total	4090	3622	17003.74
D	Total works			

Sr	Type of facility	Total works taken up	Total completed	Expenditure (in lakhs)
1	Sub-Center	2924	2417	6033.66
2	PHC	2029	1643	14958.81
3	Rural Hospital (CHC)	162	144	2144.7
4	Sub-Dist Hospital	30	28	299.59
5	District Hospital	148	136	596.17
	Total	5293	4368	24032.93

- There are however issues like lack of supportive staff for Exec. Engineers. This needs to be addressed to ensure that the momentum is maintained.
- In some aspects the Infrastructure development plan is overambitious, and not necessarily need based. Large numbers of facilities have been selected under IPHS. But it has been observed that some are underutilized for deliveries and other services e.g. PHC Kargaon, Maligre in Kolhapur has been selected for upgradation to IPHS but conducts only 2-3 deliveries /month.
- It has also been observed that distribution of villages under PHC's is slightly skewed as certain villages that are very far from the PHC and are not actually being catered by the PHC's are included under the PHC to satisfy the PHC population norms. Thus there is need for reallocation and rationalization of the villages under the PHC's.
- One of the major issues observed was that District Hospitals that have been converted into Medical Colleges have not been integrated into NRHM. This translates into lack of patient friendly services at these facilities as they are not as clean, hygienic and well developed as other district hospitals under NRHM. State may thus consider integrating them into NRHM in some aspects.
- It was also observed that there is good availability of amenities such as Solar power, running water, computerisation and internet facilities.
- Residential accommodation for providers is inadequate and is not available at all facilities[1].

[1] e.g. No staff quarters at SDH Gadhinglaj

- There is need for improving the designing of the labor rooms and Operation Theatres in the facilities as per the latest technologies.

HUMAN RESOURCES

	Public Health Staff	Sanctioned posts	Filled in
1	MMHS Grade – A Senior	1438	476 (33%)
2	MMHS Grade – A Junior	7419	6419 (87%)
3	General state service (Grade – A/B)	513	254 (49%)
4	HA (Male) – Local sector	2864	2276 (79%)
5	HA (Male) – State sector	1722	1510 (88%)
6	HA Total	4586	3786 (82%)
7	MPW (Male) – Local sector	7215	6020 (83%)
8	MPW (Male) – State sector	5360	3786 (71%)
9	MPW Total	12575	9806 (78%)
10	LHV/HA (Female) – Regular	2147	1917 (89%)
11	ANM – Regular	12528	12044 (96%)
	NRHM		
1	Additional 2nd ANM - contractual	10580	7063 (67%)
2	Staff Nurse – contractual	2180	1023 (47%)
3	Lady Health Visitor (Supervisory nurse) – Contractual	1808	1239 (69%)
4	Urban ANM – Contractual	1000	537(54%)

Maharashtra has taken some good initiatives to address the issue of Human Resources. For example Maharashtra had most severe problem of availability of Medical Officers in PHCs as it was taking very long time to get the MO through Public Service Commission. Considering this, now the posts of MO are exempted from the purview of the Commission. The Regional Deputy Directors are also delegated powers to appoint Medical Officers temporarily as per need and vacancy This has resulted in significant improvement in availability of MOs. Currently, 7419 posts of Medical Officers are sanctioned out of which 6419 (87%) posts are filled in.

However while regular posts are being filled in the State, as shown in the Table above, there are a large number of vacant contractual posts: posts of 53% contractual Staff nurses and 46% contractual urban ANMs are not filled by the State. To address this issue the State has taken an initiative to efforts to increase preservice education in nursing and for ANMs. The State Government is in process of opening 11 ANM and 6 GNM schools.

A large number of vacancies were also observed at District Hospital-cum-medical college (CPR Kolhapur).

Deployment of Workforce

Irrational deployment of available resources has been observed in many instances in the State. For example; DGO gynaecologist was posted at RH (Panhala) where C-Sections were not conducted. Only a few Gynae surgeries had been performed through deployment of surgeon from tertiary centres. A CEmOC trained doctor was posted at SDH Tiroha in Gondia where C-Sections are not conducted due to lack of anaesthetists. There was availability of a LSAS trained doctor in the district but he was posted at another facility where C. Sections were not being conducted. Thus irrational posting is definitely an important issue. However, it is commendable that the CEmOC trained doctor at SDH recognized the need for sharpening her skills and had thus taken up conducting C-Sections at the District Women hospital on Fridays and Saturdays since the past few months. This is a good initiative and all those who have been trained but have lost their skills due to irrational postings could be retrained in the above manner.

Improving availability of Specialists

Certain initiatives have been taken up by state to improve availability of Specialists:

- Seats for Post Graduation have been reserved for MOs in service
- State officials also shared the State Plan for withdrawing specialists (from the Public Health Department) who have been deputed to Medical Colleges. There are around 400 such specialists and the plan may be greatly instrumental in plugging the gaps for specialists for rural areas in the State.
- To ensure availability of specialists in rural areas Hardship allowance is being given to Medical officers and specialists

Training

It was observed that the quality of training is not optimal in certain areas. In Gondia district, training on use of partographs was not a part of the SBA training. This is a serious issue. There is lack of translation of skills into practice. Both the teams found that management and treatment protocols were not displayed at all facilities. . Medical Officers as also trained staff nurses working in the labour rooms of various facilities were generally not aware of the step by step procedure for neonatal resuscitation as observed in most facilities in Gondia District. Post training supportive supervision is non –existent and there is no follow up of the trained nurses in most cases.

State is providing training to medical officers in Basic Emergency obst Care at a number of state hospitals including district hospitals. It was however observed that the state is providing 15 days training as against national guidelines of 10 days. The training does not follow any curriculum and trainers are not fully aware of the background for this training. Ayurvedic physicians of 24x7 PHCs are also included in this training. Discussions with some trained doctors revealed lack of skills for managing emergencies before referral.

SBA training of ANMs/nurses; training in safe abortions though being undertaken does not follow any planned approach in the districts. Most ANMs at S.Cs who had undergone SBA training did not have the SBA drugs nor were they following the SBA protocols.

