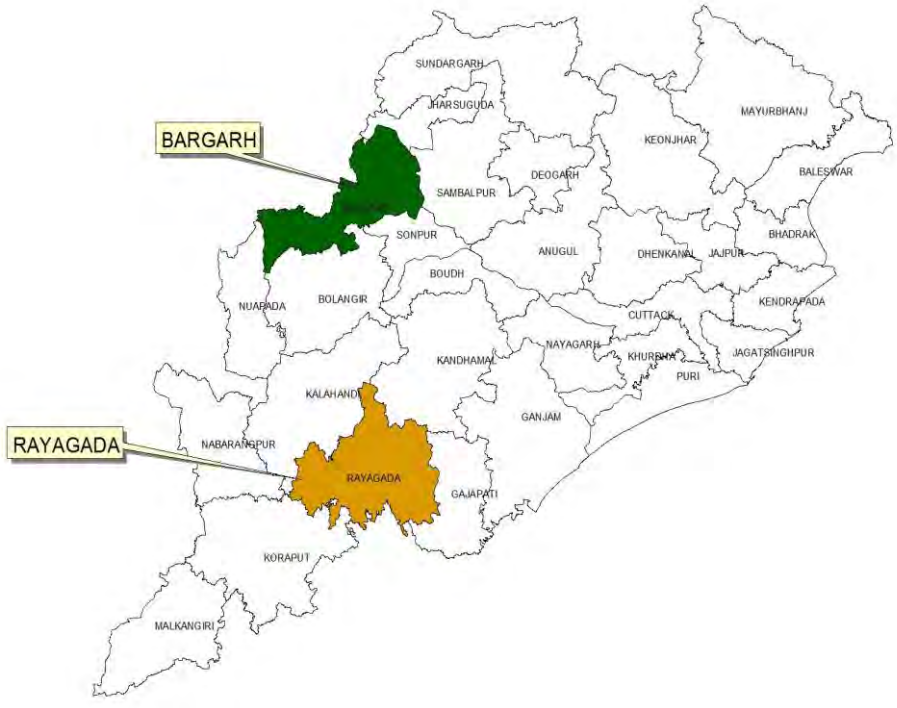
NATIONAL RURAL HEALTH MISSION



5TH COMMON REVIEW MISSION (8-15 NOV 2011)

Odisha State Report

Ministry of Health & Family Welfare
Government of India

December 2011

CONTENTS

Part- I

1.1 OVERVIEW

The 5th Common Review Mission (CRM) is the last in the series of CRMs, as NRHM is to conclude in 2012. This CRM assumes importance as NRHM completes 7 years and learning"s over the life of NRHM can now be compiled and incorporated into the next Mission. It is evident that during the NRHM period much work has gone into improving the health care delivery and in improving the health seeking behavior of the rural population in States but still a lot remains to be done.

The State of Odisha has made good progress during the period under review and has set up several systems to make this progress evident. The team was happy to note that there is openness at all the levels towards improvement and genuine efforts are being made. The community ensures that it gets its due share of services and interacts closely with health sector.

Of all the issues reviewed it has to be admitted that ASHA scheme has made good progress. ASHAs are the vibrant face of NRHM and they are fulfilling the role of an intermediary as envisaged in the scheme. The support systems for ASHAs are in place but must be improved further. This will ensure community to continue to place its confidence in ASHA. The support systems should be strengthened so that this confidence is not eroded.

The ASHA program has capacity to be developed into a multifaceted program. The ASHA support system (ASHA Resource Centre) should be institutionalized with capacity building, career path, adding more options and linkages with other departments. Upgrading knowledge and skills will ensure continuous ASHA viability.

Substantial improvement has taken place in the Infrastructure; the State has been able to meet its 10th and 11th Plan requirements. However facility up gradation has not been as per norms. This is seriously affecting the quality of health care. The civil works consumes inordinate time. Suggestions to remove bottleneck have been provided. The posting of assistant engineers at district level and support staff for block level to supervise civil works is a good step.

The State has made good efforts to expand its HR base by creating new posts and recruiting health personnel against various cadres through contractual staff. There is still a large gap between "needed" and "available" especially for specialists (Anaesthetist & Radiologists), MPW (M), Lab technician. The State must look at augmenting its various training Institutional (school/college) capacity.

Regarding facility based health care service delivery several shortcomings need to be addressed esp. pertaining to mandatory hospital stay after delivery and Standard Operating Procedures not being followed at facilities, thus putting the health of the mother and child at risk. Child deaths are not being reported under facilities but being reported under the Municipal records. Child deaths should be reported under the facility and the reasons recorded and issues taken up at the policy level. Maternal and Perinatal Death Enquiry (MAPEDI) should be put in place at the earliest.

Expanding outreach facilities further can be achieved by collaborating more with non government sector as well as private sector. Detailed protocols need to be developed. With respect to preventive and promotive health services, it is needless to state that this aspect forms the backbone of preventive health care and has the ability to reduce burden on clinical care. *Gaon Kalyan Samities* (GKSs) are a step forward and it is extremely encouraging to see that agencies like CARE India have been engaged to support GKS in their endeavour.

Maternal Health, Immunization, Family Planning, Adolescent Health comprise RCH. Various steps are being taken to improve immunization esp. logistic management. The birth rate has been declining while TFR is at 2.4. Even though the figures are good it is necessary to understand reasons for high unmet need. Adolescent friendly clinics will go a long way to improve the overall situation and these must be viewed as long term investments. At the same time reducing adolescent anaemia is an immediate requirement. Though there has been a substantial improvement under RCH, there were however quality issues on health care service delivery at facilities. A clear plan of action for putting in place Mandatory stay of 48 hrs, Standard Operating Procedures, NBCC at all delivery points is essential.

National Vector Borne Disease Control Program, Revised National Tuberculosis Control Program, National Program for Control of Blindness, National Leprosy Eradication Program together constitutes the National Disease Control Programme. The State has fared fairly well on all the counts. The LLIN scheme can be considered for extension. Malaria control may provide a "quick win" by panning a "community level effect".

The Gender and PCPNDT is a new addition this year in the CRM. This is very appropriate considering the imbalance in sex ratio as well as addressing issues of girl child. Gender sensitivity training is a must for staff in health as well as other departments. Considering that young adults freshly out of their secure environment are joining the services and being exposed to an insecure atmosphere may de motivate them and kill their enthusiasm, if sensitive issues are not addressed. At the same time government has to critically examine the extent to which PCPNDT strategy is like to be effective and thereby develop supplementary actions.

Programme Management is yet to achieve the overall PIME (planning, implementation, monitoring, and evaluation) indicators. Definite accountability mechanisms, role and responsibility of the entire team must be worked out. Regular review and plan sessions will improve efficiency and interpretation of policies. Inculcating a "culture of results" in the health system is not a simple matter, requiring not just guidelines and training, but measures to convince staff and administrators that examining data is useful – and that they are empowered to make changes and decisions on the basis of that data. All processes concerning procurement, use of electronic technology, financial management and program review have improved and could be further improved.

Decentralized local health action must be entrusted to credible agencies for them to operate in certain autonomy. Mainstreaming of AYUSH needs a big push and so does PPP.

***Acknowledgment*: The CRM Team to Odisha is privileged to have met the State, District and Block Officials and for the cooperation they received during the field visits.**

1.2 INTRODUCTION TO THE STATE

Odisha, is bound by Jharkhand on north, West Bengal on the northeast, Chhattisgarh on the west, Andhra Pradesh in the south and the Bay of Bengal in the east. Odisha is the tenth largest State in India and is spread over an area of 1, 55,707 square Km with a forest cover of 58,136.23 square Km.

Prone to natural calamities; floods, droughts and droughts regularly devastate the state. Frequent occurrences of natural calamities also stand as a barrier to overall progress in the state.

Figure 1 – Odisha, a scene from a train while travelling to Bargarh

Table 1.1 State's facts & figures[1]

Date of formation	1st April 1936
State Capital	Bhubaneswar
Area	155,707 square Km
Area under forest (total)	58,136.23 Sq. Km
Literacy rate	63.61%
Per Capita Income (03-04)	Rs.6, 487.00
No. of Districts	30
Urbanization Ratio	14.97%
Population (2001) - Male - Female	3,68,04,660 1, 86, 60,570 (50.70%) 1, 81, 44,090 (49.30%)
- Rural - Urban	3, 12, 87,422 (85.01%) 55, 17,238 (14.99%)
Scheduled Caste - Male - Female	60, 82,063 (16.53%) 30, 37,278 (08.25%) 30, 08,785 (08.18%)
Scheduled Tribe - Male - Female	81, 45,081 (22.13%) 40, 66,783 (11.05%) 40, 78,298 (11.08%)
Sex Ratio	972
Decadal Growth Rate	15.94%
Density of Population	236 per Sq. Km.
District Population - Highest (Ganjam) - Lowest (Deogarh)	 31,60,635 2,74,108
Total Literacy Rate - Male - Female	63.61% 75.95% 50.97%

[1] Data Source Census 2001

Highest Literacy Rate (Khurda)	81%
Lowest Literacy Rate (Malkangiri)	32%
No. of C.D. Blocks - Tribal - Non Tribal	314 118 196
No. of Tehsils	171
No. of villages(inhabited)	47,529
No. of villages(un-inhabited)	3,820
No. of Towns	138
No. of Panchayat	6235

[1] Data Source Census 2001

- ST and SC population constitute 22.13% and 16.53% respectively. **Together they constitute 38.66% of the state population.**
- This is comparatively higher than the All India figures of 16.20% (SC) and 8.19% (ST) population.
- Total SC population in Bargarh is 260719 out of which 242566 belong to the rural area and 18153 belong to the urban area. Out of total SC population in Bargarh, 131365 are male while 129354 are female. The Total SC population in Rayagada is 115565 out of which 99785 are from the rural area and 15880 are from the urban area. Out of total SC population in Rayagada, 57265 are male against 58400 female.
- Total Schedule Tribe population in Bargarh is 260691out of which 253944 belong to the rural area and 6747 belong to the urban area. Out of total ST population in Bargarh, 129546 are Females and 131145 males.
- Total schedule Tribes population in Rayagada is as high as 463418 out of which 449417 belong to rural area and 14001 are from urban areas. Female ST population in Rayagada is 238510 against a male population of 224908

Figure 2 - Tribal Population of Odisha

1.3 MAJOR ACHIEVEMENTS UNDER NRHM

RCH Indicators

- MMR dropped from 303 (SRS, 2005-06) to 258 (SRS, 2007-09) – a drop of 45 point decline.
- IMR has decreased from 75 (SRS 2005) to 65 (SRS 2009) - 10 point decline or 2 points decline every year.

Health Care Delivery

- The number of OPD cases increased from 1020096 in 208-09 to 18112886 in 2010-11(HIMS)
- The number of IPD cases increased from 937820 to 1073538 in 2010 -11 (HMIS)

Maternal health

- Total reported institutional deliveries(to reported deliveries) is 83% (HMIS -2011-2012
- Total reported institutional deliveries as(to estimated deliveries) is 65.5 % (HMIS-2011-12)
- 26.08 lakh mothers have benefited under Janani Surakshya Yojana (JSY) (2006-2011)
- 10 Maternity Waiting Homemade functional
- 85 MBBS Doctors are trained on Life saving Aesthetic skills (LSAS) and 37 MBBS Doctors trained on Emergency care (EmOC).
- 307 Janani Expresses are engaged for promoting referral transport for delivery purposes.

Immunization

- Full immunization coverage has increased from 53% (CES – 2005) to 59.5% (CES 2009)
- Full Immunisation coverage increased from 53.3 % (DLHS II 2002 -04) to 62.4 % (DLHS III 2007-08)

Child Health

- 16 SNCUs- operational in Angul-1, Balasore-1, Capital Hospital-1, Kandhamal- 1, Koraput-1, Mayurbhanj-1, MKCG MCH-1, Nawarangpur-1, Nuapada-1, Puri-1, Rayagad-1, Sambalpur-1, SCB, MCH-1, SDH, Jeypore, Koraput-1, Sonepur-1, VSS MCH-1
- 25 NBSU are functional
- 452 New born corners established across the state
- 3 Nutritional Rehabilitation Centres made functional
- IMNCI (Integrated Management of Neonatal and Childhood Illnesses) implemented in 20 districts

National Disease Control

- Good progress in implementation of malaria control programme.
    - State API for Malaria reduced from 10 to 8.8 a drop of 1.2 points
    - The total malaria cases have decreased from a high of 380216 in 2000 to 328767 in year 2010 a drop of 51,449 cases.

    - Death cases under malaria have decreased from 257 in 2006 to 203 in 2010 a drop of 54 points.
- Prevalence Rate of Leprosy is 0.87, 19 districts sustaining elimination level

Other Disease Control

- The State / districts have a large number of sickle cell anaemia cases. The districts are doing good job of managing these cases with limited facilities. Special mention of the good work being done by CDMO of Bargarh district.

School Health

- 1806 tribal residential school included under Intensive School Health Programme & 57972 schools included under Extensive School Health Programme

Out Reach Services

- *Mamata Diwas* (Village Health & Nutrition Day) - 797076 sessions held out of 866137 planned from 2009-10 to 2011-12 (Up to August-11) - 92 % achievement
- 2,28,641 Malnourished (different grades) Children (screened and counselled)treated through *Pushtikar Diwas* from 2009-10 to 2011-12 (Up to Augsust-2011)

Mobile Health Units

- 211 MHUs operationalised and catering to the need of beneficiaries in inaccessible areas.
- MHU-*Arogya+* new initiatives in PPP mode for LWE affected areas.
- 421 Ambulances deployed across the state for providing 2nd referral transport service.

Human Resource

- 1263 AYUSH Doctor, 3853 Medical Officers, 856 Staff Nurses, 1081 Addl. ANM & 112 LTs are in position.
- 40,637 (ASHAs) in place against total targeted 41,102 ASHAs.
- 618 ASHAs in urban slums selected out of 881
- Total number of ANM and AWW trained is 25,751

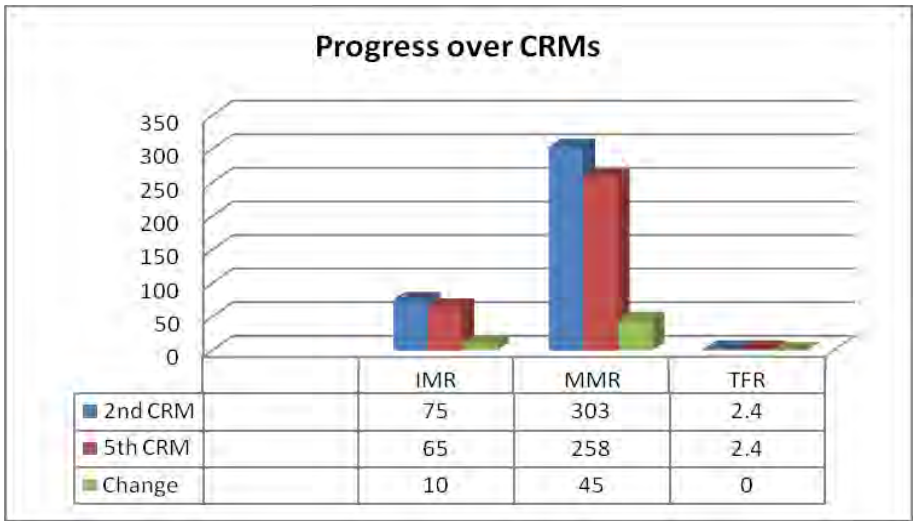
Community Participation

- 45,454 GKS have been constituted in the State
- 21 PHC (N) of 11 districts are managed by the NGOs.
- 16 Jan Aushadi Kendras initiated in 15 districts to reduce out of pocket expenses on drugs.

1.4 PROGRESS OVER SUCCESSIVE CRMS IN ODISHA

The comparative progress over different CRM has been captured from 2nd CRM, as the first CRM report majorly dealt with policy recommendation with very little quantitative analysis. The second CRM report has been included as substantive quantitative analysis was done and this has been used for assessment of progress during the subsequent CRMs[@].

Chart 1.1



	IMR	MMR	TFR
2nd CRM	75	303	2.4
5th CRM	65	258	2.4
Change	10	45	0

Note: *[@]The data used for comparison in this report is data from SRS 2004 – 06 for MMR and SRS 2005 data for IMR, as these are now available and correspond to the time period of 2nd CRM (2008). The 2nd CRM used SRS data from 2001 – 0 as this was the only data available at that time.*

- The graph signifies major achievements of state in terms of Maternal mortality health (drop of nearly 45 points) when SRS is used to assess the progress through years in the maternal health programme.) MMR fell from 303 SRS (2004-2006) to MMR 258 - SRS (2007-2009).
- The IMR also shows a drop of 10 points from IMR 75 (2005 SRS) to IMR 65 (2009 SRS), an average a drop of 2points every year.
- TFR however remains at 2.4.

Present Status of Reproductive Child Health Indicators:

Chart 1.2

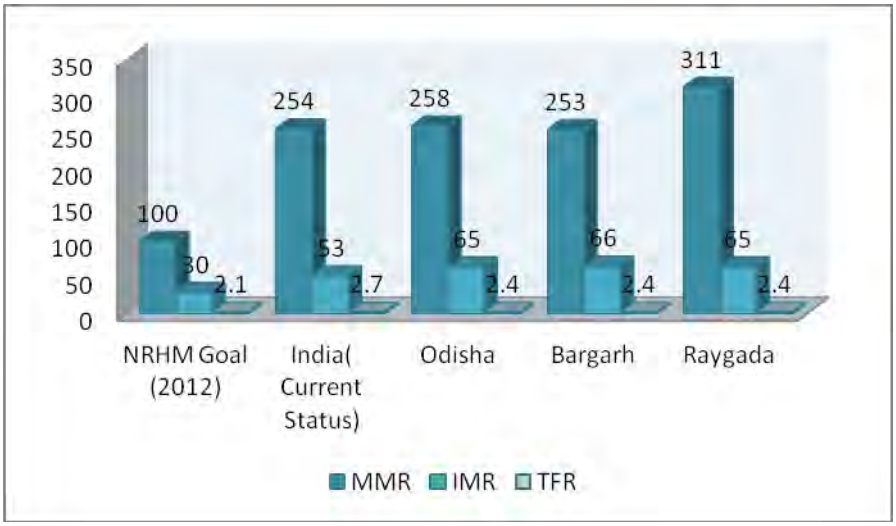


Table 1.2: Health Indicators – State *vis-à-vis* Districts

SN.	Indicators (%)	Comparative Analysis of Health Indicators			
		Odisha	Bargarh	Rayagada	Remarks
1	Improved Sources of Drinking Water	76.7	93.2	83.7	Need to improve access to drinking water to reduce cases of diarrhoea.
2	Have Access to Toilet facility	16.9	12.2	8.9	Limited access to Toilet facility across State. The State needs to increase the reach of Total Sanitation Campaign
3	Any Modern method of contraception	37.8	42.3	33.1	Contraceptive acceptance needs to be increased in light of high unmet need in the state- State to improve and expand basket of FP services
4	Total unmet need	24.0	30.1	26.5	
5	Mothers who had at least 3 Ante-Natal care visits during the last pregnancy	54.6	64.3	59.4	The ANCs are quite low overall in the State and these needs to be improved to cover all pregnant women. The mother and child tracking should be strengthened. This should help also improve the institutional deliveries. Rayagada needs special attention to improve institutional deliveries.
6	Institutional births	44.3	43.6	18.1	
7	JSY Beneficiaries	75%	98%	70%	
8	Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles)	62.4	70.4	26.8	Rayagada district needs greater focus on Immunisation.
9	Children breastfed within one hour of birth	63.7	40.1	81.8	State average is higher than the national average. Breast feeding needs greater attention in Bargarh district.
10	Women who have heard of HIV/AIDS (age group of 15-49)	47.4	41.8	21.6	The awareness on HIV/RTI among women is good but greater awareness on HIV – AIDS is required.
	Women who have heard of HIV/AIDS (age group of 15-24)		63.0	42.7	
11	Women who have heard of RTI/STI (age group of 15-49)	14.4	5.4	6.5	
	Women who have heard of RTI/STI (age group of 15-24)		6.6	8.3	

Source: HMIS & DLHS-3

Table 1.3: Progress across CRMs (1st to 5th CRM)

Progress across CRMs					
	2nd CRM	3rd CRM	4th CRM	5th CRM	Remarks
Infrastructure					
No. of Medical College and Hospitals (Government)	3	3	3	3	Need for more medical colleges keeping in view the acute shortage in doctors.
No. of District Hospitals (Capital Hospital, BBSR & R.G.H RKL)	32	32	32	32	
No. of Sub-Divisional Hospitals	22	22	22	26	Facilities have been planned as per requirement however these do not conform to IPHS norms
No. of Community Health Centres	231	231	231	377	
No. of Other Hospitals	120	120	120	79	
No. of Primary Health Centres (N)	1162	1162	1162	1228	
No. of Rural Family Welfare Centres			314	314	**Converted to PHC**
No. of Urban Family Welfare Centres	10	10	10	10	As per requirement
No. of Postpartum Centres	79	79	79	79	
No. of Sub-Centres	6688	6688	6688	6688	
No. of Health Posts	0	0	0	0	
No. of Rural Health Centres	3	3	0	0	
No. of A.N.M. Training Schools	16	16	16	16	Shortage of manpower. Need for more training centres
No. of M.P.H.W.(Male) Training School	3	3	3	3	
No. of Ayurvedic Hospitals	5	5	5	5	Main streaming of AYUSH is good. The State has increased its strength of AYUSH personnel
No. of Ayurvedic Dispensaries	619	619	619	624	
No. of Homoeopathic Hospitals	4	4	6	6	
No. of Homoeopathic Dispensaries	560	560	603	603	
No. of Unani Dispensaries	9	9	9	9	
Human Resource					
Specialist (Total)			3499	3853	Shortage of Specialists specially Anaesthetist
a. Surgeon					
b. O&G					