HEALTH CARE SERVICE DELIVERY

It has been observed that community participation and expectation for service delivery has increased in general. Well established Eye care surveillance and good quality Dental Care services are also available at designated facilities. From the discussion it has been found that not much emphasis has given to Urban areas particularly in smaller towns.

Emergency Transport System

State is currently at the stage of finalization of tender document for Emergency Medical Response Services in Maharashtra. State is expecting 150 such ambulances on road at the end of March 2011. Till then, districts have developed their own call centers from local resources and they are arranging centralized system to inform the PHC/RH ambulances to pick up emergencies particularly the ANCs. Such systems have been observed on the field in Gondia as well as Gadchiroli. However both had different models. In Gondia, each PHC had a small call centre established where as in Gadchiroli a centralized system had been established at the level of the District Hospital. Records and surprise calls to check the functioning of the systems revealed that the centralized system at Gadchiroli with a GPRS was a robust one. This has been established with the vital involvement of the district collector.

As per State policy, health facilities provide Assured Referral Transport to the Referral Centres from lower centres. However, free referrals are not being provided to all in practice.

During interactions with a patient admitted with bleeding PV at the Gondia Women's hospital it was revealed that the patient had been charged Rs. 800 for referral transport from Mulla PHC the previous day. During the visit to Mulla PHC the above was confirmed by the driver responsible for the referral. The Medical Officer and the driver revealed that the above was a regular practice. Patients were expected to pay for the petrol charges even though referral transport is supposed to be free as per the district authorities. The case was immediately brought to the notice of State and District authorities.

JSY fund flow mechanisms: In most cases there are timely JSY payments. However delays have been observed in some facilities in Gondia District where a delay of up to 2-3 months was observed.

There was availability of IEC material at the health facilities. Grievance redressal mechanisms available: complaint box/ mobile numbers. However in Gondia this was observed at only half of the facilities visited.

Availability and procurement of essential medicines

Availability of essential medicines in selected facilities

The stocks of essential medicines, as well as recent indents and corresponding supply of medicines was examined in selected rural health facilities in Kolhapur district. Overall, while supplies appeared relatively adequate with some gaps in one of the PHCs visited (PHC

Maligre), availability of essential medicines seemed to be quite inadequate in high-utilization facilities including a Rural hospital (CHC), a Sub-divisional hospital and a District hospital. In Gondia while drug were generally available, irrational use was observed at most places.

Sub-divisional Hospital, Gadhinglaj

SDH Gadhinglaj is a high utilization 100-bedded hospital catering to patients from 4-5 nearby blocks. Recent indent forms were examined and these were compared to the supplies provided, corresponding to each indent. The indent forms also indicated those items which were in 'Nil' stock at time of indenting. Analysis of these forms showed the following situation: *out of around a hundred items ordered in three recent most indents, only 11-16 items were supplied*. This was despite the situation that in the recent three indents, ***67-77% of the indented medicines were in 'NIL' stock*** at time of indenting. Even for the medicines which had been supplied, the amounts supplied were much less than what had been indented. The stock of some commonly required medicines was examined on the day of visit. Keeping in mind that this is a 100-bedded hospital with a daily OPD of about 250-300 outpatients, these stocks of commonly required medicines were considered quite inadequate (Refer Annexure 1).

Rural Hospital Ajara

In Rural Hospital Ajara, only 17-23% of the medicines indented were actually supplied. Due to the shortage of state level supply, some local purchases are being made by RH Ajara from funds such as RKS and IPHS. However, the rates of local purchase tend to be several fold higher than the standard Rate Contract prices. Local purchase is being made at 300 to 1000% higher rates compared to the standard RC rate. Thus Local purchase can only be a stop gap arrangement for small quantities of medicines, but *cannot be a substitute for adequate, regular general supply of all essential medicines*. (Refer Annexure 2).

District Hospital Satara

In this hospital the state supply of certain high utilization supplies is generally less than half of the utilization. It has been shared that currently the allocation for medicines in this DH is Rs. 22,000 per bed per year. Considering that the overall expenditure on all inputs in a District hospital in Maharashtra is about Rs. 2 lakhs per bed per year, the amount allocated for medicines is only about 10-12% of the total per bed allocation and appears inadequate. The current norms for financial allocations for medicine supply to various facilities were fixed 7-8 years ago and appear to be in need of urgent revision (Refer Annexure 3).

Issues concerning procurement and distribution of essential medicines

Recent changes in the medicine procurement system in Maharashtra

There have been certain major policy changes related to procurement of medicines for the public health system in Maharashtra, which may have been related with the drug shortages being observed in some facilities (Refer Annexure 4).

Need for adequate, transparent and efficient system for procurement and supply of medicines

Keeping in mind the observations above, the following steps, among various other measures, may be relevant to improve the supply of medicines in rural public health facilities of Maharashtra:

- Substantially increasing the norms for financial allocations for medicine supply to public health facilities; for example the core financial allocation for medicines for each PHC is Rs. 120,000 per year which translates into Rs. 4 per person per year. The current amounts are inadequate and need to be reviewed, perhaps at least doubled to reach an acceptable level. The same was discussed with the State authorities during the debriefing meeting and the State authorities clarified that the process for revision of norms has already been started.

- As recommended by NRHM, the setting up of an autonomous corporation similar to TNMSC and KMSCL may be considered, which would relieve the Health Dept. of the

burden of day-to-day procurement related decisions and processes, and could ensure efficient procurement.

- The procurement process needs to be made completely transparent, with open e-tendering and should be combined with broader monitoring by a State level committee which includes technical experts and civil society representatives.

- The planned computerized information system needs to be made fully operational at earliest; it needs to be recognized that high utilization facilities have higher requirements of medicines which need extra allocations, and in some cases medicines may be shifted from low utilization to high utilization facilities in the same block based on the stock information analyzed from the computerized and networked information system.

While the attempts to overhaul the procurement system in the state are positively intended, unless the entire system is based on an autonomous, efficient and transparent mechanism and the financial allocations for medicines are substantially increased, the current policy measures may not fulfill the objective of much improved availability of medicines in public health facilities in the state.

Irrational Use of Drugs:

It has been observed that Standard Treatment protocols not being followed universally- e.g. indiscriminate use of injection oxytocin and antibiotics was seen in a health facility in Gondia district.

> In Bangaon PHC, all women coming for delivery were first given a dose of pitocin followed by a dose of oxytocin (essentially the same) as soon as the baby's head was visible during labour. Also in treatment of dysentery irrational use of antibiotics and limited use of ORS was observed.

> At a sub-centre in Gondia (Dandegaon) district it was observed that the ANM routinely prescribed fourth generation antibiotics to all women who delivered in her facility. Thus cefixime and azithromycin were prescribed routinely to all even if not indicated and without the doctor's prescription.

Biomedical Waste Management:

Biomedical Waste Management existed in principle at all facilities. However on closer examination it was found that the proper protocols for the same are not followed in facilities. Thus the Guidelines for IMEP (Biowaste Management) need to be shared at the facility level.

Other Initiatives

- Free wheel chair and support systems for physically challenged population have been made available to patients.
- DH Gadchiroli is observed to be performing very well given the remote and tribal location of the District. Facilities like Telemedicine, CT and Doppler were available at DH Gadchiroli. Mobile Medical Units, Mobile Dental Units, emergency transport services and difficult operations like hip replacements were a part of the services delivered to the residents of Gadchiroli. In fact, the hospital also caters to patients from neighboring districts of neighboring States.

OUTREACH SERVICES

Village Health & Nutrition Days

VHND could not be observed by the Kolhapur team. Only one VHND was observed by the Gondia team and it was seen that the VHND was mainly a platform for immunisation. No ANC's were conducted at the VHND since the sub-centre was nearby and the ANM conducted ANC's on a separate day at the Sub-centre. However, good session planning and evidence of cross-sectoral linkages between frontline workers were clearly visible.

ASHA PROGRAMME

ASHA's have been the most visible face of NRHM. They have completed 5 training modules in tribal districts and 2 modules in non-tribal districts. State has taken initiatives and has facilitated making ASHA modules pictorial by involving the NGO SATHI-CEHAT. ASHAs role and support is well acknowledged by ANMs, ICDS, AWWs, mothers and communities. Interactions with patients revealed that most of them were aware of the ASHA in the village. Expanded Medicine Kits have not been supplied to all ASHA's. It was observed that in Gondia district, ASHAs were not placed at Sub Centre Villages due to a communication gap between State and District authorities and District authorities were instructed on the spot to

send in the request for more ASHA's as per norms with an assurance by the State that they would be immediately sanctioned.

Expanded ASHA kits costing about 2,000 Rs. have not been supplied to the ASHAs.

DECENTRALISATION / LOCAL ACTION

RKS has been set up at Facilities. The members are primarily Government functionaries and PRIs. Lack of NGO involvement has been observed in some areas. MOs orientation on use of RKS funds is adequate.

District Health Action Plans are available. However inadequate analysis of district level issues has been observed. Bottom up planning process is largely not followed with regards to involvement of PRIs and village level planning. There is inadequate involvement of PRIs/ CBOs/ user groups / Taluk MO/IC / ANM/ASHA in the planning process.

Village Health and Sanitation committees have been set up and are functioning satisfactorily in the state. Interactions with the representatives revealed that there is very good PRI involvement. However there is a tendency to spend large amount of funds on the up-gradation and supplies of anganwadis. Funds are also utilized for referral transport and nutrition for malnourished children.

RCH II

- Institutional deliveries have increased in the State. There were hardly any home deliveries in Kolhapur district. In Gondia district too, 70.95% deliveries were institutional deliveries in 2009-10. There has been an increase in case loads due to NRHM. The main reasons are JSY and ASHA. Interactions with a local NGO in Gondia district also confirmed the above. The NGO members commented that ASHA's motivate the women to come to the institutions. They also reported that the cleanliness and facilities in the PHC had increased leading to greater patient satisfaction.
- However this includes deliveries at subcentres – Many sub centers in Gondia district have been upgraded with construction of additional space for labor rooms. However most of the deliveries can't be termed as institutional in absence of training of ANMs as SBAs. Irrational practices like substantial use of epidosin and oxytocins for inducing labour was observed in these sub centres.

- A general Increase in OPD, IPD, immunization, institutional delivery, Family Planning, reduction in DOTS defaulters are activities showing positive trends.
- List of JSY beneficiaries was displayed at health facilities. Timely JSY payments were made at most facilities. However, delays of up to two months were observed in some facilities in Gondia District.
- Although many lower level facilities showed evidence of practice of MH technical protocols in labour room with display and with adequate availability of drugs for AMTSL and Eclampsia etc. some high volume facilities e. g. the Sub-district H at Gadhinglaj and the DH at Satara did not display any protocols in LR and maintenance of records in LR was sub-optimal, although the DH had SBA trained Nurses and it was also a training site. In contrast, in Gondia district lack of technical protocols/SBA practices was a general observation at lower and higher level facilities.
- Free diet is provided to pregnant women after delivery to encourage them to stay for 48 hours through arrangement with local kitchens/dhabas etc in the village. This has led to perceptible increase in length of stay.

  Some data from facilities that was shared during the state presentations revealed Post Partum sepsis to be an important contributor to maternal deaths even in urban areas. The state intimated that for this and also for home based new born care they are thinking of permitting ASHA's to dispense antibiotics as well as zinc tablets etc. *ASHAs , not being service providers, cannot be allowed to dispense antibiotics to mothers or children.*

  While number of deliveries has increased in the major hospitals at district levels and above, the cesarean rate has also gone up. At Daga hospital Nagpur and Gondia district hospital it was estimated to be 30%+. The explanation that these hospitals catered to emergency cases was not viable as most cesareans are reported to be elective. The purpose of mentioning it here is that this aspect needs a careful look on the issue of cesarean sections.
- Maternal Death Review district committees have been constituted but the process is yet to start as per GOI Guidelines.
- Minilap Sterilizations and NSVs are being done at PHCs in Gondia. Male sterilizations have shown an increasing trend in Gondia district. This could be attributed to the fact that it is a tribal area and acceptance of NSV is higher. In contrast, in Kolhapur there are hardly any NSVs.