Progress across CRMs					
	2nd CRM	3rd CRM	4th CRM	5th CRM	Remarks
c. Anaesthetists					and Radiologists
d. Paediatrician					
e. Radiologist					
Medical Officer					
Ayush Doctors			1269	1263	
Staff Nurse			4234	2665	Acute shortage of Staff Nurses. Need for more Nursing colleges
Pharmacist			2004	1951	
a. LT			1351	1034	
b. ANM			9087	8258	
c. MPW			3456	3685	
Training					
Maternal Health (Total)					
a. LSAS	23	50	71	84	Steady increase in capacity building
b. BEmOC (2 days + 10 days)	0	0	0	255	
c. CEmOC	0	0	0	0	
d. EmOC	12	23	30	38	
Child Health (Total)					
a. NSSK	0	0	536	2853	
b. FMNCI	0	0	0	93	**Started in Oct-10**
c. IMNCI	0	14027	19256	27326	
Family Planning					
NSV	14	16	31	1	Spacing methods need greater focus
Min Lap	26	18	81	4	
Male/Female Sterilization	38275	17879	34622	44956	
Health care Service Delivery					
Total No. of OPD Services	1020096	13210049	18182886	12687743	OPD and IPD services have increased over time
Total No. IPD Services	937820	987820	1073538	728189	
Number of Lab Test					
Referral Transport(Total)	296	460	712	728	
a. JE	37	201	291	307	

Progress across CRMs					
	2nd CRM	3rd CRM	4th CRM	5th CRM	Remarks
b. Ambulance	259	259	421	421	
ILR Points	760	1098	1135	1157	
Schools Health service	0	0	1681	1806	
Other Disease					
Programme Management					
Total Staff Strength in SPMU	46	94	110	112	Management Units are functioning at all levels
Total No. of functioning DPMUs	30	30	30	30	
Total no. of staff in functional DPMUs	85	120	276	330	
Total No. of functioning BPMUs	314	314	314	314	
Total no. of staff in functional BPMUs	531	628	628	840	
Community Mechanism/Outreach Service					
ASHA	34312	35018	40232	40614	Community Out Reach Activities services are good in the State
GKS	11774		44999	45383	
VHND	0	107741	195761	210718	
Pushtikar Diwas		36940	79173	30817	
Mamata Programme				127000	
Finance (Rs. Crore)					
Proposed Budget					
Administrative Approval (Including funds routed through treasury & kind grant)	573.06	695.56	738.63	801.31	State has been utilising its funds received under NRHM
Released (Including State share) (Excluding funds routed through treasury)	325.8	372.3	417.76	225.72	
Utilization (Excluding funds routed through treasury)	235.75	467.62	453.19	205.77	
Unspent (Excluding funds routed through treasury)	373.22	276.54	241.11	264.48	

Source: State MIS 2011

1.5. PROGRESS OVER CRMS - *KEY OBSERVATIONS*

- The professionalization of health systems management in NRHM in Orissa has been major factor in the progress being reflected in the state.
- Substantial increase in human resource with recruitments for doctors and specialist.
- The number of lab facilities functioning with technicians increased but the range of laboratory tests still limited and not available beyond DH/SDH.
- Construction process decentralized with the establishment of engineering wing integrated with infrastructure planning and monitoring process.

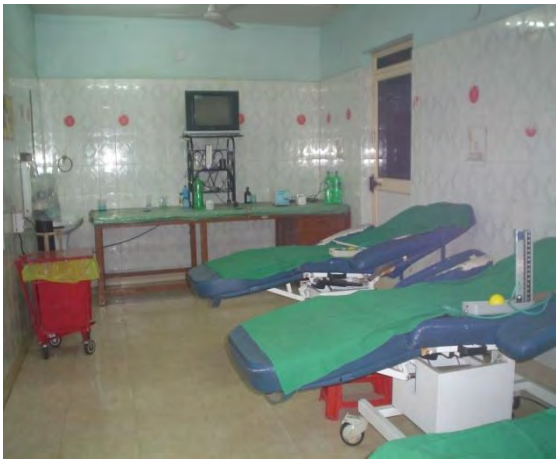


Figure 3: One of the well maintained blood banks in the State

- Equipments at facilities increased and found in sufficient numbers and in working condition. However the equipment maintenance wing needs to be strengthened and decentralized as repairs take a long time.
- FRUs increased from 20 to 81 FRUs but only 63 have blood storage facilities.
- SNCUs functional in 16 out of 30 districts.
- IMNCI training increased to cover 20 out of 30 districts but progress slow with only 58% training completed till date.
- NRCs increased from 2 – 3 NRCs
- Training of ASHA for module 5 is 100% complete. Training for 6 & 7 module just started.
- Outreach services for community are being rendered by ASHAs. ASHAs are escorting pregnant women to facility. The percentage of ASHAs escorting pregnant has increased from 57% to 78%.
- Numbers of AYUSH doctors has not changed.
- Use of Information Technology has seen a lot of progress since 2nd CRM
- Disease Control programme especially Malaria has been addressed by the State in a large way through increased distribution of LLIN since 2nd CRM resulting in reduction in malaria cases and deaths.
- OPD and IPD cases have increased substantially since 2008-09 to 2010 – 11 from 10200096 to 18182886 and from 937820 to 1073538 in respectively.

Sign outside ASHA's house in Agalpur village, Barpally, Bargarh showing various services

Table 1.4: Progress against approved PIP 2010-11

(*Achievements till date*)

Sr No.	*CRM Components*	*PIP 2010-11 targets* (Cumulative)	*PIP 2011-2012 targets* (Cumulative)	*Achievements till date*	*Remarks*
1	**Infrastructure Development** Construction of sub centre buildings		302	102	50% sub centre's running in rented building
2	**Human Resource**				
	Appointment of ANMs	Regular - 7568 Contractual - 1600	1630	1081	The deficiencies are more in KBK district and there also more in V3 and V4 areas
	Appointment of staff nurses	Contractual-1100 Regular-2422	1471	856	Poor pre training capacity is responsible for it
3	**Skills In Available Health Human Resources**				
	Percent of ANMs trained as Skilled Birth Attendant	4409 (45%)			
	Doctors trained on EMCOR	52	57	37	With low availability of specialist in non KBK district and slow multi-skilling
	Doctors trained on LSAS	98	117	85	
	Doctors trained in NSV/ Conventional vasectomy	458	224	74	Only 16% achievements have been made
	Doctors trained in Abdominal Tubectomy (Minilap)	459	244	154	33% achievement
	Doctors trained in laproscopic Tubectomy	47	75	55	Good progress
	Personnel trained in IMNCI	23466	28380	21180	The denominator is large and moreover large workforce from ICDS has been trained.
4	**RCH II** Maternal Health Institutional Deliveries (Cumulative)	70%	70%	57%	Despite all efforts 40% deliveries in KBK district are at home as private sector is not available in these areas
	24X7 Facilities	340	438	261	

	Functional First Referral Units	118	145	81	63 with Blood Bank or BSU,
	Child Health Sick New Born Care Units (SNCU)	26	24	16	The state has not been able to achieve last year"s target also
	Stabilization Units in CHCs/BPHCs	70	50	25	
	New Born Care	0	997	452	
	Family Planning				
	Male Sterilization	12000			
	Female Sterilization	148000			
	No. of IUD insertions	180000			
5	**Preventive & Promotive health services including Nutrition and Inter-Sectoral Convergence**	4 NRCs		3NRCs	
6	**National Disease Control Programme (NDCP)**				
	Case Detection Rate of TB among new sputum positive patients	70%	70%	65%	
	Treatment Success Rate among new sputum positive patients initiated on DOTS	>86%	100	87%	
	ABER for malaria	14	14	12.9	
	API for malaria	9	7		
	Annual New Case Detection Rate for Leprosy	14.53	14		
	Cataract Surgeries performed	120000	130000		
7	**Effective use of Information Technology:**				
7a	**Maternal Child Tracking System (MCTS):**				
	Tracking of pregnant mothers and children	90%	820000	125000	
7b	**Health Management Information System (HMIS):**				
	Percent districts uploading timely HMIS Data and confirming	100%	100%		
8	Emergency referral transport		372	291	

1.6 FINANCIAL PROGRESS AGAINST THE APPROVED PIP

RCH-II

- The overall fund utilization against the available fund is good. However, out of approved annual SPIP of **Rs. 253.79 crore**, expenditure of **Rs. 85.16 crore** has been reported during the year 2011-12 i.e. **34%** utilisation against approved PIP**.**

Figure 4- Financial review at Facility in Bargarh

- Expenditure reported under the heads *Janani Suraksha Yojana* (46%) and Maternal Health (Other than JSY) (45%) till 2nd Quarter of 2011-12 shows good level of utilisation of funds.

- The State has reported ***nil*** utilisation of approved PIP under PNDT Activities.

- Under the heads Adolescent Reproductive and Sexual Health/ARSH and Tribal RCH each has reported 10% expenditure. Less than 20% of the approved annual PIP under the heads Vulnerable Groups (12%), Child Health (14%) and Urban RCH (17%). The State should take necessary steps to improve utilization under these activities.

- The State has reported expenditure of less than 30% of the approved annual PIP under the heads Training (23%), Infrastructure & Human Resources (24%) and Family Planning Services (Other than Compensation and Camps) (24%), Compensation for Female/Male Sterilisation/NSV and Female Sterilisation Camps (24%) and Programme Management (28%). The State should take necessary steps to improve utilization under these activities.

Mission Flexi Pool

- Since the launch of the programme, out of the total release of Rs. 757.84 crore under Mission flexible pool, the state has incurred expenditure of Rs. 697.74 crore i.e. 92% of funds released to the State, which shows a good level of utilization of funds.

- Out of the approved annual SPIP of Rs. 304.86 crore, the reported expenditure is Rs. 80.18 crore for the year 2011-12. 26% expenditure against approved PIP.

- The State had an Unspent balance of Rs. 49.26 crore as on 1st April, 2011 and Rs. 91.01 crore has been released during the year 2011-12. Expenditure reported by the state during the year 2011-12 has been Rs. 80.17 crore which is 57% of available funds of Rs. 140.27 crore.

- Nil utilisation under Health Insurance Scheme. A summary of the activities with low and nil utilization during the year 2011-12 under RCH Flexible Pool and Mission Flexi Pool is given in Table 1.5 below:

Table 1.5: Utilization of Funds

Activities	SPIP	Utilisation	% Utilization
New Initiatives/ Strategic Interventions (As per State health policy)	1,090.04	41.80	4%
Health Insurance Scheme	23.00	-	0%
Untied Funds	5,455.87	502.91	9%
Support Services	231.60	11.64	5%

- The State has reported Negligible utilisation of approved PIP under New Initiatives/ Strategic Interventions (As per State health policy) (4%) and Support Services (5%).

- The State has reported expenditure less than 15% of the approved PIP under the heads Untied Funds (9%) and PPP/NGOs (11%).

- Less than 25% of the approved PIP under the heads Regional drugs warehouses (17%), Annual Maintenance Grants (18%), Other Expenditures (Power Backup, Convergence etc) (20%) and Planning, Implementation and Monitoring (24%).

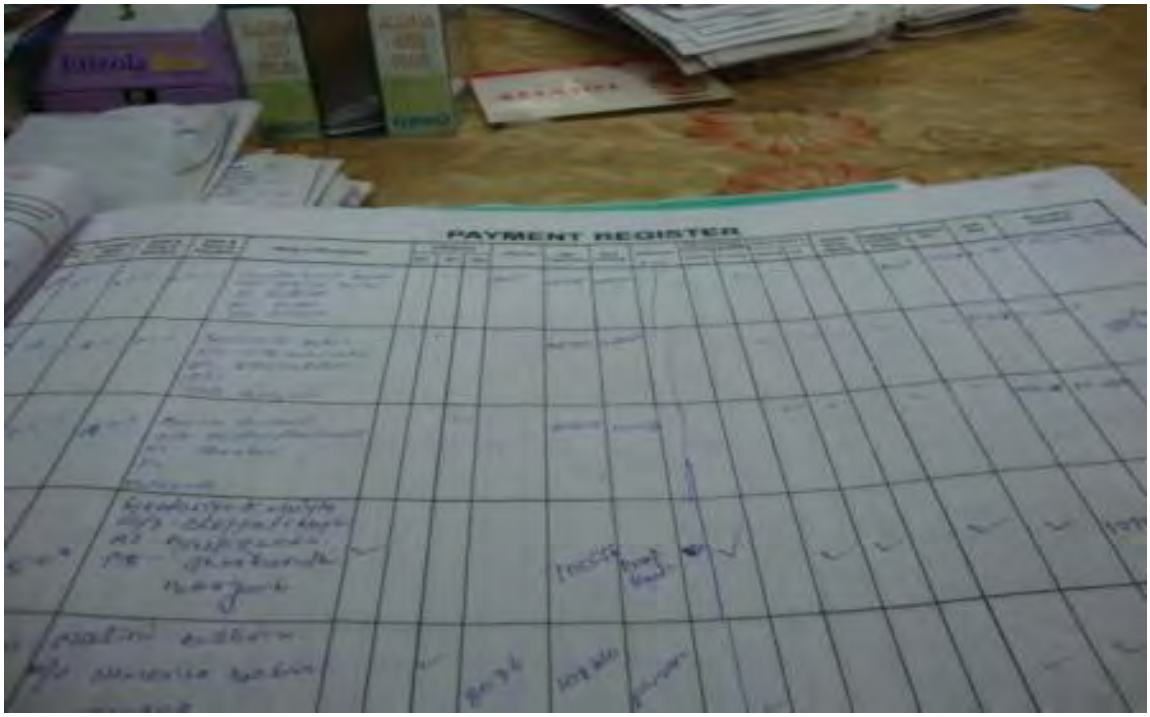


Figure 5 Payment Registers being maintained at Bargarh

Part- II

2.1 INTRODUCTION TO CRM

NRHM uses an intensive accountability framework through a three pronged process of (i) community based monitoring, (ii) external surveys and (iii) stringent internal monitoring on a regular basis. Common Review Mission (CRM) is a part of this intensive accountability framework and CRM Teams visit States regularly to review NRHM programme. This is the 5th CRM visit to the State of Odisha.

AIM OF the 5th CRM

- *A critical review of the functioning of NRHM vis-à-vis its goals and objectives-Identify the changes that have occurred in last 6 years.*
- *Assess the health care delivery system in the States to explore the main reasons for successes and failures.*
- *Document the lessons learnt in implementation of NRHM over the last six years for achieving better results in future. Point out any important observations that need further study.*
- *In depth study of major programme components including programme management, planning & design, governance, community ownership, monitoring &evaluation, so that the lessons learnt can be utilized for improving policy & performance of NRHM in next phase of NRHM. Hence the output expected is looking deeper to identify reasons of success and failure and to suggest the major changes required to move ahead in next phase of NRHM.*
- *To identify strategies and outcomes in the State in addition to the ones envisaged by the Mission, both positive and negative.*
- *To identify areas which have not been addressed so far during conceptualization of the mission (in the framework) and during implementation of the mission (that are there in the framework but have not been taken up).*

2.2 COMPOSITION OF THE CRM TEAM TO ODISHA, OFFICIALS AND FACILITIES VISITED IN TWO DISTRICTS VIZ. BARGARH AND RAYAGADA

Composition of the CRM Team to Odisha, Officials and facilities visited in two districts viz. Bargarh and Rayagada are given in the following Tables.

Figure 6: State Briefing on 9th November 2011 at Bhubaneswar

Figure 7a: District Review Team, Bargarh

Figure 7b: District Review Team, Rayagada

Figure 8-: State de-briefing on 15th December 2011 at Bhubaneswar

Table 2.1: Composition of 5th CRM Team to Odisha State

SN	*Name of Team Members*	*Designation*	*Organisation & Location*
1	Dr. Baya Kishore	Deputy Commissioner *(CRM Team Leader)*	Ministry of Health & Family Welfare, GoI, New Delhi
2	Mr. Manoj K. Pant	Director	Ministry of Health & Family Welfare, GoI, New Delhi
3	Dr. Saroj K. Adhikari	Assistant Director (M & E and Training), ICDS Programme	Ministry of Women and Child Development , GoI, New Delhi
4	Dr. A. K. Satpathy	Sr. Regional Director	Regional Office of Health and Family Welfare, GoI, Bhubaneswar, Odisha
5	Mr. T. D. Prasanta Rao	Section Officer (Finance) ,NRHM	Ministry of Health & Family Welfare GoI, New Delhi
6	Dr. Ashoke Roy	Advisor, Regional Resource Centre for NE States	MoHFW, GoI, Guwahati, Assam
7	Dr. S K.Sahu	Deputy Advisor	Department of AYUSH, Ministry of Health & Family Welfare, GoI, New Delhi
8	Dr. Pattrick Mullen	Programme Specialist	World Bank, New Delhi
9	Dr. (Ms) Anuradha Jain	Sr. Consultant	NHSRC MoHFW, GoI, New Delhi
10	Mr. Surojit Chatterji	Project Director, Health for Urban Poor Project (HUP)	Population Foundation of India (PFI), Lucknow, Uttar Pradesh
11	Dr. (Ms) Deepti Agarwal	Consultant, Assured Service Delivery, RCH	MoHFW, GoI, New Delhi
12	Ms Hena Chakrabarty	Consultant - Planning & Policy Division, NRHM	MoHFW, GoI, New Delhi

A. Central Team to District Bargarh

Dr. Baya Kishore	Dy. Commissioner, MoHFW, Govt of India
Dr Ashoke Roy	Advisor, North East RRC, MoHFW, Govt of India
Dr Patrick Mullen	Programme Specialist, The World Bank
Mr Surojit Chatterji	Project Director, Population Foundation of India
Sh.T.D.Prasanta	Section Officer, NRHM Finance, MoHFW, Govt of India
Ms. Hena Chakrabarty	Consultant Planning & Policy-NRHM, MoHFW, Govt of India

B. State Team to District Bargarh

Dr. B. K. Panda	Joint Director, Govt of Odisha
Dr. B. Dash Mohapatra	JD (RH), Govt of Odisha
Mr. A. K. Pradhan	State Programme Manager, NRHM

D. Central Team to District Rayagada

Sh. Manoj K. Pant	Director, MoHFW, Govt of India
Dr. A.K. Satpathy	Sr. Regional Director, MoHFW, Govt of India
Dr. Saroj K. Adhikari	Asstt. Director (ICDS), MoWCD,Govt of India
Dr. S.K. Sahu	Dy. Advisor (AYUSH), MoHFW, Govt of India
Dr. Anuradha Jain	Sr. Consultant, NHSRC, MoHFW, Govt of India
Dr. Deepti Agarwal	Consultant Assure Service Delivery, MoHFW, Govt of India

E. Sate Team to District Rayagada

Dr. Biswal	Director, Public Health, Govt of Odisha
Mr. P. K. Mohapatra	Sr. Consultant, PHP
Mr. D. K. Biswal	Consultant (M&E), State NRHM

Table 2.2: Officials met by the CRM Team

Smt Anu Garg, IAS	Secretary & Commissioner Health, Govt. of Odisha
Dr. P. K. Meharda	Mission Director, Govt. of Odisha
Sh. Bhabograhi Mishra	District Collector, Bargarh, Odisha
Dr. Nitin Bhanudas Jawale, IAS	District Collector , Rayagada, Odisha
Dr. U.C. Tripathy	CDMO, Bargarh, Odisha
Dr. Benudhar Nayak	CDMO, Rayagada, Odisha
Other State Government Officers & District Health Functionaries	
GKS members, PRI Members, Village Health Functionaries, ASHAs, AWWs Beneficiaries etc.	