- It was observed was that there is no focus on in-house tubectomy in immediate Post partum period in the State. This is due to a State policy and directions that dissuades the above. Interactions with the State authorities revealed that this is due to an understanding that tubectomy in immediate Post partum period would increase the chances of infection. The GOI officials communicated to the state the GOI policy on this and asked them to make the necessary changes in their directives, for which they could seek formal clarification from the FP Division of the Ministry if required. Also, there was no evidence of promoting IUD insertion/spacing methods. This has to be given due consideration by the state.
- There is need to ensure the stock of immunization vaccines, Vitamin A syrup etc .wherever cold chain facilities are available as in one of the RH (Navegaon bandh) it was observed that there were no vaccines at all though ILR and Deep freezer were available.".

- **New Born Care:**

  Equipments are in place with regards to new born care. But the quality of care in itself requires is a cause of concern and needs immediate and greater focus. As pointed out in the training section, Medical officers and trained staff nurses were generally not aware of the step by step procedure for neonatal resuscitation. There is lack of trained staff for providing new born care. e.g.Paediatricians at Satara District Hospital responsible for SNCU were also being given duties as CMO / DMO. SNCUs are not functioning upto the mark. The neonates brought to the hospital who have not been delivered in that hospital are being kept at places which are not suitable for new born care. For example, in Gondia Women's Hospital, the infant (who had not been delivered in the hospital) was admitted in a general pediatric ward where chances of nosocomial infections were very high. The temperature was also not maintained in the ward and the child was hypothermic.

NUTRITION

Nutrition interventions are being implemented through effective convergence mechanisms between functionaries of health (including MO- PHC, ANM and ASHA), ICDS and self help groups. Growth Monitoring using WHO standards is in place through AWW to identify malnourished children (SAM & MAM). Child Treatment Camps (CTC) at PHC, RH, DH for 21 days and Village Child Development Camps (VCDC) at AWC for 30 days with

compensation for wage loss to mothers are good initiatives to address the issue[2]. Nutrition counseling at DH Gadchiroli and Gondia with the help of dieticians is a special initiative.

NATIONAL DISEASE CONTROL PROGRAMMES

RNTCP: Manpower and logistics supply is appropriate, case detection has increased, conversion & cure rate has increased, fund allocation in PIP has increased.

NLEP: There is high prevalence of Leprosy in districts like Gondia with large numbers of Multi bacillary cases still being detected. Thus greater focus may be required on Leprosy in this district.

Malaria: Malaria is endemic in Gondia. Shortage of Bednets is an issue here. As per interactions with district authorities', special training of Malaria Technicians may be required in this district to improve diagnostic skills.

The alarming issue is that patients are being asked to purchase injections and drugs for PF as well as PV Malaria. This was observed in the Women's hospital and the rural hospital at Goregaon.

INSTITUTIONAL MECHANISMS/ PROGRAMME MANAGEMENT

- It has been observed that DPMU and district health officials are functioning as a team
- Most Operation Theatres and Labor Room in SDH, RH,PHC are well equipped and maintained (except at District Hospitals/Tertiary centres)
- Functioning of RKS, flexible funds: In PHCs of three blocks visited, utilisation of RKS funds is near 100% and the situation is similar for AMG and untied funds. Reg. RKS, funds are mainly utilized for drugs, equipment and supplies, furniture and food for patients.
- Presently there is no involvement of local NGOs/civil society organizations in social audit and monitoring in the districts visited.
- In DH Satara, poor planning, financial management and accounting of various flexible funds was seen seen (Annexure 5).

[2] *However, the camp initiative for nutrition does not strictly qualify to be called as an NRC and leads to an over-reporting on the no. of NRCs in the state.*

- In Kolhapur district, in 2008-09 there has been a large scale district level purchase of medicines and supplies on behalf of the RKSs of 18 PHCs and 26 Sub-centres in the district. Although formal consent of concerned RKSs was obtained, the procurement orders were centralized and specific requirements of facilities based on facility survey was not taken into account while allocating supplies (Annexure 5). .

- VHSC funds are being spent on AWC up gradation and supplies for malnourished children and referral transport. However there may be a greater focus on channelizing funds into upgrading AWCs and purchasing supplies for them, than is justified from the NRHM funds. ICDS funds should be used for this purpose.

- There may be a need to employ hospital managers at the DH, SDH and RH levels in the State. There is a distinct disparity in the cleanliness and general management seen between the PHC and hospital levels and addition of a hospital manager may improve the conditions of the hospitals.

COMMUNITY INVOLVEMENT

Strong PRI structure and significant community initiative is visible in the state:

PRI involvement in RKS at facility levels and VHSCs visible but there is need for greater involvement of PRI's in District level planning and implementation.

- One ***very positive example is the community initiative*** which has upgraded and substantially improved a Sub-centre (Belewadi Masa in Kagal block)- a classic example of intersectoral convergence and coordination.

- Generally high level of demand expression and sense of entitlement among community members.

- Local civil society organizations are not sufficiently involved in RKS. There is need for more awareness regarding other NRHM processes.

- There was a suggestion by local civil society organizations in Kolhapur for initiating Community based monitoring activity in Kolhapur district, as planned in current year's PIP.

Community based monitoring – an innovative process for ensuring accountability of health services under NRHM in Maharashtra

Community based monitoring (CBM) is being implemented in Maharashtra since mid-2007. Currently CBM is being implemented in five districts, encompassing 23 blocks and 510 villages of the state, and this process is expected to be extended to additional eight districts during the current (2010-11) PIP.

At the core of CBM is the process of recording and reporting the state of health services in villages, as experienced by community members. In each monitoring cycle, at the village level information is collected about the services at Village, PHC and Rural Hospital (CHC) level through community group discussions with emphasis on participation of women and other marginalized groups, beneficiary interviews, exit interviews and provider feedback. Community responses are recorded in a form of rating each service as good, partly satisfactory or bad. Information collected through this process is presented in a concise form as pictorial **report cards** clearly reflecting availability, regularity and quality of health services. The village report cards mark health services using 11 indicators, all indicators based on a three month recall period. Findings from these report cards are then presented in 'Jan sunwais' (Public Hearings) along with specific suggestions for improvement.

Positive impact of CBM on services - In the 220 villages spread over five pilot districts, the first, second and third rounds of CBM data collection took place between July 2008 to December 2009. At the beginning of CBM process, villages rated their health services 'good' at an average rate of 48%. This has increased by 13 percentage points to 61% in round two, and by round three it increased by an additional 5 points to 66%. The average percentage of services rated 'bad' by villages decreased from 25% to 16% to 14% over three cycles of monitoring. Specific indicators which are showing improvement are immunization, Anganwadi services, use of untied fund and PHC health services.

Higher increase in utilization of PHCs in CBM areas – A study of PHC utilization records in **Thane district** shows a general increase in outpatient, inpatient and delivery related utilization for the entire district over the period 2007-08 to 2009-10. However, the increase in utilization in **PHCs for entire district** and increase in **CBM covered PHCs** compares as follows:

Type of utilization	Increase in utilization between 2007-08 and 2009-10	
	Average increase in PHCs of entire district	Increase in CBM covered PHCs
Outpatient attendance	17%	43%
Inpatient admissions	50%	76%
Deliveries in PHC	48%	101%

While many aspects of the village health services have improved, services like local disease surveillance and village level curative services have shown inadequate improvement or stagnation. Besides quantitative improvements, a range of qualitative improvements also have taken place in areas where CBM is presently underway, including stoppage of informal charging in PHCs, re-opening of previously closed Sub-centres, increased availability of medicines in PHCs accompanied by stopping of external prescriptions and increased frequency of visits by field staff to remote villages and hamlets. The number of positive improvements witnessed over last three years are due to a combination of NRHM 'supply side' inputs and 'demand side' push in an accountable manner by the CBM.

Challenges and further directions- Involvement of Panchayat members has been limited in the initial years of CBM, though presently Sarpanches and Panchayat Samiti members are reported to be playing a more active role in CBM committees and processes. However this role needs to be strengthened much more, and the role of civil society organisations should be mainly focused on capacity building and facilitation of PRI representatives and Village health committee members, who are the primary actors. Secondly, the CBM process is raising systemic and structural issues which need to be addressed at higher levels of governance of the public health system, hence along with the supportive attitude at state level, more positive involvement of district level officials in the CBM process is required. In absence of such involvement, CBM would remain confined to the periphery of the public health system, like outreach and PHC services. Thirdly, as the smaller urban areas are under the purview of the NRHM, and remain even if NUHM is launched, the process CBM can be extended to small towns/cities. Next, there may be need for periodic capacity building and cross-district exposure learning for the block and district

nodal NGOs, to enable them to upscale and develop their work, including Community based planning. Finally, the initiation of CBM to eight new districts during the current year (2010-11) has been planned in the PIP, *but has not been initiated until late December 2010 due to official delay in approval* to nodal NGOs who would facilitate the process in new districts; this major delay needs to be promptly addressed to initiate in new districts this innovative process of community involvement and accountability led health system improvement.

Comment [N1]: This could possibly be put as a supplement, since it is in great detail

HEALTH MANAGEMENT INFORMATION SYSTEM

There are two management information systems currently active in the State namely the Maharashtra state MIS and the GOI HMIS. The issue is that both the systems are not integrated. Thus there is double entry. Also, information collected in the State MIS is translated into the GOI HMIS format at the district level. There are high possibilities of errors during this manual translation and all data elements cannot be translated. Thus there is urgent need to integrate the two systems at the State level. This task needs to be undertaken at the earliest to minimize errors and improve the completeness and quality of data. There is also need for analysis and utilization of the data at the local level. This needs to be promoted. The MIS system track the performance of District and below based on based on state level target fixation at the beginning of the year. Bottom up participatory planning needs to be integrated with the HMIS.

FINANCIAL MANAGEMENT

E-transfer of Funds at District, SDH and RH and block levels is available and timely. However, this is not available at PHC level and Delay in transfer of funds at PHC level in some instances was observed. The use of Tally at block levels needs to be promoted. There is need for greater focus on training on financial management for the service providers and accounts staff. There was no district accounts manager at Gadchiroli. Poor financial management of RKS, AMG, untied funds in certain facilities e.g. DH Satara

INTERSECTORAL CONVERGENCE

There is evidence of good intersectoral convergence with SACS, Women and Child Development, Department of Water and Sanitation, Department of Education and Tribal Affairs:

- Water collection and verification of quality of water is done by VHSCs. There is a very good system to check the quality of water at source through intersectoral coordination. Contamination of water at point of use is neglected. Therefore, epidemic like situation is being avoided but not the regular episodes.
- There is the presence of a highly effective School Health Programme – System for Screening, referral and treatment of school children is in place.
- **Focussed Strategy for Nutrition** : As a part of treating Malnourished Children, Village Child Development Camps (VCTC) at Village level(AWC) (in its 1st year) and Child Treatment Camps (CTC) at PHC/ RH/ SDH and DH level (in its 3rd year) been established. All SAM Children without any ailment are provided nutritious diet in VCDCs and all SAM and MAM Children having minor ailments are provided nutritious diet and treatment in CTCs

Mainstreaming of AYUSH

AYUSH doctors are employed at facilities from DH to PHC levels and most of the posts are filled. However medicines for the same have not been supplied as the PIP for AYUSH has not been approved by the AYUSH department. Thus there is urgent need to resolve issues and get the AYUSH PIP approved. At facilities such as the DH and RH, AYUSH medicines have been purchased from the IPHS funds. But they are unavailable at the PHC's.

At DH and RH levels AYUSH doctors are specifically prescribing AYUSH medicines. But at PHC's they are also majorly involved in providing emergency treatment and medicines for patients. Since Maharashtra has such large numbers of AYUSH doctors at PHC's, there is need for appropriate induction training for AYUSH doctors in emergency medicine at co-located AYUSH facilities. This could be followed by the regular trainings such as BEmOC that is being given to AYUSH doctors in the state. Remuneration to contractually appointed AYUSH doctors also needs to be relooked (seems to be on the lower side as compared to other states).

AYUSH medicines have been included in the ASHA kits and ASHA's prescribe the same for complaints like joint pain.