Table 2.3: Facilities visited by CRM Team

Type of Facility	*Availability status in Bargarh*	*No. of Facilities visited by CRM team at Bargarh*	*Availability status in Rayagada*	*No. of Facilities visited by CRM team at Rayagada*
District Head Quarter Hospital	1	1	1	1
No. of Blocks	12	5	11	4
Sub Divisional Hospital	1	1	1	1
No. of CHC	11	5	14	2
PHC (New)	46	6	36	4
Sub-centre	204	7	235	2
Others(MHU, Maternity Waiting Hall & GKS, AWC, VHND, VHSNC, ASHA, Beneficiary	–	8	-	8
Total		**27**		**22**
GRAND TOTAL		**49**		

Table 2.3a: Facilities visited in Bargarh district

Sl .No	*Name*	*Address / Location*	*Level (SC / PHC / CHC/ DH/other)*	*Name of the Person in Charge*
1	District Hospital - Bargarh	Bargarh	DH	Dr. U C Tripathy
2	SDH-Padampur	Padampur, Bargarh	CHC	
3	CHC-Attabira	Attabira, Bargarh	CHC	Dr. Agarwal,MO IC
4	Agalpur CHC	Agalpur,	CHC	Dr. Radheshyam Aggarwal, MOI/C
5	Barapali CHC	Barpalli	CHC	Dr. Soraj Kr. Seth, MOI/C
6	Sohela CHC	Sohela	CHC	Dr. Ranjan Mahapatra, MOI/C
7	Dava-II CHC	Dava	CHC	
8	Ghess PHC	Ghess	PHC	Dr. Jayachandra Tandi, MOI/C
9	Satlama PHC (N)	Satlama	PHC	Dr. Bharat Patel, MOI/C
10	Kumelsingh	Kumelsingha,	PHC	AYUSH MO,Kumelsingha
11	Paikamal	Paikamal	PHC	MOIC,Paikamal
12	Khadobal PHC(N)	Attabira,	PHC	MoIC,Khadobal
13	Jharbandh PHC(N)	Jharbandh	PHC	MoIC,Jharbandh
14	Kusunpuri Sub Centre	Kusunpuri	SC	Ms. Malti Dei, ANM
15	Satalama Sub Centre	Satalama	SC	Ms. Jagyaseni Sahu, ANM
16	Jhar Sub Centre	Jhar	SC	Ms. Seema Barik, ANM
17	Zaring Sub Centre	Zaring	SC	Ms. Hemlata Misra, ANM
18	Larambha Sub Centre	Larambha	SC	ANM
19	Janapara Sub Centre	Janapara	SC	ANM
20	Amithi Sub Centre		SC	ANM
21	Amamunda,	Amamunda	VHND	ANM,AWW,ASHA
22	Kumelsingha	Kumelsingha	VHND	AYUSH MO, AWW, ANM, ASHA
23	Bhubaneswarpur		MHU	MO
24	ASHA-Gruha	Padampur	SDH/CHC	ASHA
25	Shanti Nursing Home	Khadobal	Pvt Nursing Home	
26	Meeting Sarpanch & Bar Association(Life Line)			
27	Tentelpali village	Tentelpali	Village	Ms. Jayanti Sahu, ASHA
28	Amammunda village	Amammunda	Village	Ms. Fulan Meher, ASHA

Table 2.3b: Facilities visited in Rayagada district

SN	*Name*	*Address / Location*	*Level (SC / PHC / CHC/DH/other)*	*Name of the Person in Charge*
1	District Headquarter Hospital	Rayagada	DH	Dr. K.V. S. Choudhary, ADMO
2	Sub-divisional Hospital	Gunupur	SDH	Dr. Bani Prasad Choudhary, Medical Superintendent
3	CHC Ramanaguda	Block Ramanaguda	CHC	Dr. Sangram Keshari Sahu, MO (IC)
4	Subcentre Gogupada	Block Ramanaguda	SC	ANM: Ms Mayabati Sabar
5	Jhara		AWC	
6	District Drug and Vaccine Stores	Rayagada	DH	
7	Kolnora PHC	Kolnora	PHC	Dr. (Ms) G. Shylaja, MO (I/C)
8	Muniguda CHC	Muniguda	CHC	Dr. B. B. Dash Mahapatra, MO (I/C)
9	GKS	Guakona, Block Kolnora	Village	Ms Anjana Karkaria, AWW; Ms Lakshmi, ASHA; Ms Tiki Behra, Ward Member
10	GKS Convention	Rayagada Block	Block	Dr. Pradeepta Kumar Subudhi, BMO, PHC Rayagada
11	Mamata Diwas (VHND)	Relipadar AWC	AWC	
12	ASHA Training Centre, Mercy Foundation	Muniguda		Mr. Jitendra Sa, Secretary & Director

Part- III

FINDINGS OF THE 5TH CRM

As mandated by the NRHM, an in depth study of major programme components including programme management, planning & design, governance, community ownership, monitoring & evaluation and health care delivery etc was carried out for the State of Odisha. The CRM team compared the progress over CRMs and studied the output expected over different periods of NRHM and tried to identify reasons for success and failures and to suggest changes wherever required to move ahead to the next phase of NRHM.

This CRM report has been divided into the following parts, (i) State Initiatives, (ii) Observations (both State as well as District) and (iii) Recommendations. The following are the CRM Team"s observations.

3.1 INFRASTRUCTURE DEVELOPMENT

State Initiatives

The State has taken the following measures to decentralize infrastructure development and maintenance through the following steps:-

- Infrastructure Development Wing (Engineering Cell) established at the State level and is headed by a Superintending Engineer, to support all civil construction works and to expedite maintenance of health facilities.
- District Health Society (ZSS), entrusted with the responsibility of execution and monitoring of civil works at the district level in order to strengthen convergence and expedite civil works.
- The Chairmanship of Commissioner-cum-Secretary holds regular meetings to review civil works at State level.
- Similarly the Collector & DM holds meetings with line Department & executive agencies at to review all civil works District level.

Figure 7 facility at Bargarh

Observations

- Substantial improvement has taken place in the infrastructure; the State has been able to meet its 10th and 11th Plan requirements. Establishment of health facilities for the period of 10th – 11th 5 year plans[2] is as follows:

[1] *Data Source from RHS 2010 and Administrative approval of Odisha 2011.*

Table 3.1: Health Facilities in the State during 10th & 11th Plan

Type of Facilities	*10th Plan (2002-2007)*	*11th plan (2007-2012)*	*Status as on Sept 2011*
Sub Centre	5928	6688	6688
Primary Health Centre	1279	1279	1279 + 79 =1358
Community Health Centre	231	231	377
District hospital	30	32[3]	32

Data Source from RHS 2010 and Administrative approval of Odisha 2011.

**3 DHH sanctioned for new construction*

- Health infrastructure in the State has improved to a large extent. The State has upgraded many health facilities and constructed new facilities to meet its critical gap.

Table 3.2 Information on Progress of Up gradation of Health Facilities under NRHM in the State (September 2011)[4]

Health Facility	Up gradation sanctioned under NRHM so far		Progress of New Constructions					
	High Focus Districts	Non High Focus Districts	Completed		Under Construction		Sanctioned but Yet to start[5]	
			High Focused	Non High Focus	High Focused	Non High Focus	High Focused	Non High Focus
DHHs*	19	13	19	13	0	0	0	0
SDHs	13	9	13	9	0	0	0	0
CHCs	102	104	67	59	33	42	2	3
OHs & PHC-N	105	182	17	38	25	30	63	114

New construction sanctioned during Mission period:

Sub Centre (SC) - 820 new SCs constructed under NRHM out of which 156 (about 20%) have been completed and 664 (80%) are under construction.

[3] There are 30 District Hospitals+ Capital Hospital, BBSR & R.G.H RKL are falling in the same category

[4] Source – 5th CRM State Presentation 2011

[5] *A detailed report of Rayagada district shows that construction work sanctioned since 2005-2006 is in various stages of progression (from 'work not started' to 'completed, but not handed over') through various agencies. Most of the sanctioned up gradation/construction is presently incomplete.*

Primary Health Centre (PHC)

98 new PHC sanctioned out of which 56 have been completed (57%) and 42(43%) are under construction.

Community Health Centre (CHC)

10 new CHCs sanctioned 2 completed (20%), 5 under construction (50%) and 3 yet to be started.

District Head Quarters Hospital

3 DHH buildings (in Dhenakanal, Malkangiri and Jharsuguda) sanctioned but construction has not started.

Up gradation: Up gradation has been approved for 32 DHH and 21 SDH are reported as completed. According to the data shared by the state, up-gradation has been completed in 153 of the 206 CHCs. Progresses is slow; up-gradation has been completed in only 55 out of the 287 facilities.

Staff Quarters:

The state has a shortage of residential accommodation for staff at facilities. Staff quarters are mostly available at DHH, SDH, CHC & PHC level. However these are not adequate to provide accommodation to all staff.

Figure 8: Pending construction at Ghess, Bargarh

Drug Ware House

37 District and 150 Block level ware houses have been approved. 25 out of 37 District and 22 out of 150 block level ware houses have already been completed and handed over to the local administration and remaining are under construction.

District Specific Observations

- Infrastructure (OT) at CHC Sohela Bargarh, constructed 5-6 years ago under World Bank project well-maintained and well-used. Also most facilities visited generally well-maintained and relatively clean, even the oldest (i.e. CHC Agalpur built 1959)
- Responsibility for maintenance and cleanliness decentralized to the RKS at the facility level, increasing hospital responsiveness and accountability. Cleaning contracted-out, and facility manager feels more in control over the contractor (i.e. can cancel contract for poor performance i.e. CHC Sohela) Bargarh

Figure 9 Overcrowding at facility Bargarh

- Civil works seem to take inordinate time (i.e. PHC Ghess, Bargarh, new building planned 5-6 years ago, still unfinished)

- Patient amenities are largely ignored: i.e. no reception desk, no bed nets, and family sleeping on the floor. Limited facilities for attendants.

- IPHS norms are not in place. Many sub divisional hospitals, as in Rayagada, have only been renamed as DHH without the accompanying bed strength or human resource. Similarly, many facilities have been renamed without adhering to norms for sanctioned beds or human resource, e.g. CHC in Muniguda & PHC in Attabira in Bargarh District.

- This has led to a situation where the health facilities are deficient in number of functional beds and Health Manpower. These facilities also do not have the support services (eg; labs, blood banks). Staff quarters for various cadres of health personnel are lacking. Facility up gradation has not been as per norms. This is seriously affecting the quality of health care.

- DHH Rayagada (besides SDH Gunupur) is one of the health facilities in the district that has a potential to serve as a tertiary care centre. There is an increasing demand for health services at this centre. Renovation and reconstruction or up gradation of health facilities has its limitations, therefore construction of a new building should be considered. *As informed by the District Magistrate, 5 acres of land is available for this purpose, located at the site where new CDMO office has been constructed.* The State could include this in there Action plan to meet the health services demand.

Fig 11a: DHH, Rayagada

- A new drug store has been constructed in Rayagada but not yet commissioned for use. The drug store is currently located in a rented building. There is no provision of racking /binning of drugs and the supplies are dispatched by identifying the batch numbers (the one closest to expiry- no inventory management).The drugs are arranged reasonably well (given that the rented space is a house and not constructed as a drug store). The drug warehouse does not have any power backup currently. ASV and anti- rabies vaccine are stocked in the fridge/refrigerator which has no power backup. This could compromise the entire stock in case of power failure. UPS/ Inverter back up is urgently required.

- All ILR points visited at both the districts (Bargarh & Rayagada) had functioning equipments and requisite power back up. Recommended temperature was being maintained.

Recommendations

Bottlenecks in civil works need to be addressed immediately at all levels: The following are the recommendations:-

- The technical specifications/bills of quantities to be very clear and detailed as much as possible, ideally using standard layouts and technical standards for construction materials and fixtures that have been adopted state-wide (with relevant modifications to the local context).

- Capacity to manage and supervise civil works needs to be developed (with in the Health Dept) at the state and district levels to remove reliance on other government departments and consequent delays.

- Defined system for tracking, management and repair or major medical equipment is needed, with decentralized responsibility to the appropriate level (District?) and necessary budget allocation.

- Regular assessment by a qualified architect/engineer (with no conflict of interest) and consequent strengthening of the technical specifications/bills of quantities to adapt to local conditions can avoid problems.

- Practice of underbidding and then delaying works to achieve price escalation is tricks that are practiced worldwide. There are well-known mechanisms to address the under bidding and subsequent price escalations. Under-bidding can be discouraged by the following:

    a. Including a price escalation formula in the bid documents that provides standards for price variation in key inputs for a maximum of 15% increase only.

    b. Specifying in the bill of quantities of a maximum allowable increase in quantities of key inputs, i.e. 15%.

    c. Specifying that the cost of new items, introduced/required after contract signature, needs to be competitive with market rates, or consistent with standard rates adopted by the state government.

- Contract management by the state government should not introduce delays and complications (i.e. due to changes in requirements, delays in payment, etc.).

- The posting of assistant engineers at district level and support staff for block level to supervise civil works is a good step.

- The State could consider Built, Operate and Transfer mechanisms for all civil works including equipment and Human Resource to tide over extra ordinary delays.

3.2 HEALTH HUMAN RESOURCES

State initiatives

- The State Government has established a State Human Resource Management Unit (SHRMU), and a Nursing Management Support Unit (NMSU) and has brought about the following changes:

    1. Entry level posts for Medical Officers upgraded to Jr. Class – 1
    2. Retirement age has increased to 60 years.
    3. More promotional avenues created
    4. Special Incentives for staff working in KBK & KBK plus districts being dispensed. However it is not attracting suitably qualified staff, in absence of a long term assured career progression opportunities.
    5. Non – financial incentives – Credit marks in PG study for the doctors working in KBK & KBK plus districts.
    6. The Medical Colleges admission seats increased (addition of 129 additional seats in MBBS).
    7. The Nursing Colleges/schools and Para-medical Institutes admission seats have also been similarly increased.
    8. 5 years mandatory pre – PG periphery services.
    9. Legislation for protecting the health services providers against violence is in place, but implementation is yet to be streamlined (ex. Harassment of the ANM posted at Jhar Sub Centre under Bargarh district, Supervisors of all level including Medical Officer visited once after the incidence)

- The State has adopted a decentralized recruitment process.

- RKS is empowered to recruit critical personnel, as and when the need arises.

- A State Human Resource Management Unit and Nursing Management Support Unit have been established. A data base of health personnel is now being created.

- Introduction of various allowances and incentives, creation of more promotional avenues and development of a rational and transparent promotion policy (in process) are some of the steps that have been taken to retain and attract doctors in public health service.

OBSERVATIONS

The State has made good efforts to expand its HR base by creating new posts and recruiting health personnel against various cadres through contractual staff. However the gap between "needed" and "available" is immense. This is especially seen in the case of specialists (Anesthetist & Radiologists), MPW (M), Lab technician etc. The table below highlights the various health personnel situation in the State.

Table 3.3: Status of Human Resource

Position	*Requirement as per IPHS*	*Sanctioned strength*	*In Position*	*Vacancy against sanction*	*Vacancy against IPHS 2010*
Specialist		1819	1123	696(38%)	
Medical Officer	6422	4394	3853	541(12.3%)	2569 (40%)
AYUSH		1476	1273	203(13%)	
Pharmacist	2704	2114	1951	163 (7.7%)	753(28%)
Staff Nurse	11088	3522	2665	857(24.3%)	8423(76%)
MPHW (M)	6695	5727	3685	2042(35.7%)	4653(45%)
MPHW (F)	14724	9237	8258	979(10.6%)	6466(44%)
Radiographer	941	235	115	120(51%)	826 (88%)
Laboratory Technicians	2667	1639	1034	605 (37%)	1633(61%)

- The vacancy against various sanctioned positions for health personnel ranges from 7% (for pharmacists) to 51% (for Radiographers). However the vacancy situation worsens on comparing it to the IPHS norms.

- During the NRHM period (2005 -2010), the State has focused on filling the critical gaps in terms of recruitment and availability of health personnel in the health system. The State has increased the number of sanctioned posts from 824 specialists in 2005, to 1819 in 2010, an increase of sanctioned specialist"s positions (110% increase). However, as against 1819 posts only 1123 posts could be filled i.e. 62% (1123/1819). This is an increase of nearly 90% (from the 2005 level) as the number of specialists available was only 673 in 2005).

Figure 10: Interaction with Health HR at Bargarh

- There has been little change in the position of regular medical officers [3457 (2005)/ 3575 (2011)][6].

- The position of staff nurses in the health system is poor. The numbers of Staff Nurses (SN) in position has increased marginally with 537 SNs being added during the mission period against the sanctioned strength of 1,278.
- The shortage of SN is more in the high focus, tribal, and difficult to reach districts like Rayagada etc, where the local administration has failed to recruit new staff nurses despite repeated

[6] (Ref: Annexure F)

recruitment drives. This highlights the urgent need for establishing nursing schools in some of these difficult districts.

- AYUSH doctors have been added to the health workforce. In 2005, there were no sanctioned positions for them; presently 1123 AYUSH doctors are in place as against 1819 sanctioned positions. It is to be noted that most of these doctors are in regular positions. Only 278 out of 3575 doctors across the state are contractual.

- 1225 medical officers were recruited last year, out of which 792 were through OPSC recruitment process; 124 more medical officers were appointed on ad-hoc basis; and 302 medical officers engaged on contractual basis.

Table 3.4: Details of recruitment done during 2010-11 to meet the critical gaps in paramedical personnel

Para medical personnel	*Periphery*	*NRHM*	*Total*
Staff Nurse	251	884	1135
Pharmacist	71	32	103
MPHW (F)/ Addl.ANM	NA	1186	1186
MPHW (M)	421	NA	421
L.T	215	109	324

Source – State MIS 2011

- The Management Unit at the State & district has 671 qualified professionals with the educational background of MBBS/ CA/MBA/MA/MCA etc.
- Human resource allocation (hiring, allocation, transfers) needs to be re-aligned with the existing needs at facility level and keeping in view the attrition rate, due to retirement and transfers etc. Frequent changes in crucial management positions (i.e. five CDMOs changed during the calendar year 2010 at Bargarh) affects the strong implementation. The picture at Rayagada is totally different with the District Magistrate leading the mission himself.

- Low expenditure is reported against additional incentives for MOs at CHC / PHCs, salaries for computer assistants and incentives to SNs and ANMs (2010). Vacancy in positions of ADMO at DHH and SDH is impeding the implementation of the NRHM programme effectively.

Training

- In terms of training institutions, there are 16 government ANM training institutions, while 50 schools are in private sector. Together they have an intake of more than 2000 students per year.

- 5 GNM schools in government sector. There are beside government institutions 41 private institutions; however these are yet to be recognized by NCI. Together they have a yearly intake of more than 700 students.

- There are 32 Pharmacy colleges in private sector and 1 in government sector making about 1800 seats available in the state.

- 3 MPHW training schools in government sector have a total intake of 120 per year.
- However the state is lacking in terms of nursing schools, there is only one government nursing school while 11 are in private sector awaiting accreditation/approval.
- Three institutions provide Diploma to Lab technicians.

- The overall Progress on Training has been average – The progress for maternal and child health has been good but lacking for family planning (especially trainings for IUCD insertion, Minilap, PPIUCD, NSV) and needs to be improved.

District specific Observations

- District Rayagada reports a total of 51 SBA trained service providers of which only 36 are currently posted at delivery points. Considering that only two facilities in the district (DHH, SDH) have the delivery load to meet the requirements of SBA training centre, the selection of staff has to be judicious. However ANMs from non MCH centres were being trained in order to ensure that home deliveries are attended by a SBA trained personnel.

- Rayagada district has neither ANM or LHV training schools nor Nursing training school. KBK districts may be accorded priority in establishing new schools. States may consider giving 10-20% advantage to candidates belonging to and willing to work in these KBK districts after completion of training.

- Trainings of service providers has been concentrated more to L3 facilities. Most of the SBA, NSSK trained staff is presently posted at Level 3 -DHH & SDH) and few at Level 2 & 3 facilities - (Rayagada & Bargarh).

- Surprisingly many CHCs have neither the Specialist nor SBA trained provider. Many Sub-centres and PHCs also do not have SBA and NSSK trained personnel (Bargarh & Rayagada); also most PHCs and SCs are conducting so few deliveries that they have failed to be designated as delivery points. This is true for both the districts.
- Supportive supervision and monitoring in the field is lacking at all levels (i.e. in District Bargarh) Rayagada under the District magistrate has a good leadership.

- Large vacancies exist in the districts e.g. Rayagada, has 50 vacancies against a sanctioned strength of 124 medical officers. In Bargarh 17 SN are in place against a sanctioned number of 26 and only 100 doctors are in position against a sanctioned strength of 135.

- Availability of gynaecologists (8/15), paediatricians (4/8) and anaesthetists (0/3) indicates a poor situation as far as specialists are concerned. (Rayagada). In Bargarh the position for specialist is equally poor with just two paediatricians and one Anaesthetist at the DHH and one LSAS trained person at Dawa CHC.

- The gap in availability of medical officers is adversely affecting the health services delivery in the district, resulting not only in shrinking of the range of services available across the health facilities but also reducing the number of facilities that can provide the health services mandated for First Referral Units.

- *Incentives and HR polices:* Difficult area allowances are being provided to the health service providers. However interaction with the medical officers brought up many issues which were causing dissatisfaction among them. Firstly the large difference in incentives to those posted at difficult District Headquarters (3,000) and the difficult District periphery (8,000). This may be taken care by providing incentives according to classification of areas based on vulnerability assessment (V1 to V4 areas).

- Most medical officers posted in difficulty areas continue to be posted in these areas for years with no avenue for transfers.

- Promotions take a very long time and most of the doctors getting the first promotion after 20 years of being in service and most of them retiring within two promotions at the most.

- During the state briefing the CRM team was informed that the state had a provision of giving 10% weight age for each year spent in HFD (up to a maximum of 30%) in PG admissions (but doctors should first be able to get selected).

Recommendations

- Given the shortage of specialists in the district and the state of Orissa it is recommended that multi-skilling of doctors be under taken to meet the critical gap. Considerable numbers of medical officers could be trained in LSAS and EmOC and F-IMNCI.

- Focus on **non monetary incentives** for example posting in better districts after serving in difficult districts for a certain period of time, preference /reservation quota in academic and professional institutions for children whose parents have served for long in HFD, letters of appreciation, additional weight age for each year spent in HFD /LWE affected district/tribal district/V3, V4 districts during promotion , special quota in post graduate studies for young doctors willing to serve in difficult areas should find greater preference.