NEW INITIATIVES / INNOVATIONS…

- Maher- (Mother's house) –a birth waiting home model to promote institutional delivery is working well in tribal areas of Gondia. It includes new constructions

adequately equipped with bathroom, solar heating with beds and food for patient and one attendant.

- Promotion of Breast Feeding by provision of HIRAKANI CHAMBER in the facilities at Kolhapur is a good initiative. State may like to upscale to the same to other districts.
- **Initiatives on PC and PNDT Act** -have been useful in improving sex ratio:

➢ In Kolhapur - checks on misuse of ultrasound for sex determination & selection – use of SILENT OBSERVER on account of adverse sex ratio in Kolhapur. *However,what would be the outcomes of the analysis of data from this intervention needs a serious assessment by the state.*

➢ Felicitation of Mothers delivering a female child with thermal set, baby kits, sari, certificate through the LAXMI ALI GHARI Scheme is also a useful initiative.

- Solar panels at PHC's are capable of ensuring 24 hours availability of electricity in remote areas in certain conditions.

- Mobile Dental Clinics (at Gadchiroli) have been instrumental in providing dental services in tribal populations.

- Sickle Cell Anemia programme is running quite well. Screening and blood transfusion facilities available for affected individuals

- Good 1056 system for referral transport is present at Gadchiroli. This model could be considered for replication in Gondia.

- In Chandrapur group of doctors have come togather to provide for specialist consultaions/services under PPP.

- Hardship allowance is paid to doctors @ Rs 18000 for speciaslists and Rs 12000 to MBBS doctors.

- Biomedical Waste disposal pits have been constructed in most CHCs/rural hospitals. However clear guidelines on their use and also on disposal of placenta etc before actual disposal need to be provided to the facilities.

Progress against Programme Implementation Plan

- In the State PIP, it has been proposed to establish 67 new ARSH clinics. All 67 clinics have been have been established as proposed in the State PIP
- The initiation of CBM to eight new districts during the current year (2010-11) has been planned in the PIP, but has not been initiated until late December 2010 due to official delay in approval to nodal NGOs who would facilitate the process in new districts; this major delay needs to be promptly addressed to generalize this innovative process of community involvement and accountability led health system improvement.
- State is currently at the stage of finalization of tender document for Emergency Medical Response Services in Maharashtra.
- All ASHA's have been appointed. There is 30% utilization of the total budget for ASHA's. State had proposed the accreditation of ASHA's (9000 ASHA's to be accredited and evaluated). However there has been no expenditure on Accreditation and Evaluation of ASHA's. The supply of drug kits to ASHA's also needs attention.
- Involvement of Private Specialist Organization for Providing Specialists was proposed in the PIP. As proposed, MOU is done with IMA Parbhani & Harshal Gramin Vikas Bahu. Sanstha, Doctors Forum Chandrapur and the services are operational in two districts.
- Grievance Redressal Cells have not been operationalized yet at regional levels as per the current year's PIP, this needs to be ensured.

RECOMMENDATIONS

Infrastructure

- Infrastructure planning / location – needs to be linked to decentralised village microplanning/ tagging of hard to reach areas.
- Need to rationalise the nos. and location of facilities selected for upgradation as IPHS.
- There is need for Provision of residential accommodation for the staff (doctors, ANMs, etc)
- Rationalization and reallocation of coverage of villages under PHC's is required.

- Need to provide for latest architectural concepts in hospital/health facility building- perhaps the state can get the basic designs of various areas done up with involvement of hospital architects and these can then be adapted to local facility environment.

Human Resources:

- There is need for rationalization of postings of trained human power supported by a Government Order to address the issue of irrational postings of trained manpower.
- Vacant posts of specialists/doctors/nurses need to be filled up at all levels
- There is need for a good HR Policy especially for Contractual appointments. Appointments should be for the project period and not on yearly basis to ensure continuity and efficiency of staff. Clearly defined TORs are also a must.
- Progressive HR Policies for specialists, MOs and paramedical staff to provide opportunities for career progression are needed.
- Performance based remuneration to ASHA's for treatment of minor ailments may be considered and the same may be routed through the VHSC.
- Short term work arrangements with specialists for engagement of their services in remote and inaccessible areas can be considered.

District Planning

- There is need to strengthen decentralized district planning processes, linking with other sectors –ICDS, TSC and expand planning to block and village level (bottom up)

Procurement

- Strengthening of State Procurement System though formation of an autonomous body and transparent procurement similar to TNMSC as per NRHM guidelines may be considered
- Significantly increased financial allocations for purchase of essential medicines must be ensured.

Service Delivery:

- **Ensuring assured transport** facilities for pregnant women from village / sub-centre for conduct of deliveries, etc is an area that requires attention in the current PIP.

- Biomedical waste more attention required at PHC /RHs/HSCs
- Patient Friendly atmosphere is required at facilities (soft skills and instruments like wheel chair, trolley, signage's are the need of the hour)
- Grievance Redressal Cells need to be operationalized at regional levels as per the current year's PIP.
- Informal Payments to be addressed in respect of referral transport, free food.
- Operationalization of CBM in eight new districts as per PIP should be ensured at earliest. This would also be instrumental in addressing the issues of informal payments
- Display of guaranteed health services in all IPHS PHCs and rural hospitals with display of medicines to be provided free under the system should be encouraged.

RCH II

- Family planning activities have to be streamlined in accordance with latest policy directives from the GoI especially with regard to post partum sterilizations
- Greater focus on neonatal health at the facility and community levels is the need of the hour.

Programme Management

- Arrange hands on training for uploading and utilisation of HMIS in the periphery and follow up by district and state level for reviews and planning.
- There is a dire need for integration of State MIS and central HMIS
- **Monitoring and Evaluation** needs to be strengthened with special focus on regular field visits. Ensure better maintenance and updating of mandatory registers

Financial Management:

- Untied funds, RKS and AMG should be released in the first installment as unless and until they are released in one go, it is difficult to plan and make the necessary

purchases to ensure smooth functioning of facilities. This is a policy decision and the same can be considered by the GOI.

- Financial management capacity of health facilities, related to management of flexible funds needs to be strengthened.