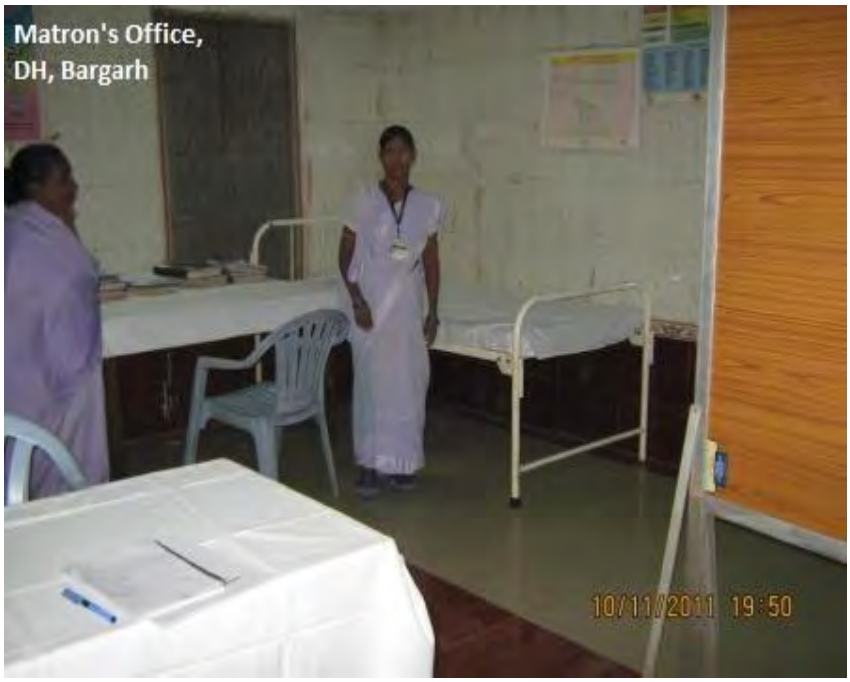
- Cadre reform in terms of Dynamic Assured Career Progression should be put in place. KBK allowances could be considered for doctors in senior administrative positions (eg; ADMO).

- **Health Manpower Information System s**hould be energised to address the bottlenecks in HR management (i.e. transfers, posts filled, tenure of middle-management etc should be readily displayed on Govt website.

- Staff remuneration, incentive structures, and career paths, need to be defined and assessed for reform. Improved conditions for medical doctors could be a quid pro quo for banning private practice.

- The creation of posts for health facility/hospital and public health administrators should be considered to handle planning, programming and management tasks.

- More number of Schools and Colleges for various cadres/personnel (MO/SN/ANMs etc) could be considered keeping in the overall requirement and attrition rate in the State.



3.3 HEALTH CARE SERVICE DELIVERY- FACILITY BASED- QUANTITY AND QUALITY

State Initiatives

- The State has re-designated its facility as Level 1, Level 2, and Level 3 depending on the service delivery package being provided.

- Untied Funds and RKS funds and maintenance grants are being used to strengthen service delivery and quality of care in providing for (i) non- planned infrastructure and contractual services, (ii) supporting epidemics by procurement of additional drugs and consumables, (iii) providing transport services and managing the utility back-up services (diesels for DG sets, increased in electricity consumption).

- Increased funding in the past years has translated into overall reanimation of government health care service delivery by making better infrastructure, staff, equipment, medicines and other consumables available for general public.

- Demand for maternal and child health care services has clearly been stimulated by JSY and by the use of Janani Express to transport pregnant women to the facility.

Observations

- The State has renamed many facilities as PHC/ CHC without proper bed strength or following norms
- Inadequate number of hospital beds for the admitted patients, resulting in patients being placed on floor beds. This arises from the fact that there are no sanctioned beds as per the facility norms. (Example – Attabri CHC in Bargarh).
- As envisaged, in a average population of 30000, Minimum Assured services, eg. OPD services, inpatient facility, 24 hours emergency services, 24 hours delivery services, essential new born care services, safe abortion services, implementation of NDCPs, basic laboratory services, referral services, etc. need to be rendered through the PHCs, which is not happening. All these services are being available for the first time only at the Block CHC.
- The medical records were not being stacked properly and were dumped on floor (SDH Padampur).
- The Facilities, labs and imaging services don"t comply with regulations related to Biomedical Medical Waste (BMW), fire safety and safe practices among others.
- Infection control and asepsis in the laboratories, safety measures for the laboratory technicians in terms of usage of gloves, handling sharps with needles cutters, segregating BMW, disposal of liquid waste is not adequate.

Figure 11: Bio Medical Waste Management at DH, Bargarh

- The use of **Thermo Luminescent Dosimeters badges (TLD)** for assessment of radiation exposure for the safety of radiographers is not practiced.

Recommendations

- Mandatory 48 hrs stay after delivery should be ensured at facilities. This is not happening at the present, mainly due to lack of sanctioned beds. The mother and the newborn child are bundled and sent home thus putting the health of the newborn and the mother at risk. The State should make provisions for sanctioned beds at facilities with proper HR and equipment.
- Standard Protocols (Operating Procedures) are not being followed despite Guidelines on SOP being made available at facilities. This is again leading to a situation where the health of the mother and the newborn is being compromised. Standard Protocols should be made mandatory.

Figure 12 - new born baby of 1.8 kg delivered by caesarean at DHH Bargarh lying on the ground not fully wrapped/ covered.

- Tribal belief of burying the placenta should be supported by the facilities and make use of this belief to help bury the placenta with the help of the family in earmarked area within the premises. This will help in the safe disposal of the placenta and also help in keeping with the tribal customs.
- Large number of facilities visited had unusable and broken equipment and furniture locked in rooms. Thus depriving the facility of valuable space. There is a need to operationalise State/District condemnation policy in a systematic manner to ensure better utilization of the available space.
- Facilities at PHCs needs to be improved/ strengthened with inpatient facilities, adequate HR, and Laboratory Technicians, to provide round the clock services.
- Future demand for services from the population could be met by including the private health sector services (PPP), particularly in towns and cities.

3.4 OUTREACH SERVICES

Figure 13-•Branding of MHU and treatment point

State Initiatives

- Maternity Waiting Home. A temporary home (5 bedded) with facilities like providing food for expectant mother & one escort, compensation for loss of wages etc.
- More maternity Waiting Home to be established in all 7 districts having presence of V4 areas & one for every 20000 V4 area population
- MHUs in tribal Blocks & Blocks in KBK+ Districts
- GPS tracking piloted at Rayagada district
- Health care services are being contracted to NGOs, corporate bodies to facilitate effective and qualitative delivery of services to the targeted population in rural and urban areas and to people in difficult to reach pockets.
- Development of the sickle cell preventive, comprehensive care and research center at VSS Medical College, Burla for Referral patients from districts.

Observations

- Current status of Maternity Homes – 13 operational out of 22 sanctioned in tribal and hilly areas.
- The sub centres are providing outreach services.
- Information regarding holding of VH&ND to the community is through Village *Kantha* (Wall Writing with Health Messages) was evident and also through AWWs and ASHAs. VHNDs are planned in coordination with ICDS and ASHAs. But the coordination is limited to holding the event only and does not include follow up of mothers and children in the community.

Figure 14 - Faded *Swasthya Kantha* on Sub Centre wall

- Identified malnourished children are being referred to the nearby CHC to attend the *Pustikar divas* on 15th of every month. However lack of Nutrition Rehabilitation Centre (NRC) and dietician is affecting the care and follow up of the referred children.
- Iron Tablets and nutrition supplement (2.5 Kg of powdered rice, peanuts, sugar, and wheat) is provided to every Pregnant Women once every fifteen days.

- Micro-planning for Immunization sessions are prepared at the sub centres, prior to outreach immunization sessions, the due drawn list of the targeted children and pregnant women of the locality is shared with ASHAs for information.

Recommendations

- Expand partnership with private sector and NGOs in the difficult areas in the State.
- Involvement of NGOs, SHGs, Corporate bodies in increasing the reach of health care services in the implementation of disease control programmes.
- *Swathya Kantha* is a good medium to bring about awareness and should be placed at more centres and facilities and should be repainted as and when required.
- More NRC should be considered to address malnutrition in the State.

Figure 15 Sub Centre at Bargarh with good display of IEC on its wall

3.5 ASHA PROGRAMME

State Initiatives

- Provision of additional ASHA - in V3 & V4 Sub Centres (1348 additional ASHAs selected)
- One ASHA per habitation having a minimum of 100 population
- Additional incentive provisions
- Need based capacity development.
- Special Incentive provisions:
  - + 25% of total earnings – In V3
  - + 50% of total earnings – In V4

Observations

- ASHAs are the vibrant face of NRHM in Odisha and are doing good work and understand their responsibilities towards the community. Out of 41102 ASHA recruited 40714 are in place. 388 positions are vacant. Attrition rate is below 1% (0.94%)
- ASHAs have been well trained and retain the skills learnt. Training of ASHAs is being done by NGOs. One of the NGOs visited was doing very good work. Module 1 – 5 completed and Module 6 & 7 has just been started.

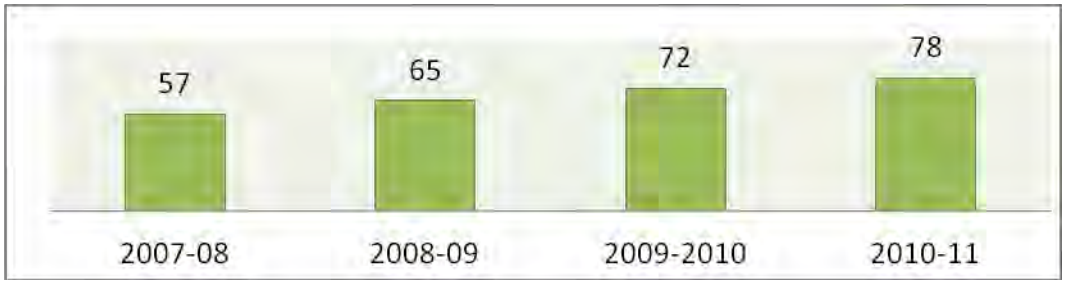
Figure 16 : Module 6 & 7 Training at Padampur,Bargarh

- 10th of every month is the designated day for discussion on ASHA programme at the block level - ***"Block ASHA Diwas***", where in analysis of the sector level reports, drug kit replenishment, incentive payment, address issues, grievance redressal, plan for next month are being done. ASHAs receive incentives through E-transfer. Fixed day payment on 10th of every month.
- "ASHA Gruha" – Help Desk cum Rest House are operationalized up to the DH/SDH level, which are being managed by ASHAs on rotation.

Figure 17 ASHA Gruha Pdampur

- ASHA Grievance redressal in Block and District has been institutionalised.
- „After nurturing a pregnant woman for 7-8 months throughout the antenatal period, taking all the expected care, for what so ever reason, if the delivery does not happen in health facility, for ASHA it is an „Opportunity Lost", she does not get any incentive" – An ASHA in Bargarh district informed.
- Districts have given water bottle, umbrella, uniform, bi-cycle, torchlight etc for ASHAs to support her work.

Chart 3.1



- ASHAs showing positive variance for escorting reported institutional delivery. The percentage increased from 57% in 2007-08 to 78% in 2010-11.

Recommendations

- ASHAs should be made aware of the standard protocols for the care of the new born and care of the mother, so that she along with the staff nurse/ANM can ensure that protocols are followed properly to ensure the well being of the mother and the child.
- Many of the pregnant women are from tribal areas, the ASHAs of these areas should be provided with IEC materials in local language with pictures to bring about better awareness of care of the mother and the child.
- The training of 6th & 7th module being highly technical requires facilities where enough case loads of pregnant mothers and new born babies exists, so that hands on training for ASHAs could be provided.

Figure 18: Module 6 & 7 training at Padampur,Bargarh

- Additional ASHAs in areas where the habitations are scattered is a good move. However this has resulted in the monthly incentives per ASHA going down significantly as the incentives get divided between two or three ASHAs for the said population. Also the total number of beneficiaries being less translates into lower incentives. Many ASHAs in tribal areas make less than 500 Rs. per month. This in the long run could be de-motivating factor.
- More SHG should be developed in remote and difficult areas to provide mother and child health services.

3.6 PREVENTIVE & PROMOTIVE HEALTH SERVICES INCLUDING NUTRITION AND INTER- SECTORAL CONVERGENCE

State Initiatives

- *Mamata Diwas* (VHNDs)
- *Pustikar Diwas*
- Joint mother and child protection card
- Regular meetings of VHNSC (GKS) with participation of health personnel (LHV/ANM/ASHA) on the planned dates.

Observations

The State government has made significant efforts in bringing about better synergy between the health and ICDS programme at the community level. Observance of *Mamata Diwas* (VHNDs), *Pushtikar Diwas*, joint micro planning at district and block level (for immunisation, health checkups and referrals) are found to be effective in bringing functionaries of two departments together in addressing common issues. Also, use of the new joint mother and child protection (MCP) card, regular meetings of VHNSC (GKS) with participation of health personnel (LHV/ANM/ASHA) on the planned dates have fostered stronger convergence between health and ICDS, PRI.

Key factors observed (in Rayagada district) which have played significant role in bringing better convergence between health and ICDS are:

Figure 19: A baby is being weighed at Kumelsingha PHC (N) in VHND

- ✓ *Strong, committed and a pro-active leadership at the district level by the District Magistrate, the Chief District Medical Officer (CDMO), and the District Programme Management Unit (DPMU) under NRHM*
- ✓ *Clarity on goals, needs and problems among the district and block NRHM teams;*
- ✓ *Excellent field level coordination between frontline functionaries of ICDS and health particularly between AWWs and ASHAs;*
- ✓ *Demand for better quality health and nutrition services from the community through community mobilization efforts like Gaon Kalyan Samities (GKS); and*
- ✓ *Support from NGOs and development partners (DFID/UNICEF/CARE India)*

Strengthening GKS through NRHM-NGO Partnership

The State NRHM has initiated a process of strengthening the functional capacity of the GKSs through NGO partners. In Rayagada (along with other 7 tribal districts in Odisha), CARE India has been entrusted as the lead Nodal Agency to facilitate the process of conducting training for GKS members, field assessment of functioning of GKS and hand holding support to GKS members through the local NGO partners.

The outcome of this initiative is to create the village based empowered GKS who would be the catalytic agents for improved public health at the community level.

As part of the process, CARE India has undertaken an exercise of gradation of functional GKSs based on the following criteria:

(i) Monthly meeting
(ii) Village health plan status
(iii) Activities implemented
(iv) Updating of *Swasthya Kantha* (Health Bulletin on wall)
(v) Record maintenance
(vi) SOE submission

Figure 22a: Members of GKS at Village Guakona

A report of 2010-11 shows that about 23% GKS are found to be in „excellent" category, with 39% moderate and about 13% of lowest category that are performing poorly in respect of the above five criteria.

The GKS Gradation is an effort to improve its performance and also make it a vibrant village based community body.

Recommendations

Figure 20 Children at AWC Giaconda (Rayagada District)

- State"s initiative of strengthening functioning of the GKS through partnership with organizations like CARE India could be replicated in other districts for better community involvement.
- Periodic training of GKS members on key aspects of health, nutrition, sanitation etc, Government"s initiatives, several financial and other norms, eligibility etc. *vis-a-vis* their roles on these issues is essential. Local NGOs may be roped into for such training; Inter-block/district exposure visits of poor performing GKS members for cross-learning.
- Establishment of NRCs in all districts (especially with districts with high mal nutrition) to enable treatment of severely malnourished children may be taken up on priority. .

  Data on severely malnourished children that are generated through Monthly Progress Reports of the AWWs and /CDPOs in ICDS programme may be shared with the ASHA and ANMs on a regular basis for taking timely actions and referrals of the children during *Pushtikar Diwas* held at PHCs.

- Joint training of health with ICDS functionaries may be an integral part of the annual training plans of both the departments, which seemed to be lacking at present. Funds from ICDS training budget may be leveraged wherever required.
- Recent guidelines of GoI (MWCD) on formation of monitoring & support committee at the AWC level under the chairpersonship of PRI Member to monitor AWC activities may be considered and roles of such committee may be appropriately integrated with that of GKS, to have better convergence and to avoid any overlap/duplication.
- State may ensure close coordination with other line departments/programmes with technical support from NRHM as required. For example, for location mapping of diarrheal cases and to match the same with mapping of potable water sources, commissioning of sanitary toilets, etc., technical support may be sought from the Health & FW Dept.

3.7 RCH II (MATERNAL HEALTH, CHILD HEALTH AND IMMUNIZATION NUTRITION FAMILY PLANNING ETC)

MATERNAL HEALTH

State Initiatives

The State in order to improve maternal Health is implementing the following schemes:-

Figure 21: JSSK Beneficiary at Bargarh District

JSSK

- Launched on 1st Nov 2011.
- Ensures free institutional services (focus on peri-natal period)
- Comprehensive guidelines developed for all components
- Standard Treatment Protocol developed with support of FOGSI and IAP

JSY

- Integrates the financial /cash assistance with, institutional care during delivery and immediate post-partum care (focus on intra-natal & post-natal period)

Mamata

- Conditional cash transfer scheme ensures basic services from antenatal period till child completes 1 year (focus on ante-natal & post-natal period).
- While IGMSY has been piloted in two districts (through MWCD), the state has on its own initiative extended similar benefits through *Mamata* scheme to the entire state.

Table 3.5: Entitlements - complementary approaches

	Ante-natal	Peri-natal	Post-natal
JSSK	---	All 6 entitlements	---
JSY	---	Mothers package	---
Mamata	**1st Instalment (Rs. 1500/-)** **(at the end of the second trimester of pregnancy)** Early registration Inj. TT & IFA as per schedule Counselling Utilize services before 24 weeks	---	**2nd Instalment (Rs. 1500/-)** Completion of 3rd month of child BCG, Polio & DPT-1 & 2, weighed at least two times after birth, EBF **3rd Instalment (Rs. 1000/-)** Completion of 6th month of child Polio & DPT-3, EBF & CF **4th Instalment (Rs. 1000/-)** 9th to 12th month of child RI + measles vaccine , CF

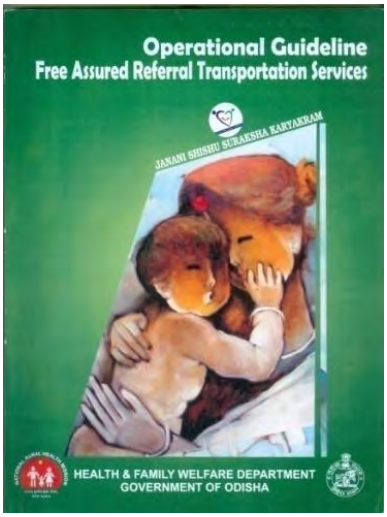
MCH CENTRES

(Delivery points)

For every 30000 population - At least 1 institution from any level (L1/2/3) identified and targeted for up-gradation.

Category	*Target*
L1 (24 X 7 with SAB trained manpower)	899
L2 (24 X 7 with BEmOC services)	438
L3 (24 X 7 with CEmOC services)	145

Currently there are 382 delivery points in the state; 243 in HFD and the rest in non HFD. All these have been designated as institutions for JSSK implementation in the first phase. The state has identified 272 delivery points in the state where more than 500 deliveries take place in a year.



- Labour rooms in L2 and L3 facilities are being standardized for essential requisites that includes equipment and infrastructure (eg; attached toilets, partitions between labour tables). According to facility assessment made in October 2011, most of the L3 facilities meet the norms for equipments but many are currently falling short on infrastructure. However many L2 facilities require up gradation to meet the standards.
- MA MTA Gharas" (Maternity Waiting Homes) have been established in V4 areas through PPP model so as to circumvent the need for emergency transportation. A branding exercise has been under taken for the JSSK along with launch of comprehensive IEC/BCC campaign.

Figure 22 Janani Express at Attabir CHC

- State specific logo for JSSK (branding)
- Branding of complaint /suggestion box
- Branding of Janani Express and empanelled vehicles
- Citizen charter in all health institutions

- Display of names of designated institutions in all health institutions

Observations

- The number of delivery points in the State has increased. The State is targeting for one delivery point for every 30,000 population.
- A total of 1482 MCH centre"s have been planned. (i) 899 L1 where a SAB trained person would be stationed for 24 x7; (ii) 438 L2 where a BEm OC trained person and (iii) 145 L3 where a CEmOC trained person would be available.
- Out of a total 1482 MCH centre"s planned, 1328 MCH centre"s are already in place and are conducting deliveries.
- However, post delivery women are not being kept for 48 hrs at the facilities. Many facilities conducting deliveries do not have running water or attached toilet.
- Performance in terms of some key outcome indicators in Q1 & Q2, 2011-12 shows improvement over the same period last year.
- Pregnant women registered within first trimester for ANC (up from 33.9 % to 39.4%)
- Percentage of women receiving postpartum check-up between 48 hrs and 14 days after delivery (up from 63.5% to 73.5%) However, there are several areas, wherein State"s performance has dipped i.e. pregnant women registered for ANC (from 89.6% to 78.5%)
- Percentage of institutional deliveries has dropped from 64.4% to 57.3%
- Percentage deliveries conducted in public institutions declined from 63.9% to 55.1%
- Women discharged at least 48 hrs after delivery out of deliveries at public institutions also declined (from 36.9% to 25.6%)
- Home deliveries conducted by SBA down from 25.8% to 15.9%
- Out of the 308 maternal deaths reported, 49% (151) were classified as "Others". This calls for better orientation on the importance of reporting maternal deaths and to investigate the causes in detail. State needs to operationalisation the Maternal Death Review mechanisms as per GoI guidelines.

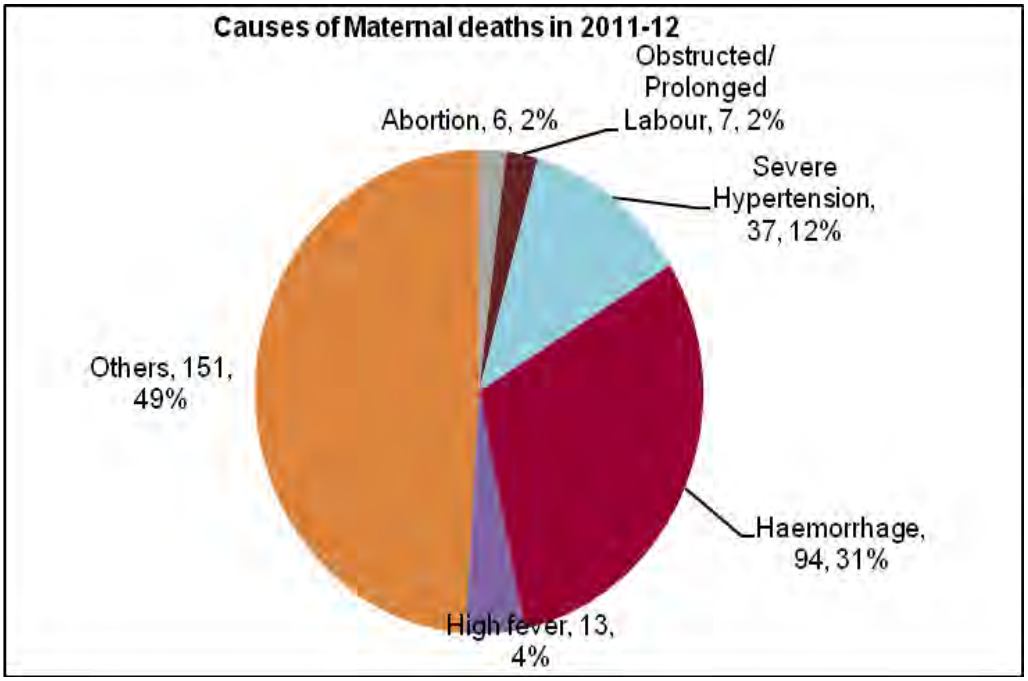


Chart 3.2

JSY

- Though the absolute number of JSY beneficiaries for institutional deliveries has increased from 174112 in 2010-11 to 175134 in the first six months of current year of 2011-12, ASHAs who were paid the incentive has come down from 89201 to 75072 in the same period. The state needs to look into the reasons for the same.
- High proportion of macerated still birth and birth asphyxia are being reported (Rayagada) which indicates good identification and reporting but poor ANC.
- PNC for post delivery and referral for sick newborn lacking.

CHILD HEALTH

State Initiatives

Piloted at Rayagada district

- Standard case sheets developed with Follow up card
- Software based data entry is being done
- Telephone directory of AWWs & ANMs available at SNCU
- DEO informs AWW / ANMs on the day of discharge
- AWW visits newborn & follows up. Data entered in Follow up card
- Web based software being developed

Figure 23 Radiant Warmer at Sohela CHC

Table 3.5: Status of SNCU in the State

SNCU -II							
District	Mandate	Progressive target 2012	Functional Status			Under Process	Remarks
			Beds		Total functional		
			12	24			
High Focus	21	17	8	1	9	5	2 by Nov-11 3 by Feb-12
Other	13	7	5	2	7	3	3 by Feb-12
Total	**34**	**24**	**13**	**3**	**16**	**8**	

Table 3.6: Status of NBSU in the State

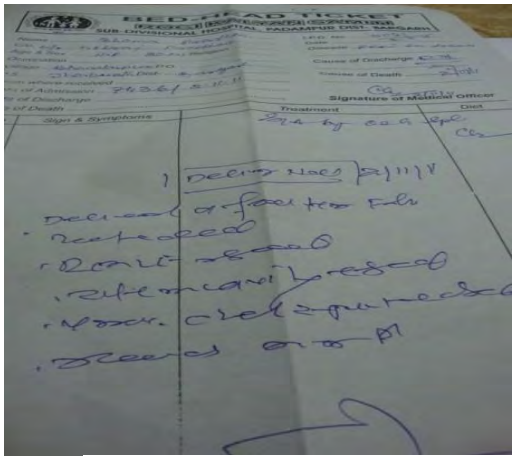
NBSU							
District	Mandate	Progressive target 2012	Functional Status			Under Process	Remarks
			Beds		Total		
			2	4			
High Focus	49	25	15	2	17	10	By Feb-2012
Other	63	25	5	3	8	15	By Feb-2012
Total	**112**	**50**	**20**	**5**	**25**	**25**	

Table 3.7: Status of NBCC in the State

District	Mandate	Progressive target 2012	Functional Status	Remarks
High Focus	908	531	248	Campaign planned in the month of Dec-2012
Other	719	467	204	
Total	**1627**	**998**	**452**	

Observations

- State has reported nearly 67.4% live births (2.90 lakhs) as against the estimated live births (4.30 lakhs) in the first half of 2011-12.
- Proportion of Newborns breastfed within one hour has increased from 62.2% in first 6 months of 2010-11 to 85.7% in 2011-12.



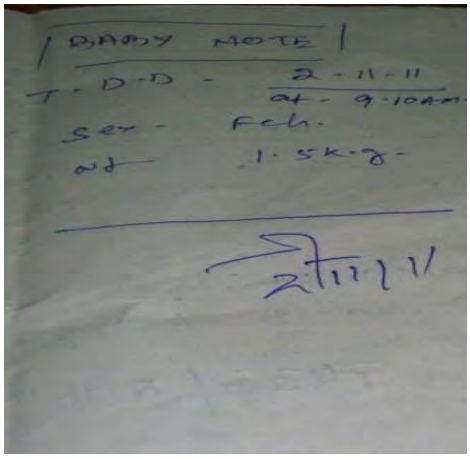


Figure 24Figure 25: Case Sheet from SDH Padampur showing no referral to specialist for LBW

- In the same period, the number of newborns weighed at birth has increased from 66.0% to 83.0% in the current year:
- Pediatricians were present at DHH/CHC Muniguda and they reported high LBW and asphyxia cases.
- Cases of malnourishment and malaria cases seen at Rayagada.
- SNCU were functional at most facilities but NBCC and NBSU were lacking in general.

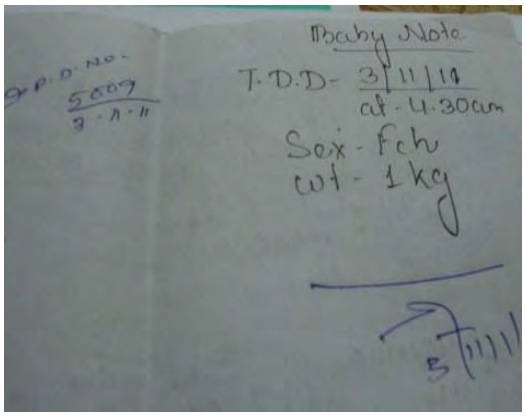


Figure 25 Case sheet from SDH Padampur with no referral to specialists for LBW

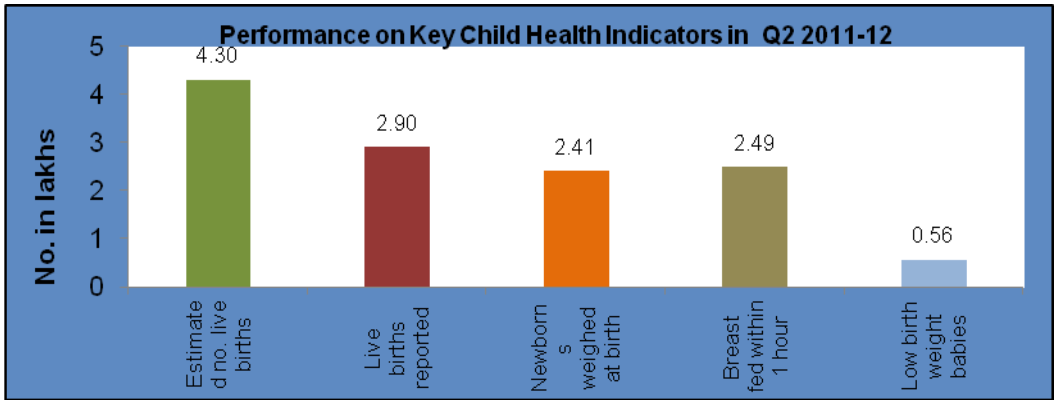


Chart 3.3

Recommendations

- Standard Operating procedures (SOP) for newborn should be made mandatory at all facilities providing institutional deliveries.
- Setting up of NBCCs should be prioritized over other newborn facilities, since essential care at birth remains the most important intervention and only one third of the target has been achieved so far. A clear plan of action for NBCCs should be developed at state level and reviewed on monthly basis.
- The community based programme and facility based care of children with Severe Acute Malnutrition requires to be strengthened in order to benefit from fixed day approach to addressing malnutrition at primary health facilities**.**
- MCP cards should be reviewed after 6 months as the same information is already being fed into MCTS and is available in registers both at SC and AWC (and probably will bring no value addition, but entail additional cost and effort).

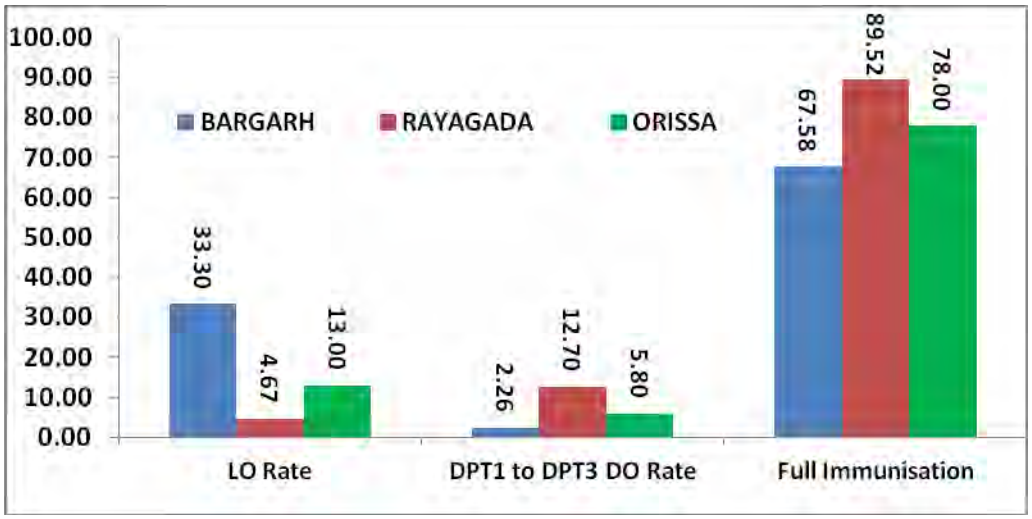
IMMUNIZATION

State initiatives

- The state currently has 1157 ILR points, 1 State Vaccine Store, 8 Regional Vaccine Stores and 30 District Vaccine Stores. Across the health facilities visited in the two districts (Bargarh and Rayagada), the cold chain equipment is functional and stock registers are well maintained.
- External monitoring strengthened through 3 medical colleges and PHFI to improve quality of RI, cold chain management and vaccine and logistics management
- Internal monitoring and supervision strengthened by using block level, district level and state level RI monitoring teams using structured formats and updating on standardized excel sheets.
- RVCCM, DVLM posts created in all districts, RVCCCM in all RVS, DVLM posted in 11 districts. 4 WIC Operators posted at each RVS – trained on RI.
- 30 CCT and 27 ICA in position.
- Pipeline stock of vaccines being reported from ILR points – for the first time, vaccine pipeline stocks included in stock management.

- State Vaccine store expansion completed and being used.
- Training of staff to improve quality immunization – Training of Health Workers, Medical Officers, Cold chain handlers and at district and block level supervisors through Training of trainers.

Chart 3.4



Observations

- Full immunization coverage for the first six months in 2011-12 was 70.5%, a drop of 13.3% age points as compared to the same period in 2010-11.
- OPV zero dose coverage rates were low at 45.0%.
- Though immunization sessions held have remained the same as compared to last year; the immunization coverage rates have come down which suggest missed opportunities.
- The state has taken various steps to increase immunization coverage. These include development of micro plans for RI sessions, introducing Alternate Vaccine Delivery System and establishing a monitoring system at various levels. An important step is the Vaccine logistics assessment of stocks through MIS, which helps in logistics management.
- No cases of Whooping Cough has been reported since last two years; only a total of 5 Diphtheria cases reported in 2010-2012, while 3238 cases were reported in 2009-2010. No cases of Hepatitis B and Childhood Tuberculosis have been reported over last three years.

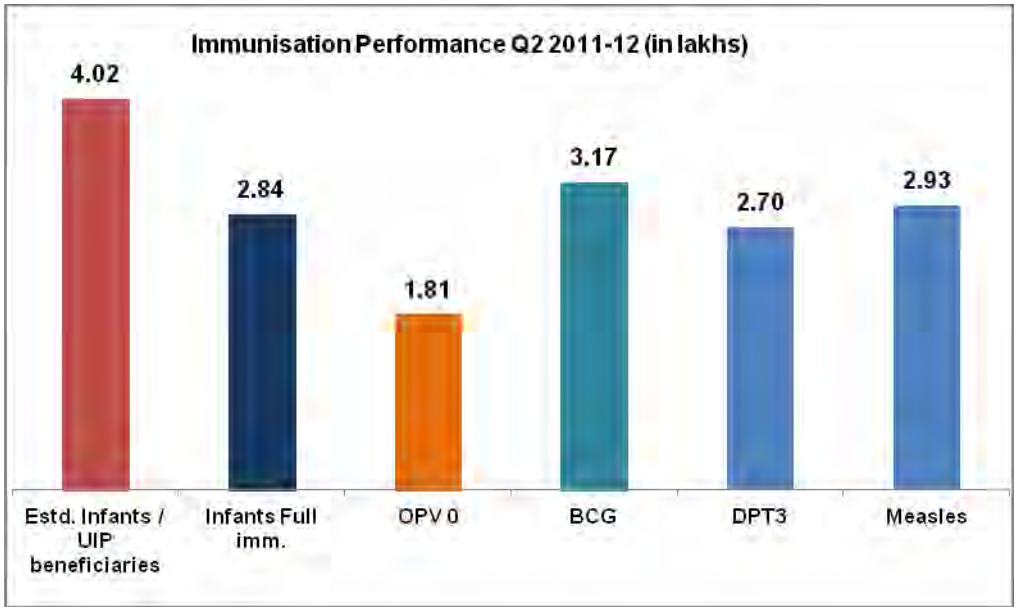


Chart 3.5

COLD CHAIN /ILR POINTS/ DISTRICT VACCINE STORE:

All ILR points visited in the district had functioning equipments (Deep freezers, ILR) and with adequate power backup. Recommended temperature was being maintained. Stock registers are well maintained**.**

Recommendations

- Immunisation needs to be improved in the State. The Mother and Child card should be used to track all children.
- Outreach sessions should be utilized to improve immunization and to reach out to missed children.
- ASHAs should be tasked to ensure that all children in their respective villages are immunized.

FAMILY PLANNING

State Initiatives

- Development & Implementation State „Family Planning Plan Document" (2011-12) addressing local specific issues.
- Orientation & Sensitization of „Data Personnel" in an attempt to enhance their skills on „FP Data Interpretation & Analysis" leading to quality Data Management.
- Rapid Assessment of Family Planning Services in L-3 Institutions for System Strengthening in order to promote quality FP services through Facilities.
- Commissioned a „Formative Study on Acceptance & Use of IUCD in Orissa to Derive Empirical Evidences" for promoting IUCD both as a spacing method & an alternative for sterilization.
- To improve quality of FP Data Management & Analysis, Govt Medical Colleges have been engaged for Conducting „FP Data Validation Exercise".
- Extensive „Community Mobilization Campaign" through Innovative Folk media

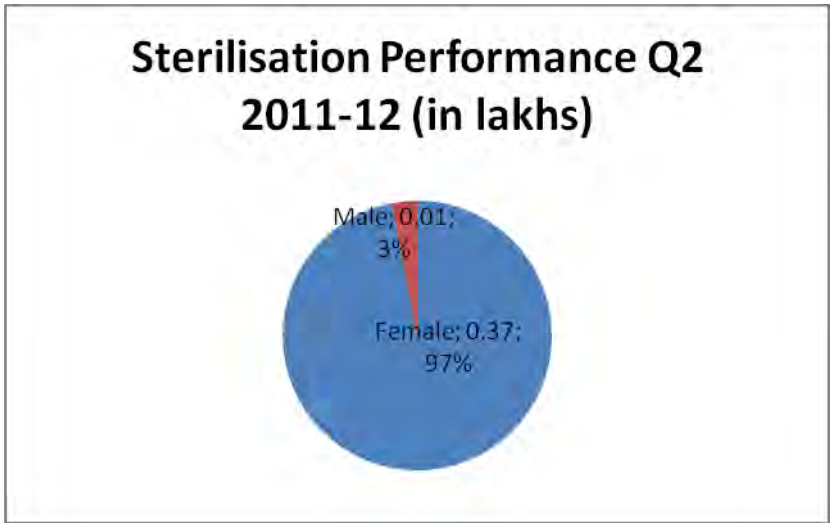
- Engaged NGOs across the state through Partnership in expanding the ambit of FP services.
- Quarterly Review of Poor-performing Districts by Director of Family Welfare resulted in improving their performance in providing FP Services.
- Review & Capacity Building of PPC & Labour Room Staff has increased the Post-Partum & Post-Abortion FP Service uptake by Clients.
- Programme Officers & Operating Surgeons were oriented on „FP Programme Guidelines" has resulted in prudent clinical practice in FP Service Delivery.
- Strengthened 16 district level Quality Assurance Committee
- „Home Delivery of Contraceptives by ASHA at the Door step of Beneficiary" Scheme launched in 18 High Focused Districts.

Table 3.8: Achievements in Population Stabilization Fortnight-2011

Sterilization			*IUCD*		
ELA	***Achievements***	***% of Achievements***	***ELA***	***Achievements***	***% of Achievements***
65520	**28088**	**42.86**	**53850**	**41933**	**77.87**

- State has reported an increase in number of sterilization cases in the first half of 2011-12 as against same period last year (from 35398 to 38283) Male sterilizations account for a slender percentage (3%) of the total reported sterilizations:
- However by end of Sept 2011, the Sterilization achievement was the 27.72 as against a 35% of ELA and for IUCD, the achievement was 44.35 by end of Sept as against a 50% of ELA)

Chart 3.6



Observations

- Birth Rate shows a declining trend since 2005 and currently stands at 21. Total Fertility rate stands at 2.4 while the unmet need is estimated to be high.
- Female sterilization and IUD insertion has gone up only very slowly; male sterilization has also not picked up significantly in FY 2009-10 and 2010-11. However the state performance

during the Population Stabilization Week in 2011 has been „excellent", with achievement of 43% of sterilization ELA and 78% of IUCD insertion ELA.

- The state has taken steps towards improving the performance on the „family planning" front. A SMS based „C-LMIS" (Logistics and Supply Chain System for Contraceptive Products) software has been developed.
- Paramedics are being updated on contraceptives, staff in labor rooms is undergoing capacity building and data personnel are being oriented to better interpret and analyze the FP data.
- Fixed Day services are being planned across the state.
- More emphasis on female sterilization
- Fixed day sterilization is not fully established at all facilities.
- MTP and minilap training have not been conducted.

Recommendations

- There is too much focus on sterilization especially on female sterilization. Female sterilization has its accompanied morbidity and mortality. Male Sterilization should be recommended instead which has least morbidity and no mortality.
- Spacing methods should be promoted specially among younger couples. Spacing between children is an evidence based intervention for reducing maternal and child mortality. Incentive could be considered for promoting spacing.
- Distribution of contraceptives through ASHAs should be promoted more vigorously.

ADOLESCENT HEALTH

State Initiatives

- Adolescent Health programme has been taken up in 19 districts of which 9 districts have the SABLA programme as well.
- RTI/STI screening at *Kishori Mela* at VHND every 6 months.
- Mass de-worming at *Kishori Mela* every 6 months
- Anemia Control – IFA tabs are distributed

Observations

- Till date about half of the Medical officers (227/415) have been trained. Only one fourth (1033/4500) of the other staff (ANM, LHV, SN, ICTC Counselors) have been trained.
- 35 Adolescent Friendly Health clinics are functional against a target of 135. Data from the attendance registers show that it is mostly girls who are accessing services; only 15% are boys.

Recommendations

- Considering the adolescent friendly clinic is the only avenue currently available to adolescent boys for information advice and counseling, special effort should be made to create awareness about these services among boys and increase the mobilization efforts through schools and through community workers.
- Adolescent Anemia Control Programmed is being implemented through NRHM –ICDS convergence with technical support from UNICEF. IFA and Albendazole are being procured through NRHM and weekly supervised administration of IFA (at AWC) is being coordinated through ICDS. Similar initiative can be extended to schools if it is not already being implemented through the School Health Programme.

3.8 NATIONAL DISEASE CONTROL PROGRAMMES (NDCP)

The State is doing quite well on the National Disease Programme front. The case load and deaths due to diseases over the years have been declining. The details of the programmes being implemented under NDCP are as follows:-

3.8A NVBDCP

State initiatives

- Involvement of all related Stake holders to synergize the programme.
    - All ASHAs and AYUSH doctors are being trained for early detection and prompt treatment. (33619 ASHAs & 646 AYUSH doctors)
    - Use of MHU for detection and management of cases in difficult to reach areas.
    - Involvement of Community Based organization to help in early detection and treatment.
- Districts prioritized on the basis of endemicity.
- Fund allocation on the basis of endemicity and fund utilization.
- Protection of vulnerable population through LLN especially to pregnant women.
    - (18.99 Lakh LLN distributed)
- Indoor residual spray and release of Larvivorous fish in 200 high endemic blocks.
- Mass awareness campaign
- Special vulnerability plan of 13 high endemic districts (world bank)

Figure 26: Dry Tank for gampusia fish culture at DH Bargarh

- VHSC (13,000 GKS) involved in LLN distribution.
- As a result of the above initiatives the:-
    - Malaria Mortality in the State has declined by 73 %. However cases of falciparam are not showing any decline.
    - Dengue cases reduced by 52 %
    - There are no Kalazar cases reported.