Others:

- Process of disposal of condemned articles needs to be streamlined.
- Ensure payment of JSY funds to beneficiaries before discharge of the patients.
- State is advised to make appropriate proposals of AYUSH for obtaining funds from the Department of AYUSH.
- Appropriate training should be given to AYUSH doctors in emergency medicine at co-located AYUSH facilities.
- There is need to take a relook at remuneration amounts for contractually appointed AYUSH Doctors.

Annexure 1

Sub-divisional Hospital, Gadhinglaj

SDH Gadhinglaj is a high utilization 100-bedded hospital catering to patients from 4-5 nearby blocks. Recent indent forms were examined and these were compared to the supplies provided, corresponding to each indent. The indent forms also indicated those items which were in 'Nil' stock at time of indenting. Analysis of these forms showed the following situation:

Date of indent	Number of items ordered in recent indent	Number of items in NIL stock in indent	Number of items supplied
10/11/2010	115	88	11
26/11/2010	115	89	16
10/12/2010	92	62	12

Here is it clear that *out of around a hundred items ordered in three recent most indents, only 11-16 items were supplied*. This was despite the situation that in the recent three indents, ***67-77% of the indented medicines were in 'NIL' stock*** at time of indenting.

Even for the medicines which had been supplied, the amounts supplied were much less than what had been indented, as indicated below:

Date of supply	Medicine	Amount requested	Amount supplied
10/11/2010	Tab. Paracetamol	25,000	10,000
10/11/2010	Inj. ASV	200 vials	55 vials
26/11/2010	Tab. Ciplox	10,000	1,000
26/11/2010	IV sets	2000	400

10/12/2010	Tab. Diclofenac	20,000	10,000
10/12/2010	Disposable syringes	10,000	2,000

The concerned staff and officials stated that frequently required medicines and supplies (like IV fluids) were in short supply, and this shortfall could not be made up entirely by purchase from available funds. Generally RKS or IPHS funds were used for purchase of medicines that were short in supply. The annual RKS funds are Rs. 2.5 lakhs and IPHS funds are Rs. 18 lakhs. In last year (2009-10) Rs. 2.04 lakhs were used from RKS and IPHS funds on purchase of medicine. However these funds were found to be inadequate to cater to the high demand of medicines.

The stock of some commonly required medicines was examined on the day of visit, which showed the following situation:

Medicine	**Available stock**
Tab. Cotrimoxazole (SS)	2000
Cap. Amoxycillin	NIL
Tab. Metronidazole	545
Syp. Paracetamol	200
Syp. Furazolidone	NIL

Keeping in mind that this is a 100-bedded hospital with a daily OPD of about 250-300 outpatients, these stocks of commonly required medicines were considered quite inadequate.

Annexure 2

Rural Hospital Ajara

Rural hospital Ajara has 30 beds with moderately high utilization, and caters to patients from various villages of Ajara block. The situation of indent vs. supply of essential medicines in recent indents was observed as follows:

Date of supply	Number of items indented	Number of items supplied
3/11/2010	112	19
1/12/2010	114	27

Here we see a picture similar to the SDH, here only 17-23% of the medicines indented were actually supplied.

Even regarding the medicines which were supplied, the amounts supplied were much less than requested, exemplified as follows:

Date of indent	Medicine	Amount indented	Amount supplied
3/11/2010	Cap. Ampicillin	5000	2000
3/11/2010	Cap. Tetracycline	5000	2000
1/12/2010	Tab. Ciprofloxacin	10000	1000

The stock of certain essential medicines in RH Ajara was compared with expected stock, (calculated as being three times the stock required for a PHC) as follows:

Medicine	Available stock	Expected stock
Tab. Paracetamol	9000	37500
Tab. Cotrimoxazole	3000	7500

(DS)		
Tab. Metronidazole	1500	3750
Tab. Ciprofloxacin 250	500	3750
Cap. Amoxycillin	1000	3750
Syp. Paracetamol	NIL	750
Anti Snake Venom	50	40
Anti Rabies Vaccine	100	150

Due to the shortage of state level supply, some local purchases are being made by RH Ajara from funds such as RKS and IPHS. However, the rates of local purchase tend to be several fold higher than the standard Rate Contract prices, as seen below

Medicine	**RC rate**	**Local purchase rate**	**% Local purchase rate / RC rate**
CPM	3.08	21.64	702%
Ciprofloxacin 250	53.1	170.14	320%
Diclofenac injection	1.3	7.93	610%
Dexamethasone inj.	2.3	24.04	1045%

Looking at these proportions, where local purchase is being made at 300 to 1000% higher rates compared to the standard RC rate, we can conclude that local purchase can only be a stop gap arrangement for small quantities of medicines, but *cannot be a substitute for adequate, regular general supply of all essential medicines*.

Annexure 3

District hospital Satara

The District hospital at Satara with 242 beds is well utilized, and it receives patients from various parts of the district, including cases referred from various Rural hospitals. However, from scrutiny of records and discussion with hospital officials it appeared that the state supply of several medicines is not commensurate with the requirement, and significant quantity of medicines and supplies (like IV fluids) are inadequately supplied, hence are being purchased in large quantities from flexible funds or are even being obtained from the RH supply (in case of ASV), as seen in the table below:

Name of Medicine	State govt. Supply.		Purchased from PLA, IPHS		Utilised from RH stock & other hosp.		Total utilisation		State supply as % of total utilisation
Inj. Anti Snake Venom (ASV)	600	vials	500	Vials	200	vials	1300	vials	46
IV Dextrose 5%	5700	btls	5400	Btls	0		11100	btls	51
IV D-NS	3470	btls	5400	Btls	0		8870	btls	39
IV-NS	1500	btls	5000	Btls	0		6500	btls	23
IV-RL	2000	btls	6000	Btls	0		8000	btls	25
IV-Metro	2650	btls	3000	Btls	0		5650	btls	47

In case of these important items, the state supply is generally less than half of the utilisation. It has been shared that currently the allocation for medicines in this DH is Rs. 22,000 per bed per year. Considering that the overall expenditure on all inputs in a District hospital in Maharashtra is about Rs. 2 lakhs per bed per year, the amount allocated for medicines is only about 10-12% of the total per bed allocation and appears inadequate. The current norms for financial allocations for medicine supply to various facilities were fixed 7-8 years ago and appear to be in need of urgent revision.

Annexure 4

Recent changes in the medicine procurement system in Maharashtra

There have been certain major policy changes related to procurement of medicines for the public health system in Maharashtra, which may have been related with the drug shortages being observed in some facilities Some recent steps have been -

- In the month of April 2010, the state Govt. had made an announcement to change the existing drug procurement system in the state of Maharashtra, and to implement a new system of procurement from the month of May 2010. As part of the new procedure, all procurements were to be made at state level and not at district level.

- During April 2010 to July 2010 there were proceedings from State govt. towards revamping of existing drug procurement system. As per new plan, it was proposed to have 8 warehouses in the state, out of which 3 warehouses were purchased by Govt in this period.

- However, by the end of July 2010 this policy change was challenged in the court by some of the drug manufacturers on the basis that if the system is changed and existing contracts are discontinued, it was claimed to be a breach of contract with the manufacturers with whom rate contracts (RC) are already made by the Health Department. Hence State govt. has withdrawn the change and older system is continued now.

- However due to the proposed change, no medicine purchase was done at district level during April to July 2010; this resulted in shortage of medicines in many of the health facilities in the state.

- Subsequently orders were issued to respective districts and health facilities in August 2010, to resume purchase following the old system of procurement. However these orders took some time to reach districts and to be acted upon.

Annexure 5

Some instances regarding management of flexible funds

District Hospital Satara – case of poor planning and accounting of flexible funds

- Scrutiny of accounts of RKS, AMG and Untied funds for DH Satara showed significant problems related to planning and accounting of these funds.

- All financial decisions reg. RKS / AMG / UF are taken in the RKS Governing body; however in each of the years 2007-08, 2008-09 and 2009-10, only one GB meeting was organised in the entire year.

- In 2009-10, the GB meeting was organised on 30 Jan. 2010, and all the funds were spent in last two months of financial year. The tender for purchase of instruments was published in newspapers on 23rd March 2010; the major order for various constructions was given on 26th March 10 – all these expenditures being made in the last week of the entire financial year. This indicates very poor planning related to use of these funds.

- The expenditures actually made on construction were nearly double of the plan approved in the GB; there was major divergence in allocation of funds as shown in the financial report, compared to expenditure given in the audited financial report for RKS.

- There is no regular accountant to manage all flexible funds (RKS, AMG, Untied funds), instead a statistical assistant is managing the accounts for the DH which together amount to over Rs. 46 lakhs annually.

Large, bulk purchases of medicines and equipment made at District level on behalf of PHC and Sub-Centre Rogi Kalyan Samitis in Kolhapur

In the year 2008-09, an IPHS facility survey was conducted in 18 Primary health centers (PHC) and 26 Sub centers (SC) in Kolhapur district, and data regarding facility wise requirement of medicine and equipments was collected. Subsequently an amount of Rs. One crore and sixteen lakh was sanctioned for these health care facilities, based on allocation of Rs 5 lakh for each PHC and Rs 1 lakh for each SC. (total 1.16 crores = Rs 90 lakh for 18 PHCs + Rs 26 lakh for 26 SCs).

In the month of Feb. 2009, demand notes from each selected PHC and SC were sent to the CEO, duly signed by Medical officer, President, Rogi Kalyan Samiti and Taluka Health officer, requesting allocation of fund for desired medicine and equipments.

In the month of Feb. 2009, a proposal to spend the sanctioned amount at the district level was proposed and approved in the executive body of the District Health and Family Welfare Society, Kolhapur. The President, Zilla Parishad Kolhapur also gave a similar suggestion to the CEO regarding this purchase, to provide health care services to the patients.

Subsequently the CEO Kolhapur requested the Commissioner, Family Welfare, seeking permission to make purchase of required medicines and equipments from various companies on Rate Contract basis. ***However while seeking permission from the Commissioner it was not mentioned that the entire purchase would be coordinated at the district level.*** In response to the request made by the CEO regarding this purchase, the Commissioner, Family Welfare gave approval for the purchases in the month of March 2009. It was also clarified in the Commissioners response that, routine purchases can be done even during period of electoral code of conduct, in order to provide regular services to the patients. However the Commissioners order did not mention that purchase of medicine for PHC and SC RKSs could be made at the District level.

Following this correspondence, a number of purchase orders were made to various pharmaceutical companies by the District Health and Family Welfare Society, all orders being made on 15 March 2009. These medicines and equipments were purchased in bulk, and were ordered to be distributed in equal proportion to all facilities, despite the need of each facility being different, which would be evident from the facility survey data.

While reporting back to the Commissioner, Family Welfare on 25 March 09, it was communicated by the CEO that medicines and equipment have been purchased at the **District level** on the following grounds -

- Based on the consent of Commissioner, Family Welfare
- Purchase was made during a period of applicability of electoral code of conduct
- Purchase amount was more than Rs 1 lakh

It may be noted that none of these reasons appear to be mentioned while seeking permission from the Commissioner, Family Welfare regarding the purchases from IPHS fund for RKSs of 18 PHCs and 26 SCs, with an allocated amount totaling Rs. 1.16 crores.

In this context, it appears that -

- The decision to ***purchase in centralized manner at the district level*** a large quantity of medicine and equipments was in some sense imposed on individual RKSs, and the

autonomy of RKSs in 18 PHCs and 26 SCs in Kolhapur district was not respected, even though formal endorsement was obtained from these RKSs.

- The need based purchase and allocation of medicines and equipments was ***not done in keeping with the entire facility specific information*** collected during the recent IPHS facility survey.
- Examination of actual rates of purchase and manufacturers reveals that ***some of the purchases were made at rates higher than the RC rates***; and some of the suppliers were outside the list of approved RC suppliers.
- This entire set of purchases were made in one shot, orders were given on a single day at the ***end of the financial year***.

In this context, this entire large transaction needs to be scrutinised by state NRHM officials in consultation with district authorities, and further recurrences of such centralized purchase orders related to use of PHC and Sub-centre level IPHS / RKS funds should be avoided. In addition, generally regular bulk requirements of medicines should be met from adequate state supplies rather than from RKS / IPHS funds.