Observations

- Rayagada district is one of the high burden districts so far as malaria is concerned. Majority of cases are from two blocks - Kashipur and Chandrapur.
- Good vector control measures (LLIN distribution & IRS) and good surveillances (266 HW (F) workers, 40 HW (M), 1331 ASHAs 261 AWW, 17no. of VSS animator & 39 nos. of AYUSH doctors trained in malaria detection and management) the disease burden due to malaria has come down drastically. Deaths have declined to 8 (eight) as against 20 (twenty)

last year. Kashipur block which earlier reported highest no. of deaths in the district has reported nil death till date.

- The district received 80,000 LLIN from Govt, which were distributed in cluster approach, mainly in the two high burden blocks of Kashipur and Chandrapur.
- 19,224 LLIN under "MO *Masari* Scheme" under state initiative supplied to pregnant mothers in different blocks. With introduction of ACT as the prime line of treatment of all the Pf. positive cases and use of LLIN by a good no. of recipients, there is a good impact in containment of the disease.
- There are 5 nos. of MTS against 6 sanctioned, and this number is not able to monitor all 13 blocks in the districts.
- There was outbreak of dengue fever in the district. 73 blood samples were sent to Dist. Head Qtr. Hospital, Koraput, MKCG Medical College, Berhampur (where NIV Kits are available) & 8 were positive & 2 death cases occurred. With intensive vector control measure the disease was brought under control.

Figure 27: Need of Bednets for new born

- The District is not having adequate supply of ACT & RDK against the actual demand; supply chain needs to be strengthened.
- ASHAs are getting regular incentives for Malaria activities as ascertained from interaction with ASHAs in the field.
- Lack of LLN for the inpatients and wire mesh for windows are affecting in malaria case reduction.

Recommendations:

- All private practitioners (Allopathic / MO ESI Dispensary / MO Accredited Hospital should be sensitized to Anti Malarial drug policy 2010
- Private practitioners and nursing homes to be trained on New NVBDCP guideline and drug policy to act as FTD.
- District level Officer to posted.

3.8B REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

The State is making good progress in RNTCP. 3 DOT Plus wards have been established in 3 Medical Colleges. Reference laboratories have been made upgraded. Mobility support for supportive supervision at all blocks. 50 additional microscopes to strengthen case detection at referral laboratories procured. Pregnant women were found to be lying along with malaria affected case without LLN. Case detection of TB cases in migratory population (Rayagada) needs to be strengthened as cases of HIV positive are on the rise.

State initiatives

- Sub centre wise mapping of suspect"s cases referred and cases diagnosed.
- Acting tracking of contacts of sputum positive cases.
- Sputum collection centres opened in areas which where inaccessible.
- Home visit and supervision of DOTS by health workers.
- Medical Colleges involved.
- All TB cases screened for HIV to rule out mix infections.
- HR increased (LT increased from 505 to 549, MOTC increased from 101 to 109)

Observations

i. During the 3rd quarter of 2011, only 9 (Nine) out of total 30 districts are having NSP case detection rate at desired >70%, the performances of other 21 districts are below par and are responsible for pulling down the overall performances. 9 (Nine) districts are having NSP case detection rate at <49.9%.

ii. Out of 3 nos Sanction of STLS post, one post is lying vacant since one year.

iii. Regarding Lab. Technicians out of 20 DMCs 3 nos of LT post lying vacant since 2010 (i.e ESI J.K.Pur, Ambodola and Puttasing). The work is managed by the adjacent LTs of DMCs. So, 3 LT posts may be sanctioned under RNTCP on contractual basis.

iv. Funds are getting released for programme from SHS in time (RNTCP account being sub account under main NRHM account).

v. Financial Managements guidelines of NRHM are being shared with programme officers.

vi. In Bargarh, out of total 19 (nineteen) PHIs under 3 (three) TUs, the suspect referral rate is below 1 in 8 (eight) PHIs.

vii. The NSP Treatment Success Rate also is below the desired level, resulting into pulling down the overall performances of the state.

Recommendations

- Strengthen surveillance and monitoring. Increase the reach of laboratory facilities by expanding the laboratory network.
- Gaps in critical manpower should be filled at the earliest.
- A District level Programme Officer with exclusive responsibility for implementation of RNTCP should be posted.

3.8C NATIONAL PROGRAMME FOR CONTROLLED BLINDNESS

State initiatives

- Strengthening of cataract surgery at districts
- Capacity building of MOs /SN etc at district level
- Support of NGOs

Table 3.9.Cataract Cases

	2007-2008	*2008-2009*	*2009-2010*	*2010-2011*	*2011-2012 (up to 10/2011)*
Target	2960	3577	2945	2945	2945
Detection	1250	1439	1946	1147	448
Operation	1044	1210	1771	937	348

Observations

- The State is not performing to its optimal level. (17 out of 58 positions are lying vacant)
- There are at present 57 Eye Operation Theatres functioning in the State (30 DHH and 25 SDH).
- The total eye surgeons in the State are 58 posted at various DHH.
- Out of a target 200,000 Eye Operations, 37608 Eye Operations were conducted. As against a School Eye Screening target of 45, 0000 – 56, 4225 screenings were performed and 4198 students were provided glasses.
- There is only 20 beds in district headquarters hospital, 10 bedded hospital at SDH is unsafe for use.
- There are 2 Surgeon only, No NGO Hospital, Private Hospital cataract performance is poor, 15-30 cases per year. No Staff Nurse, no driver for Mobile van in Rayagada district. If a driver is provided from NRHM, it will be convenient to shift the patients from remote area by DBCS vehicle.
- Two Eye Surgeons have to perform other duties like emergency managements, post mortems, attending boards etc.
- The Senior Eye Surgeon being senior has to manage the work of the wing officers like ADMO (PH) etc. The government has announced Rs.25000/-P.M as contractual salary to Specialist, which is quite inadequate and Surgeons are not willing to join with this remuneration.
- Govt. of India is providing Rs.1500/- for office assistant but the office assistant is having so many other responsibilities along with DBCS. So reporting etc is delayed, if a contractual Data Entry Operator with Accountant is provided by NRHM, then the work could have been easier.

Recommendations

- Incentive could be considered for Surgeons and Staff participating in Eye camps. Asst. Surgeon, O&G Specialist and staff gets incentives for Vasectomy and Tubectomy but there is no provision of incentive for Eye Surgeon conducting a national programme.
- Announcement of incentive may give the programme a boost in achievement in government sector

3.8D NATIONAL LEPROSY ERADICATION PROGRAMME

The State has achieved leprosy elimination but 15 districts are still to achieve this. The case detection of new cases is going up and proportion of child cases is high indicating the presence of active transmission in some pockets in the State. The backlog of disability cases is increasing showing that cases are being diagnosed late as against early detection.

State Initiatives

- Focus on 15 endemic districts and 111 blocks
- Capacity building of ASHAs
- Urban Leprosy Eradication Plan
- Monitoring and supervision at State and district level
- Plan for reconstructive surgery Disability prevention and medical Rehabilitation (DPMR)
- Intensive cased detection drive in 50 high endemic blocks from 2012

Observations

- MDT drugs are readily available at every PHCs/CHC and DHH.
- Prevalence rate at Bargarh is 2 per 10000 and at Rayagada is 0.40 per 10000.
- The district wise annual new case detection rate (ANCDR) at Bargarh is 37. 72 per 100000 and at Rayagada it is 5.33 per 100000 populations.
- 17 districts have a prevalence rate of more than one per 100000 with Bodh district having the highest prevalence of 3.61
- Kendrpara has the lowest prevalence of 0.23 per 100000.
- Availability of funds and drugs at all levels – the budget received its adequacy and its utilization and the drug logistics.
- DLO Post is vacant and MODN not yet selected.
- The DPMR implemented as per guideline in entire district
- MCR footwear: - GI MCR footwear supplied by State Leprosy cell and being supplied to Beneficiaries.
- New cases are referred by ASHA, HW (F) to block CHC. Block CHC MO i/c screen cases and Validate done by MODN Rayagada ADMO (PH) then after MDT is given.

- According to patients cards Master registers are maintained by block CHC Pharmacist for respective blocks and DHH Pharmacist for Rayagada Municipality.
- The block Pharmacist Indent MDT BP from central store Pharmacist at DHH.
- According to their indent, district central store Pharmacist supplying MDT BP to all blocks.
- The new case detection rate may increase due to involvement of ASHAs at grassroots level.
- At Sub-center level case detection and follow up and IEC activities are done by block HW (M&F) and ASHA.

Recommendations

- The State should continue the good work under NLEP.
- The focus should be on those districts which have a high prevalence rate.
- DLO post should be filled at the earliest

3.8E INTEGRATED DISEASE SURVEILLANCE PROGRAM (IDSP)

State Initiatives

To address out breaks the State has adopted the following initiatives:-

- Multi Sectoral approach
- Identification of vulnerable pockets
- Health Education
- Drinking water and sanitation facilities improvement (for diarrhoeal out breaks)
- Strengthen routine surveillance and reporting

Observations

- The State has one surveillance Unit and 30 district surveillance units functional with IT manpower.
- The State surveillance officer and district surveillance officer and state and district epidemiologists are in place. 26 posts of Epidemiologists are lying vacant.
- All districts are reporting on time with the exception of two districts (Bargarh & Keonjhar). Early Warning System (EWS) is in place and is reporting outbreaks.
- Out of 42 weeks – 39 weeks EWS report sent to centre.
- Out breaks reported –
    - Acute Diarrhoea – Ganjam/ Keonjhar Kurda etc
    - Measles outbreak – Malkangiri/ Koraput etc
    - Anthrax – Koraput/ Sundergarh etc.
- The IDSP data are analyzed at District level every week & the epidemiological situation assessed.

- Though the State claims that all posts were filled the District Surveillance Medical Officer & Epidemiology posts are vacant.
- As the IDSP data are not analyzed at Block level, the Block RRT cannot take action timely.The Surveillance units are examined at various level i.e.
    i. At Sub- centres level data are collected by Health Worker & examined by Sector MO in Sector meeting.
    ii. At Sector level data are prepared by Pharmacist & examined by Block MO I/C.
    iii. At Block level data are gathered by Block Pharmacist which is examined by ADMO (PH) at district level.
- The IDSP Early Warning report generating every week (even if "Nil" report also) & submitted to the State Surveillance Unit in time.
- The District & Block Rapid Response Team have investigated all the 16 nos. of Media Alert (including one media alert from Central Surveillance Unit) & 3 nos of rumours, and submitted the investigation report to the State Surveillance Unit within 48 hours in the Year 2011.
- For the newly appointed AYUSH Doctors, MHU Doctors, Pharmacist of MHU, Health Workers, BPOs are not yet trained on IDSP.
- Refresher training for the Medical Officers & Pharmacists is also required.
- The trainings are also required for the other sector Hospital Staff (Medical Officer & Pharmacist).
- In the year 2011 two other sector hospital (JK Paper Mill Hospital, J.K. Pur & Christian Hospital, Bissam Cuttack) have been included for IDSP weekly reporting. Three hospitals (IMFA Hospital Therubali, ESI Hospital J.K. Pur & Railway Hospital Rayagada) are being considered for future IDSP weekly reporting.
- The analysis reports are shared with district administration in the Monthly Review meeting & also at the State Health Review meeting.
- Weekly reporting of Key diseases done regularly.

Recommendations

- The heath administration at the state and district levels should become sensitive to the possibility of increased demand under the various disease-control programs during the 12th Plan. For example- identification of and planning for the capacity required to implement MDR-TB response etc.
- Malaria control may provide a particular opportunity for a "quick win" in Orissa, where malaria transmission is in many places moderately endemic, and may therefore be amenable to control. Government should consider mass distribution of LLINs which would provide a "community-level" effect, breaking the transmission of the parasite, as well as individual protection, with the potential to substantially reduce malaria incidence. This should be accompanied by ensured access to malaria diagnosis and effective treatment.
- In health facilities, inpatient beds should systematically be covered by LLINs. This should be specially considered for the vulnerable population of. Women and children.

3.9 GENDER ISSUES & PCPNDT

State Initiatives

- 13 districts identified with sex ratio below the State average.
- A State gender and equity cell established
- Odisha State legal Service Authority for capacity building of officers and stake holders.
- Workshop for O & G specialist through FOGSI
- Strengthening of Institutional mechanisms through:-
- child sex ratio mapping
- Monitoring of ultrasound clinics
- Appropriate action on defaulter clinics
- Mobile US machine banned in the State

Observations

- Child sex ratio has decreased by 19 points from 953 in 2001 to 934 in 2011
- 601 clinics have been registered in the state under the Act
- A total of 19 ultrasound machines have been seized and 17 prosecutions launched against violations of the PC & PNDT Act
- Against the quarterly budget of Rs. 3.35 lakhs under „PNDT & Sex Ratio", the State has reported nil expenditure.
- The role of ANMs and ASHAs is crucial in facilitating access to services by girls/women and improving the health/nutrition of girl children.
- Under NRHM JSY/JSSK and referral transport (Janani Express) have increased utilization of maternal health care services.
- Expansion of basic health services has resulted in substantial increase in number of women health workers, notably nurses, ANMs and ASHAs.
- Issues of gender discrimination and security are hardly considered. The team visited a young ANM who felt threatened by a group of young men in the community, and it required the mission to get the supervisors/administrators to promise to intervene, despite the fact that it was apparently a long-standing and well-known problem.
- The career path for female health workers is unclear as all mid- and upper-level management of the health system is filled entirely by males. The team observed a prescription for ultrasound issued by a government doctor (DH Baragarh).
- A very encouraging fact is that Rayagada district has a child sex ratio of 959 (in 0-4 years age group), which is higher than the State. The district has four registered Ultrasound machines only.

- District Task Force and District Level Advisory Committee have been formed under the Chairmanship of Collector and District Magistrate and representation from the police (Deputy Superintendent) besides representatives from DPMU, Directorate of health services and Social welfare officer. The committee has met once in 2010 and then in 2011. Independent inspections have been carried out for one clinic in 2010-11 and two in 2011-2012.

Recommendations

- A plan for tracking and responding to gender-related security threats and incidents affecting female health workers should be developed. The first step is to collect information from all (or a sample) of female health workers in the state on the incidence of such problems.
- Gender sensitivity training for mid- and upper-level management in the health system should be done.
- Career paths for female health workers should be defined, assessed and improved, in order to improve their potential for further training and advancement.
- The creation of health facility management and public health administrator cadres/posts could provide a pathway into mid- and upper-management for non-physician female health workers.
- Implementation of the current PCPNDT strategy should be a priority. At the same time the state and central governments should critically examine the extent to which this strategy is likely to be effective and develop supplementary actions (i.e. intensified mass communication, IEC on the issue).

3.10 PROGRAMME MANAGEMENT

State Initiatives

The State is recruiting fresh graduates and is training them to become managers and placing them after a bond of 3yrs at districts to man the PMUs

- 118 Hospital/FRU Managers recruited
    - fresh graduates trained for 6 months and employed after filling of 3yrs bond
    - SPMU & BPMU posts are filled

Observations

- After introduction of NRHM, investment in the health sector has increased manifold. Unilateral increase in health budgets will not be sufficient to attain the health outcomes unless sound and enabling structures, institutions and adequate manpower is in place. In order to provide techno managerial support to programme, accounts and data analysis and monitoring for Mission activities; there is a programme management unit at block and district levels. DPMs, Accounts Managers, DHIOs for MIS are in place in all DPMUs to facilitate overall management.
- In addition to the staff available, all blocks that have initiated MCTS (Mother and Child Tracking System) will have an additional Data Entry Operator/MIS Coordinator and a Community level mobilizer. The managers are good, dedicated, but lack of supervisory skills, which required to be supported by the technical knowledge of regular health services officers, both at the State level and at the district level. The gap between the Programme Officers (State & district) and the SPMSU/ DPMSUs was evident without any effort. Annual Performance Appraisal of Management staff has been shifted from „On line examination" to „Composite Index".

Recommendations

- Supervisors and administrators should be accountable for supervision and support to the health facilities/workers under their responsibility. Training and tools (i.e. checklists, guidelines) should be provided.
- The state and districts could consider regular (six-monthly) "mini-CRMs."

3.11 PROCUREMENT SYSTEM

State Initiatives

To make available good quality drugs and medical consumables at the right time and as per the required quantity to patients in government health institutions, the State has Drug and procurement policy in place since 2003.

The STATE DRUG MANAGEMENT UNIT (SDMU) is in place with a mandate to look after:

- Drug Management policy on Procurement, Distribution & Quality Control
- Essential Drug List (310 drugs in Generic Name & 10 Combipacks)
- Essential Drug List (Children) 2011 (165 drugs in Generic Name)
- Standard Treatment Guideline: Treatment protocol of 78 most common diseases.

While these were seen in districts, the team could not substantiate the same with State during the visit.

Figure 28: Newly procured Baby warmer + photo therapy unit

Under NRHM the State shares the major portion of the drug budget; resulting in a remarkable increase in the budget allocation of the State over last five years. Other contributions to the drug budget include non-plan fund, TFC and OHSP. The graph below clearly indicates that the drug budget is steadily increasing year after year.

The drug budget for 2011-12 is (Non-Plan): 4740 Lakhs out of which 80 % is under SDMU (80%) i.e. 3777 lakhs and Districts & Medical Colleges (20%) : 963 Lakh. State BCL (Bedding, Clothing & Linen) is for Rs. 150 lakhs. Following is the detail of equipment, drugs etc.

Table 3.10: Budget for Equipment, Drugs & supplies

Item	Budget (*lakhs)*	Level of procurement
Equipment	720.44	Decentralized (At District Level)
Drugs & Supplies	1165.66	Centralized (Majority of the Drugs)
Total	**1886.10**	

For inventory management Web based application software ProMIS has been functioning since 2010. To Deal with Stock entry, tender evaluation, payment processing, Purchase order etc. procurement of Drugs & consumables standalone application software named DIMS is also in use which takes daily backup by email from Districts and gets updated at SDMU Govt. of Orissa

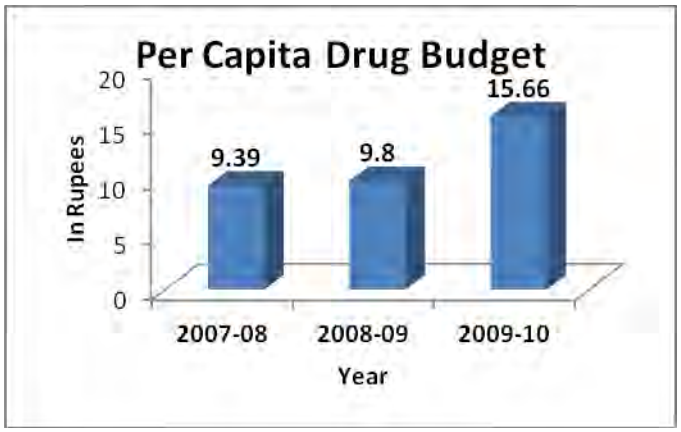


Chart 3.7

While the drug budget in 2007-08 has almost doubled in 2009-10, the percentage of utilisation of the allocated budget varies from 83.72 % in 2007- 08 to 96.91% in 2008 – 09 and 88.37 % in 2009 - 10. .

While NRHM contributes 40% of the total drug budget, non-plan fund shares only 20%. Under the non-planned fund about 12.53 crores is being allocated from the State budget. The per capita drug budget has massively increased.

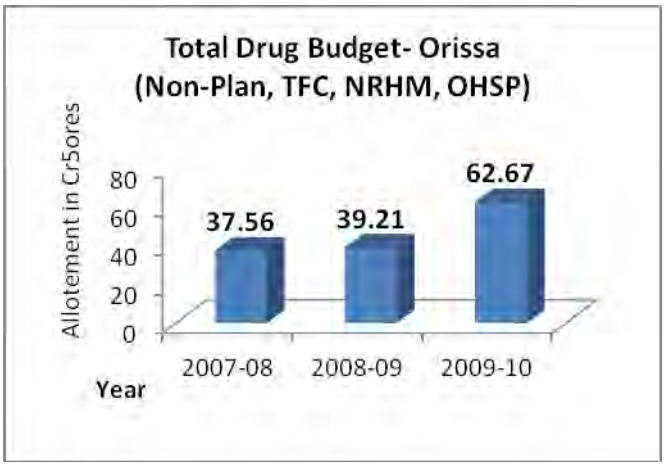


Chart 3.8

Observations

- Essential drug list was available at all facilities.
- All facilities visited had adequate stock of drugs and drugs were found to dispense to beneficiaries.
- Janaushadi is in place to reduce out of pocket expenses.
- There was no stock out at any facility visited.
- However the inventory management was weak.
- Proper storing facilities were also not in place.

Figure 29: Excellent Dispensing at Bargarh

RECOMMENDATIONS:

- All Pharmacists should undergo inventory management training for better utilization of stocks.
- The State has requested for vaccines supply to be made every 6 months rather than qtly. This will help them to plan immunization sessions much in advance. The irregular supply from centre has caused problems in planning regular sessions.
- Good practices by pharmacists should be appreciated and replicated at other places.

Figure 30 List of Essential Medicines displayed

3.12 USE OF INFORMATION TECHNOLOGY (IT)

e-Blood Bank

- e-Blood Bank system is a web based blood bank application for tracking and tracing system of blood collections, Issue & disposals, including inventory management. The application facilitates automation to the entire work process of a blood bank.
- It features: Blood Collection, including Donor Information Management Blood Issue, Blood Stock Management, Inventory/Assets Management, Camp Management, User Profile Management, and Instant Citizen Services through m-Governance.
- Currently e-Blood Bank has been implemented in two major blood banks of Orissa, i.e in Capital Hospital, Bhubaneswar and CRC BB, Cuttack.
- Any citizen can get the updated blood status of a blood bank by web or through SMS to know the availability status of a particular blood group.
- It needs a robust publicity through print and electronic media. At least 10 (Ten) mobile phone users were interviewed in Bhubaneswar regarding the availability of such services through sms and unfortunately none were aware of.

  Website: (http://bbmis.nrhmodisha.in)

e-Swasthya Nirman

- ***e - Swasthya Nirman*** is an web-enabled system, developed to track and trace the physical and financial progress of all construction activities undertaken by NRHM at State, district and block level. This online application integrates all activities of construction unit such as forecasting, tender processing, work execution, monitoring of financial utilization, user tracking, allotments etc.
- It features Project Code Wise physical work progress and Financial Expenditure, District wise physical work progress and financial expenditure, State level users can centrally monitor, State/district Users can easily track and trace the physical Work progress and Financial Expenditure for every project.
- The Application has been developed, hosted and training has been imparted to all JEs for necessary updating. Initial hand holding, supervision and monitoring is required for proper implementation, as timely updating of different works by the concerned JEs is crucial.

  Website :(http://cms.nrhmodisha.in)

Drug Testing and Data Management System

- This Application automated the day-to-day work processes of State Drugs Testing and Research Laboratory (SDT&RL) The Service of the System will be extended to citizens, who desires to submit their samples at SDT&RL and get report online
- Receipt and withdrawal of sample, Diary of samples, Preservation in sample section, Testing & submission of Test reports, Disposal of the sample, Maintenance of Reference standard /

Working standard. The Application has been developed, hosted and training has been imparted to all officers of SDT &RL (DC, ADC,PSO, GA, SLA and Drug Inspectors).Tentative date of formal launching- 28th November 2011

Website (http://dtdms.nrhmodisha.in)

MHU Track

- A GPS based tracking system has been developed and implemented at Rayagada District on pilot basis. Currently, the system has been piloted at Rayagada District
- It helps in real-time tracking of the MHU with local route map, speed and mileage, unauthorized travels/ deviations, warning system to the MHU operator, control panel for the administrator

Website (http://mhutrack.nrhmodisha.in)

e- Attendance

- The attendance of the staffs of all DHHs and Medical colleges are being captured through time based attendance system (Bio-metric device), installed at all locations. It"s going to be linked with payment of salary/ compensations.

Website (http://e-attendance.nrhmodisha.in)

HRMIS

- The Human Resource Management Information System, initiated in February 2010 captures all information of persons working under the contract of the project. It also gives GIS facility for employee tracking.
- All Employees data are being updated at each quarter and the data are being used for HR management and Planning.

Website (http://nrhmorissa.gov.in/hrmis)

Mission Connect

- Under this scheme, selected field level service providers have been provided with CUG post paid SIM cards for better communication and service among employees of H & FW departments. The related cost is being managed from the untied fund of the sub centres.
- It helps in better communication and service delivery, Strengthening MIS and reporting tools, develop interaction between user groups, prompt information sharing during epidemic & other emergencies

HMIS

- This system is supported by NHSRC and running in the state since January, 2009.

  Certain data, eg. Body weight at birth below 1.8 Kg, use of oxytocins, blood units, anti-hypertensive"s, etc in management of complicated pregnancies, etc. are not being generated at the facilities, which is training issue.

  Website: (dhis2.nrhmodisha.in)

MCTS

- This system is supported by NIC and running in the state since April, 2011.

Recommendations

- The state government should urgently remove the printing bottleneck.
- Inculcating a "culture of results" in the health system is not a simple matter, requiring not just guidelines and training, but measures to convince staff and administrators that examining data is useful – and that they are empowered to make changes and decisions on the basis of that data. A pilot project to increase the effective use of data at every level of the system may be considered.
- Adequate efforts need to be undertaken for taking community in stride about these e-initiatives to bring transparency in the system.

3.13 FINANCIAL MANAGEMENT

- The State has generally been regular in submitting its Financial Management Reports. The State has its financial managers at State / District and Block in place. Its utilization certificate for the year 2010-11 has been received.
- It regularly conducts audit of all its NRHM accounts. Auditors are appointed by the State through open tender system. However, the LWE areas have been difficult areas for auditing. The State contribution (15%) is regularly accounted for in the State budget.

Observations

- No diversion of funds during the current Financial Year and is being utilized for the activities approved by the NPCC.
- TDS is being deducted regularly and deposited in treasury.
- E-transfer of funds is in place up to GKS level. The main account is with ICICI Bank and programme accounts at district and block level are with SBI.
- Model Accounting Handbooks are being used up to Block level.
- Monitoring visits by Finance person under NRHM is taking place, however, no monitoring report was not available at district.
- Induction training completed, however on-going capacity building training has yet to be provided to the District Accounts Manager, Block Accountant and Data Assistant.
- Unspent Balance under EAG is still pending with the State.
- The implementation of Tally ERP is pending since 2009.
- The State Programme Management Unit, District Hospital, District Health Society, Bargarh and CHC, Dava, accounts are being maintained through Tally soft ware other than the Authorized Version. This has at places resulted in the data crashing resulting in books being maintained manually.
- RKS meetings are being held, however it is not being held quarterly. For example RKS meeting of the DHS, Bargarh was held twice during the last F.Y. 2010-11 (21.04.2010 and 28.09.2010). During the current F.Y. it was held only once i.e. 18.05.2011.
- Further, it was also observed that in PHC (New), Paikmal, an amount of Rs.1.00 Lakh was released by the Block and the same was utilized without the RKS meeting to approve the action plan.
- Effort are being made to maintain books of accounts at all levels i.e. SPMU, District and Block levels such as CHC, PHC (New) and Sub-centre, however, the financial status is not being updated under HMIS by the District (Bargarh).
- Funds are not being received timely at Sub District Hospital, Padampur and PHC (New), Paikmal. Funds were received only on 19.08.2011 and 27.09.2011 respectively. It appears that the delay is at the district level.
- It is mentioned that „Advances" are not being treated as expenditure.

Recommendations

- RKS Meetings should be held quarterly and not twice a year as it is being done at some place.
- Capacity Building for Finance Personnel should be planned. The State / District should ensure that the training to the Finance personnel including the Block Accountant and Data Assistant, ANMs and AWW takes place on regular basis.
- Implementation of Accounting Software Package is very essential for better financial management. It was observed that during the visit of the team those books of accounts at the block and below are being maintained manually. The accounting software package would help the State in consolidation of FMRs at the State in no time and also help the State to speed up the Auditing process and as well the tracking of funds on regular basis.
- Regular supervisory visits by the officials from the State to the Districts and from the Districts to the Blocks and below would improve the overall Financial Management. Further, the visit report has to be shared with the facilities and compliance be sought with regard to the observations made. The regular visits of the officials would help the utilization of funds also.
- The State / District should ensure that Concurrent Auditor visits the Districts and Blocks on a regular basis. Compliance to the observations of the Concurrent Auditor should be strictly complied with and the Districts should share the observations and compliance with the State.

3.14 DECENTRALIZED LOCAL HEALTH ACTION

The decentralized institutional mechanism of ZSS, BSS and GKS are functioning under NRHM and are actively contributing to the decentralized local health action plan. Care in many villages is supporting the sensitization of community persons on health issues and also reviewing GKS. This is a good model and could be scaled up in other districts.

- The facility-level RKS are active, in some cases making very effective use of the resources available to them (i.e. PHC (N) Ghess).
- Effective action by community-level GKS (VHSC) was not evident during the field visit.
- Although some facilities had "suggestion boxes," there is little evidence that a grievance redressal system is effectively functioning. On the contrary, in several instances during the field visit, community members vocally expressed their unhappiness with health services to the team.

Recommendations

- CARE type of initiative could be considered for other districts.
- Awareness campaign to sensitize PRI members and GKS members.

3.15 MAINSTREAMING OF AYUSH

State Initiatives

- Integration of AYUSH for strengthening of public health care service.
- Involvement of AYUSH in Planning in Dist, Block level etc.
- Co-location & Involvement in all National Prog.
- Essential AYUSH drugs being provided.
- AYUSH doctors are utilizing the laboratory facilities of PHCs/CHCs.
- Separate OPD for consultation

Table 3.11: Human Resources

No. of posts under AYUSH at CHCs/PHCs	Total AYUSH Doctors in position	
Ayurveda	**796**	**688**
Homoeopathy	**680**	**585**
TOTAL :	**1476**	**1273**

Training of AYUSH Doctors for mainstreaming

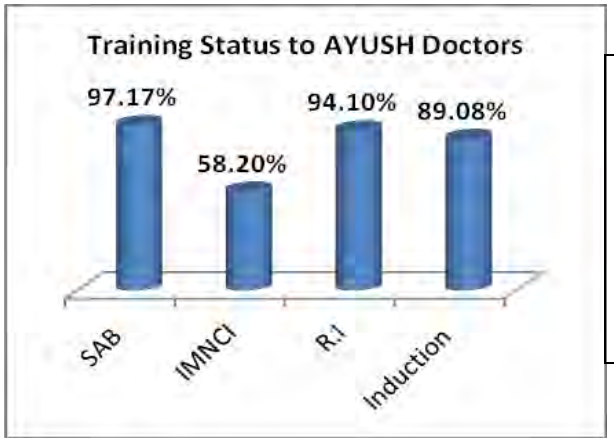


Chart 3.9

SAB	1273	1237	97.17
IMNCI	1273	741	58.20
R.I	1273	1198	94.10
Induction	1273	1134	89.08

Diseases being treated under AYUSH:

Homoeopathy: - Respiratory illness; Skin; Gastrointestinal disorders; Rheumatic diseases and various chronic ailments etc.

Ayurveda: Prevention and management of many life style related chronic ailments; Neurological disorders; Anorectal diseases; Geriatric care etc.

Observations

- There are 11 CHC"s and 34 PHC"s (New) in the Rayagada District. However AYUSH facilities available in 29 centres (5 CHC"s and 24 New PHC"s) and Physicians have been posted (17-Ayurveda & 12-Homoeopathy).
- AYUSH doctor 48 in place/54 sanctioned in Bargarh
- 24 New PHC"s and the Ambulance services are being managed by AYUSH Physicians.
- The Ayurvedic Physicians are SAB trained for conducting normal deliveries.
- The AYUSH Physicians are being involved national programmes in addition to daily OPD work.
- Supply of AYUSH drugs inadequate.
- No AYUSH Pharmacist and paramedical staff available.

Recommendations

- Salary of AYUSH physicians is Rs. 12,000/- per month only, this is causing a lot of heartburn among the AYUSH personnel. It should be at par with other contractual staff (should be at par with MO/Surgeons and not at par with ANM/LHV)under NRHM.
- Timely and adequate supply of drugs
- Capacity building of AYUSH doctors for national programs.
- Caseload dependent posting of AYUSH Pharmacist and paramedical staff

3.16 OTHER ACTIVITIES

a. Public Private Partnership

- Public-Private Partnership (PPP) has emerged as one of the most important strategies for health sector reforms in Odisha. NRHM provides a unique opportunity to expand partnerships with unconventional partners to ensure the maximum outreach to marginalized people and to meet the growing needs for health services including RCH-II and other national health programmes.
- Health service is primarily delivered through doctors, para- medics and contractual staffs across the State. In the context that there is gross inadequacy in health staff across the state, delivery of services to beneficiaries suffers. Secondly, with more than 40% of the blocks in remote and geographically inaccessible areas, delivery of services is often disrupted affecting health indicators negatively. Most importantly, with more than 15 districts affected by left wing extremism (LWF) retention of staff in these areas is becoming a major concern for the health department. In this background, it is critical to opt for alternative and unconventional partners for effective and efficient delivery of health services; especially to marginalized and vulnerable communities. PPP has therefore emerged as an important strategy of intervention under NRHM.
- Health care services are being contracted to NGOs, corporate bodies and philanthropic institutions to facilitate effective and qualitative delivery of services to the targeted population in rural and urban areas and to people in difficult to reach pockets. State specific guidelines have been developed for implementation of PPP programs like PHC management, Urban Health Programme, Program for the Vulnerable community, Janani Express, Maternity Waiting Home, Arogya Plus (MHU run through NGOs), Special focus to V-4 sub centres through the NRHM NGO scheme. The details are given below.

Table 3.12: Details of support from NGOs/Corporates

PPP Programs	***Current status***	***Remarks***
PHC (N) management by NGOs	20 in 10 of districts	Govt. & NGO contributions i.e. 95:05 ratio on project cost.
PHC(N) Managed by Corporate Houses	9 in 4 districts	Out of the corporate CSR budget. No Govt. funds.
Urban Health Project	31 in 7 cities/towns	Out of Govt. funds
Vulnerable community	14 in 14 districts	Out of Govt. funds
Arogya Plus (MHU run through NGOs)	14 in 7 districts	Out of Govt. funds
Janani Express	237 in 30 districts	Out of Govt. funds
Maternity Waiting Home	24 in 7 districts	Out of Govt. funds
NRHM NGO	Process completed in 7 districts for selection of partners	182 SCs under V4 category covering 7 districts though the NRHM NGO scheme

Innovations under PPP

- Management of AROGYA + (MHU +) are operational and providing the preventive, curative and community based health mobilization services in LWE affected areas of the State through the local NGOs. Local steering Committee constituted under the chairmanship of Sarpanch (PRI) to regular monitor the programme at ground level.
- Partnership of urban local body (ULB) has been explored for management of the urban slum health program in Bhubaneswar Municipal Corporation (BMC).

  Specific health issues of the targeted community (fisherman, Tribal‟s, SC, ST etc) has been addressed through the vulnerable community programme

Technical support from the Development Partners/External Agencies

- UNICEF provides technical support through
  - 4 Professionals at the State level
  - 1 Professional each at the district level in all 30 districts
- DFID provides financial & technical support through
  - 4 Consultants provided at the state level
  - 4 Consultants provided each at the district level for the 15 High Burden Districts

Part-IV

STRENGTHS, WEAKNESSES, STATE SPECIFIC ISSUES AND OVERALL RECOMMENDATIONS

4.1 STRENGTHS

A. Management of Primary Health Centres

Health care service delivery in remote PHCs in Orissa remains a challenge due to shortage of trained manpower and poor infrastructure. In this context, DoHFW, Government of Orissa in order to strengthen health care delivery in remote areas, has entered into a partnership with non government organizations to manage PHCs since 2005. The scheme seeks to operationalise non-functional PHCs through Public Private Partnership as an alternative strategy to make public health facilities functional. This is being done as follows:-

- Corporate partnership has been initiated for management of such 9 (PHC) in remote and in-accessible areas. Corporate Organizations are managing the program from their CSR funds.
- Management of health institutions (PHC) in remote and in-accessible areas by the NGOs under PPP.

This is a good example of taking forward health care to remote areas.

B. Management of Urban Health Centres by NGOs

- Cities and particularly urban slums are the fastest growing areas of the country with a decadal growth rate of 5–6% (Census, 2001) as compared to the country"s average of less than 2%. Health indicators for the urban slum population are particularly poor. In Orissa, more than 7.35 lakh urban slum dwellers have little access to primary health care services and cannot afford private care. The government of Orissa has started a PPP initiative in 2008 to contract out the provision of basic health care services including outreach services for urban slum dwellers to NGOs.
- 11 Urban Health Centers (Tier one Urban Health Centre) have been started through NGOs in Rourkela, Balasore, Bhubaneswar, Sambalpur and Cuttack covering about 3,50,000 slum population.

This again is a good example of taking forward health care to urban slums.

C. Janani Express: Referral transport

- In an attempt to encourage institutional delivery and make available transportation 24/7, DoHFW, Government of Odisha launched "Janani Express" in 2008.
- Based on GIS mapping using methods of accessibility, connectivity & proximity analysis, vehicles were based at strategically located government facilities in 18 backward districts of the state to women to deal with emergencies arising during pre and post-delivery periods; as well as sick infants. Vehicles are equipped with basic facilities; drivers have mobile phones so that they can furnish information about the health status of the patient, in advance, to the health facility.*Rogi Kalyan Samittis* also play a key role in the management of the service including contracting, providing fuel, monitoring and paying incentives.

GIS mapping using methods of accessibility, connectivity & proximity analysis, vehicles were based at strategically located government facilities in 18 backward districts of the state is a good use of referral care services to deal with emergencies.

D. Geographic Information system in improved health Management

Emerging technological developments such as remote sensing, Global Positioning System and Geographical Information Systems (GIS) have applications in disease surveillance, control, monitoring and evaluation. In this context, Orissa took several initiatives starting from 2004-05 with technical assistance of Orissa Space Application centre. The GIS has been in used for:

- Generate urban and village level geo database consisting physical, demographic, socio-economic information along with information on health care services and facilities
- Mapping and monitoring the spatial dimension of incidence of epidemics/killer diseases like malaria, diarrhea, TB, AIDS, etc and modeling its spatial trend and determinants so that prioritized pockets can be identified for allocation of resources
- Regular monitoring and updating of health database linked with GIS database especially in relation to programme monitoring, achievement status and gap analysis
- Analyzing the availability and density of health care services and facilities so that regions needing prioritized attention can be delineated and regional imbalances in their spatial distribution can be avoided.
- To map the various indicators of health, women and child development with other demographic parameters at macro to micro level (State to village level) so that cross comparison and correlation analysis between various indicators can be made and the spatial dimension of their interrelationship can be established. This can support the effective planning and policymaking
- GIS training programs specifically custom-designed for public health professionals

4.2 WEAKNESSES

- System Strengthening – is weak in the State. The State has tried to meet its infrastructure requirements without providing for the commensurate human resource and ancillary services. This has resulted in the quality in service delivery being compromised at facility level.
- Health Facilities have been re-named rather than being upgraded as per norms (GoI/IPHS) resulting in mismatch in infrastructure and Human Resource and equipment. There are no sanctioned beds at many PHCs though they have been designated as PHCs (N). These PHCs are also delivery points and deliveries occur but since, there are no sanctioned beds the women after delivery are not kept for mandatory 48 hrs. This is resulting in the health of the mother and child being compromised. The State has a very high MMR and IMR if these quality issues are not addressed the MMR and IMR will continue to be high. e.*g. Rural Training Centre Attabira was re named as PHC (N).As per Government Order of Odisha, PHCs (N) have no sanctioned beds. Thus PHC (N) at Altamira had no sanctioned beds despite having delivery load of 30 per month. This has resulted in no patients for 48 Hrs staying after delivery. This has also caused acute shortage of HR as HR is sanctioned against bed strength.*

- District ownership of NRHM is weak. Majority of the district officials are there for a short period and nearing the retirement age with no public health background. Five CDMOs changed during the calendar year 2010 at Bargarh). This is leading to weak ownership at district level.

4.3 STATE SPECIFIC ISSUES

- Standard Protocols/Guidelines are not being maintained though these guidelines have been issued by the Govt of India as well as Govt of Odisha and are to be found at facilities. *e.g. District Hospital, Bargarh has no SNCUs but has NBSU with radiant warmers/photo therapy units. It has new born care protocols printed and pasted on the walls. However, the protocols are not being followed. New Born baby of 1.8 Kgs delivered through C-Section had no referral sent out to the Paediatrician (Two are posted at DHH) and the new born baby was lying partially covered on the ground with the grandmother and had not been put to breast though four hours had passed since delivery.)*
- Regular monitoring and supportive supervision is lacking at all levels. Supportive supervision is one of the important mechanisms for improving health care delivery at facilities.
- Neonatal deaths at facilities are not being reported under the facilities but reported under the Municipal records. This is a wrong procedure. Any death occurring at a facility should be recorded under that facility. SDH Padampur, Bargarh annual report showed no new born deaths for the last two years, despite having a heavy delivery load (more than 30 deliveries in a month). On probing further and checking all admissions and case sheets at O&G ward and Paediatric ward, it was found that a total of 13 deaths had occurred at the facility – 6 neonatal deaths, 6 Infant deaths and one under five deaths. All these deaths were being missed by the facility as they were being reported under the Municipal reports. This is not acceptable. All deaths should be recorded and investigated. There appears to be no mechanism for death enquiry for child deaths at facilities.
- Primary Health Centres remain weak link in the Health System as many new PHCs do not have adequate HR and sanctioned bed strength, resulting in poor health care delivery.
- As envisaged, in a average population of 30000, Minimum Assured services, eg. OPD services, inpatient facility, 24 hours emergency services, 24 hours delivery services, essential new born care services, safe abortion services, implementation of NDCPs, basic laboratory services, referral services, etc. need to be rendered through the PHCs, which is not happening. All these services are being available for the first time only at the Block CHC.
- Training on Essential New Born care (NSSK) was mostly being given to health staff posted at district/ sub district hospitals and yet to be given to staff at delivery points (L1/L2 etc.) where these skills are most needed.
- Though the State has carried out a facility survey for HR rationalization. However, there appears to be a need for further facility survey for better HR utilization.e.g *Amithi Sub Centre, had two ANMs (One regular and one additional ANMs) with hardly any delivery load.* The second ANM could be adjusted at a centre where there is adequate delivery load.
- Facility data is being collected and reported but is not being used for analysis. Lack of analysis and utilization of facility data is resulting in preparing Facility Action Plan which

does not reflect the true picture. Data analysis is mandatory to prepare a true de-centralized district health action plan.

- IPHS norms are not in place. Many sub divisional hospitals, as in Rayagada, have been renamed as DHH and PHCs, as in Attabira & Muniguda, as CHCs. This has led to a situation where some of the health facilities are deficient in number of functional beds, and infrastructure support services (eg; labs, blood banks). Staff quarters and sanctioned positions for various cadres of health service providers are also lacking. Facility up gradation has not been thought out properly. It is suggested that the State plan it"s up gradation through a needs/gap/feasibility assessment and develop a Master Plan keeping in view the IPHS norms

4.4 OVERALL RECOMMENDATIONS

- District ownership of NRHM is weak. Majority of the district health officials are there for a short period and most nearing the retirement age with no public health background. Five CDMOs have changed during the calendar year of 2010 at Bargarh. This leads to weak leadership of the NRHM programme.

  It is suggested that a District Mission Director with a fixed tenure of minimum 2 years be considered (on the same pattern as State Mission Director with delegated powers under NRHM and with over all command of NRHM) to improve the ownership and also to bring about greater accountability under NRHM at district level.

- Monitoring and supportive supervisory is lacking and needs to be strengthened at the State and district level. Monitoring and supportive supervisory is an important mechanism under NRHM to provide hand holding for ensuring proper delivery of services. Monitoring visits therefore should be made mandatory at all levels and should be made part of State and District Health Action Plans (DHAP) and should be reviewed regularly. Monitoring visits would also help in ensuring that PIPs (action plans) are being properly implemented.

- NRHM Framework for implementation makes the State eligible for Infrastructure development fund to the extent of maximum 33% of its total annual budget plan. The State should make good use of this to fulfill its infrastructure requirement.

- Civil works seem to take inordinate time (i.e. PHC Ghess, new building planned 5-6 years ago, still unfinished). Many times the CDMO has to keep running to various agencies to expedite the civil and electrical works. This leads to hardship and bad relations between related sectors. It is suggested that the State consider the Build, Operate and transfer mechanism for all civil works including HR and equipments for construction of health facilities.

  It is also suggested that to overcome in ordinate delays in civil works due to Under-bidding the following could be considered:

  - Including a price escalation formula in the bid documents that provides standards for price variation in key inputs, allowing for 15% increase at most.
  - Specifying in the bill of quantities a maximum allowable increase in quantities of key inputs, i.e. 15%.
  - Specifying that the cost of new items, introduced/required after contract signature, needs to be competitive with market rates, or consistent with standard rates adopted by the state government.

- One of the most important is that technical specifications/bills of quantities be as clear and detailed as possible, ideally using standard layouts and technical standards for construction materials and fixtures that have been adopted world-wide (with relevant modifications to the local context).

- Many of the facilities have meager staff in place and are not fully functional. The facilities could be strengthened by:
  - Strengthening of Sub Center/ PHC (New) with trained AYUSH doctor, Staff Nurses, Pharmacist.
  - DHAPs should reflect the actual requirement (HR, equipment, and infrastructure) based on facility survey and on IPHS norms.

- All the PHCs should be made functional with minimum Assured services, eg. OPD services, inpatient facility, 24 hours emergency services, 24 hours delivery services, essential new born care services, safe abortion services, implementation of NDCPs, basic laboratory services, referral services, etc. so that these essential minimal services are to be made available to an average of 30 thousands population.

- There is lack of proper waste management in the State. State and District Pollution Control Board could be considered to monitor all waste disposals. At present there is no system in place for Biological and hospital waste management. Most places have a poor disposal mechanism and generally (biological waste) are discarded in open places creating a health hazard.

- Better convergence between health and other related sector for optimal utilization of resources (funds and manpower). Accelerated results may be ensured through development of district integrated plans. ICDS has budget for training of its field functionaries and IEC, which can be used for joint training and IEC on nutrition. Similar exercise can be undertaken for the other health related sectors like water and sanitation and rural development.

- Maternal Perinatal Death Enquiry (MAPDE) should be put in place at the earliest. Neonatal deaths go unreported at facilities (SDH Padampur, where 6 Neonatal Deaths, 6 Infant deaths and 1 under five deaths were not reported in their Annual Report). Peri-natal death enquiry system should be put in place to address neonatal deaths at facilities. Only when deaths are reported and enquired would the remedial measures be put in place.

- First 48 hrs after delivery are crucial for the mother and child. Most maternal and child deaths occur within this period. Mandatory 48 hrs stay after delivery is not happening at facilities. This is mainly due to lack adequate bed strength at facilities. The mother and the newborn child are bundled and sent home within a few hours of delivery, thus compromising the health of the newborn and the mother. The State should provide for sanctioned beds at facilities with proper HR and equipment. This would help the mother stay at the facility for 48 hrs.

- Standard Protocols (SOPs) (Newborn baby of 1.8 Kg delivered by caesarian at DHH Bargarh was lying on the floor not fully covered on the floor with the Grand Mother and with no referral to pediatrician despite one being available at the DHH) are not being followed for maternal and child care in spite of these being available at facilities. This is leading to a situation where the health of the mother and the newborn are being put at risk. This is not acceptable. Standard Protocols should be made mandatory at all facilities throughout the State.

- Setting up of NBCCs should be prioritized over other newborn facilities, since essential care at birth remains the most important intervention and only one third of the target has been achieved so far. A clear plan of action for NBCCs should be developed at state level and reviewed on monthly basis.
- IMNCI is a child survival strategy and should be implemented in all district and not restricted to 20 districts especially when the State has a high IMR.
- Tribal belief of burying placenta should be made use of by supporting burial of the placenta in an earmarked area within the premises of the facility. This will help in the safe disposal of the placenta and also help to keep the tribal belief/customs.
- Large number of facilities visited had broken and unusable equipment and furniture lying locked in rooms. Thus depriving the facility of valuable rooms and space. The State should operationalise the condemnation policy in a systematic fashion at these facilities to ensure better utilization of available space.
- The non-availability of medical officers and specialists is adversely affecting the health services delivery at First Referral Units (FRUs) in the district, resulting not only in shrinking of the range of services available across the health facilities but also reducing the number of facilities that can provide the all the components of health services mandated at FRUs.
- The State Institute of Health and Family Welfare should be revived and made responsible for all capacity building under NRHM, especially when there is an acute shortage of specialists. SIHFW should monitor quality of trainings to ensure proper skill transfer. Similarly the District Training Centers and the District training Teams should be revived and made responsible for all trainings at the district level. This should help in improving the monitoring of trainings.
- The focus under family planning is more on sterilization especially female sterilizations which has its accompanied morbidity and mortality. The male sterilizations should be promoted as they have almost nil morbidity and mortality.
- The State should consider incentives for spacing methods as spacing between children is an evidence based intervention to reduce maternal and child mortality. A gap of 3 years between children reduces maternal mortality by nearly half and infant mortality by 36 %.
- Capacity building of the *Gaon Kalyan Samittis* (VHNSCs), through ongoing technical support from CARE India and which is being piloted at Rayagada district may be replicated across the State for better community participation in NRHM programme. Periodic training of GKS members on key aspects of health, nutrition, sanitation etc is important in increasing their participation in the programme.
- The State has requested for vaccines supply from GOI to be made every 6 months rather than every qtly. This will help them to plan their logistics and storing and for planning State immunization sessions much in advance. The irregular supply from centre has caused problems in planning regular sessions.
- The State could look at Accreditation of facilities in a phased manner through National Accreditation Board so that all facilities over a period are according to norm and are providing quality health care services.

Part V

Annexure

STATE NRHM DATA

Name of the State/ UT: Odisha

Infrastructure Up gradation

A 1. Overview of Health Infrastructure and achievements in the Mission - High Focus Districts

Number of High Focus Districts in the State = 19

Health Facility	Required as per population norms (census 2001)	Number of facilities functional in 2005 (i.e. at the start of Mission)			Number of facilities functional as of 30th September 2011			Number of new facilities under construction	Total no. of facilities which will be functional at the end of the Mission period
		Govt. building	Rented building	No. functioning in other bldgs without paying rent*	Govt. building	Rented building	No. functioning in other bldgs without paying rent*		
					1	2	3	4	1+2+3+4
District Hospitals (DH)		19	0		19	0		1	20
Sub-Divisional Hospitals and other hospitals above CHC		16	0		16	0		0	16
CHCs + PHCs * (Annex-B)		204	0	0	204	0	0	0	204
PHC-Ns *(Annex-C)		512	0	72	541	0	43	29	570
Other Health facilities above SC but below block level (may include APHC etc.)		32	0		32	0		0	32
Sub-Centres (Annex-D)		2024	1455	0	2122	1357	0	540	2662

* Facilities functional in other buildings like Panchayat buildings/ voluntary/ social organization, etc.

- All PHCs (116 nos.) existed during the year 2005 have been recently converted to CHCs in terms of nomenclature.
- PHCs as per GoI mandate are popularly known as PHC (N) s in Odisha, which is a single doctor PHC.

A 2. Overview of Health Infrastructure and achievements in the Mission - Non High Focus Districts

Number of Non High Focus Districts in the State = 11

Health Facility	Required as per population norms (census 2001)	Number of facilities functional in 2005 (i.e. at the start of Mission)			Number of facilities functional as of 30th September 2011			Number of new facilities under construction	Total number of facilities which will be functional at the end of the Mission period
		Govt. building	Rented building	No. functioning in other buildings without paying rent*	Govt. building	Rented building	No. functioning in other buildings without paying rent*		
					1	2	3	4	1+2+3+4
District Hospitals (DH)		13	0		13	0		2	15
Sub-Divisional Hospitals and other hospitals above CHC		10	0		10	0		0	10
CHCs +PHCs * (Annex-B)		173	0	0	173	0	0	0	173
PHC-Ns *(Annex-C)		587	0	41	614	0	14	13	627
Other Health facilities above SC but below block level (may include APHC etc.)		63	0		63	0		0	63
Sub-Centres (Annex-D)		1439	1770	0	1497	1712	0	124	1621

* Facilities functional in other buildings like Panchayat buildings/ voluntary/ social organisation, etc.

- All PHCs (116 nos) existed during the year 2005 have been recently converted to CHCs in terms of nomenclature.
- PHCs as per GoI mandate are popularly known as PHC (N) s in Odessa, which is a single doctor PHC.

A.3 Status of Block-wise Availability of Health Facilities

Sl. No.	District	Block	Population	No. of DHHs	No. of SDHs	No. of CHCs	No. of PHC(N)s	No. of OHs	No. of SCs
1	Anugul	Anugul	144783	1	0	1	5	0	24
2	Anugul	Athamallik	96812	0	1	1	3	0	19
3	Anugul	Banarpal	180275	0	0	1	4	0	23
4	Anugul	Chhendipada	145259	0	0	2	4	0	23
5	Anugul	Kaniha	136530	0	0	1	4	0	20
6	Anugul	Palalahada	112847	0	1	1	5	0	20
7	Anugul	Rajkishore nagar	95502	0	0	1	3	0	16
8	Anugul	Talcher	143603	0	1	1	3	0	21
9	Balasore	Bahanaga	120846	0	0	2	4	0	17
10	Balasore	Balasore	217988	1	0	1	6	1	27
11	Balasore	Baliapal	176526	0	0	2	5	0	25
12	Balasore	Basta	162910	0	0	1	5	0	23
13	Balasore	Bhogarai	253290	0	0	2	9	0	32
14	Balasore	Jaleswar	173329	0	0	2	10	0	26
15	Balasore	Khaira	159514	0	0	1	6	0	23
16	Balasore	Nilagiri	110232	0	1	1	5	0	32
17	Balasore	Oupada	70551	0	0	1	3	0	14
18	Balasore	Remuna	153664	0	0	1	6	0	23
19	Balasore	Simulia	105564	0	0	1	5	0	15
20	Balasore	Soro	121002	0	0	1	5	0	18
21	Baragarh	Ambabhana	63671	0	0	1	3	0	12
22	Baragarh	Attabira	153195	0	0	2	6	0	22
23	Baragarh	Baragarh	151671	1	0	1	4	0	23
24	Baragarh	Barapali	102323	0	0	2	3	0	19
25	Baragarh	Bhatali	84909	0	0	1	2	0	15
26	Baragarh	Bheden	122362	0	0	1	6	0	21
27	Baragarh	Bijepur	95843	0	0	1	3	0	14
28	Baragarh	Gaisilet	79335	0	0	1	3	0	14
29	Baragarh	Jharabandha	69266	0	0	1	3	0	12
30	Baragarh	Padmapur	99882	0	1	1	3	0	17
31	Baragarh	Paikamal	100032	0	0	1	4	0	16
32	Baragarh	Sohella	125570	0	0	1	6	0	19
33	Bhadrak	Basudevpur	195674	0	0	1	7	0	32
34	Bhadrak	Bhadrak	187705	1	0	1	7	2	26
35	Bhadrak	Bhandaripokhari	117344	0	0	1	6	0	18
36	Bhadrak	Bonth	135211	0	0	1	4	0	20
37	Bhadrak	Chandbali	217638	0	0	1	8	0	31
38	Bhadrak	Dhamnagar	163727	0	0	1	11	1	28
39	Bhadrak	Tihidi	175379	0	0	1	7	0	23
40	Bolangir	Agalpur	87636	0	0	1	4	1	15
41	Bolangir	Bangomunda	91342	0	0	1	4	0	16
42	Bolangir	Belapada	74357	0	0	1	3	1	19

43	Bolangir	Bolangir	87392	1	0	1	3	0	15
44	Bolangir	Deogaon	84544	0	0	1	3	0	14
45	Bolangir	Gudvella	52528	0	0	1	0	0	10
46	Bolangir	Khaprakhol	70112	0	0	1	4	0	17
47	Bolangir	Loisinga	84756	0	0	1	3	0	14
48	Bolangir	Muribahal	93201	0	0	1	3	0	16
49	Bolangir	Patnagarh	98013	0	1	1	4	0	22
50	Bolangir	Puintala	95660	0	0	1	3	0	17
51	Bolangir	Saintala	99661	0	0	1	3	0	18
52	Bolangir	Titilagarh	99934	0	1	1	4	0	18
53	Bolangir	Tureikela	66104	0	0	2	1	0	15
54	Boudh	Boudh	123012	1	0	1	5	0	22
55	Boudh	Harabhanga	109677	0	0	2	4	0	20
56	Boudh	Kantamal	122658	0	0	2	3	0	25
57	Cuttack	Athagarh	127407	0	1	1	5	0	26
58	Cuttack	Banki	99097	0	1	1	4	0	21
59	Cuttack	Baramba	134269	0	0	2	3	0	26
60	Cuttack	Baranga	84068	0	0	1	3	0	18
61	Cuttack	Cuttack	130385	1	0	1	5	6	28
62	Cuttack	Dampara	86393	0	0	1	2	1	16
63	Cuttack	Kantapada	81550	0	0	1	2	0	15
64	Cuttack	Mahanga	163321	0	0	1	6	1	30
65	Cuttack	Narasinghapur	138309	0	0	3	3	0	27
66	Cuttack	Niali	132295	0	0	1	4	0	26
67	Cuttack	Nischintakoili	169670	0	0	1	5	0	29
68	Cuttack	Salepur	174692	0	0	1	5	1	31
69	Cuttack	Tangi-Choudwar	141838	0	0	1	6	0	26
70	Cuttack	Tigiria	68364	0	0	2	4	0	13
71	Deogarh	Barkote	95474	0	0	2	2	1	13
72	Deogarh	Reamal	93628	0	0	1	3	0	17
73	Deogarh	Tileibani	64910	1	0	1	2	0	12
74	Dhenkanal	Bhuban	91880	0	0	3	4	1	15
75	Dhenkanal	Dhenkanal	137299	1	0	1	5	1	23
76	Dhenkanal	Gania	137525	0	0	1	6	0	23
77	Dhenkanal	Hindol	159395	0	1	1	5	0	27
78	Dhenkanal	Kamakshyanagar	103611	0	1	1	3	0	21
79	Dhenkanal	Kankadahad	96037	0	0	1	2	1	16
80	Dhenkanal	Odapada	127115	0	0	1	3	1	21
81	Dhenkanal	Parajang	121102	0	0	1	4	0	21
82	Gajapati	Gumma	65292	0	0	1	3	0	19
83	Gajapati	Kasinagar	48625	0	0	1	2	0	13
84	Gajapati	Mohana	115808	0	0	2	5	0	33
85	Gajapati	Nuagada	46936	0	0	1	1	1	17
86	Gajapati	Paralakhemundi	70302	1	0	1	3	0	17
87	Gajapati	R.Udayagiri	55010	0	0	1	3	0	14

88	Gajapati	Rayagada	63976	0	0	1	3	0	23
89	Ganjam	Aska	138362	0	0	2	3	0	23
90	Ganjam	Beguniapada	112970	0	0	2	2	0	22
91	Ganjam	Belaguntha	103077	0	0	2	3	0	20
92	Ganjam	Bhanjanagar	122449	0	1	1	4	0	21
93	Ganjam	Buguda	106747	0	0	1	4	0	19
94	Ganjam	Chhatrapur	125675	0	1	1	3	0	20
95	Ganjam	Chikiti	93941	0	0	2	5	0	17
96	Ganjam	Dharakote	101533	0	0	1	4	0	17
97	Ganjam	Digapahandi	136618	0	0	2	6	0	27
98	Ganjam	Ganjam	82702	0	0	1	4	1	15
99	Ganjam	Hinjilikatu	107053	0	0	2	3	0	19
100	Ganjam	Jagannath prasad	117894	0	0	1	4	0	23
101	Ganjam	Kabisurya Nagar	102441	0	0	1	2	0	17
102	Ganjam	Khallikote	137173	0	0	1	4	0	24
103	Ganjam	Kukudakhandi	124598	0	0	1	2	0	20
104	Ganjam	Patrapur	118116	0	0	1	6	0	23
105	Ganjam	Polasara	117281	0	0	1	4	0	22
106	Ganjam	Purusottampur	129506	0	0	2	4	0	25
107	Ganjam	Rangeilunda	139627	1	0	1	4	0	21
108	Ganjam	Sana Khemundi	147788	0	0	1	6	0	25
109	Ganjam	Sheragada	117625	0	0	1	5	0	19
110	Ganjam	Sorada	126075	0	0	2	5	0	21
111	Jagatsinghpur	Balikuda	151279	0	0	1	6	0	31
112	Jagatsinghpur	Biridi	75352	0	0	1	2	0	15
113	Jagatsinghpur	Erasama	134211	0	0	1	5	0	24
114	Jagatsinghpur	Jagatsinghpur	132539	1	0	1	4	0	28
115	Jagatsinghpur	Kujanga	159310	0	0	2	6	0	34
116	Jagatsinghpur	Naugan	73316	0	0	1	2	0	14
117	Jagatsinghpur	Raghunathpur	77583	0	0	1	4	0	17
118	Jagatsinghpur	Tirtol	149590	0	0	1	8	3	27
119	Jajpur	Barachana	206129	0	0	1	8	0	34
120	Jajpur	Bari	140240	0	0	1	5	0	24
121	Jajpur	Binjharpur	155265	0	0	1	7	0	27
122	Jajpur	Danagadi	104116	0	0	1	4	0	17
123	Jajpur	Dasarathpur	181707	0	0	2	5	0	33
124	Jajpur	Dharamsala	195545	0	0	1	9	0	32
125	Jajpur	Jajpur	153072	1	0	2	3	0	24
126	Jajpur	Korei	138504	0	0	1	6	0	22
127	Jajpur	Rasulpur	154548	0	0	1	5	0	26
128	Jajpur	Sukinda	125364	0	0	1	4	0	21
129	Jharsuguda	Jharsuguda	68753	1	0	2	3	0	16
130	Jharsuguda	Kirimira	38868	0	0	1	2	0	7
131	Jharsuguda	Kolabira	38890	0	0	1	2	0	8
132	Jharsuguda	Laikera	46868	0	0	1	3	0	9

133	Jharsuguda	Lakhanpur	130452	0	0	1	5	1	26
134	Kalahandi	Bhawanipatna	140431	1	0	1	5	0	26
135	Kalahandi	Dharmagad	116599	0	1	1	4	0	20
136	Kalahandi	Golamunda	107377	0	0	1	4	0	20
137	Kalahandi	Jaipatna	115287	0	0	1	3	1	22
138	Kalahandi	Junagarh	147832	0	0	2	5	0	25
139	Kalahandi	Kalampur	52534	0	0	1	1	0	9
140	Kalahandi	Karlamunda	48930	0	0	1	2	1	10
141	Kalahandi	Kesinga	97861	0	0	2	3	0	17
142	Kalahandi	Koksara	104234	0	0	1	3	0	19
143	Kalahandi	Lanjigarh	75145	0	0	2	3	0	25
144	Kalahandi	M Rampur	67725	0	0	1	4	0	12
145	Kalahandi	Narla	102309	0	0	1	4	0	19
146	Kalahandi	Th. Rampur	65767	0	0	1	2	0	18
147	Kandhamal	Baliguda	63570	0	1	1	3	0	14
148	Kandhamal	Chakapad	41445	0	0	1	3	0	13
149	Kandhamal	Daringibadi	93530	0	0	1	5	1	25
150	Kandhamal	G.Udayagiri	30631	0	0	2	2	0	11
151	Kandhamal	Khajuripada	46755	0	0	1	3	0	14
152	Kandhamal	Kotagarh	40860	0	0	1	3	1	10
153	Kandhamal	Nuagaon	47402	0	0	2	2	0	13
154	Kandhamal	Phiringia	72099	0	0	1	3	1	22
155	Kandhamal	Phulabani	34976	1	0	1	3	0	12
156	Kandhamal	Raikia	48090	0	0	1	3	0	13
157	Kandhamal	Tikabali	46688	0	0	1	3	0	13
158	Kandhamal	Tumudibandha	38061	0	0	1	3	1	12
159	Kendrapara	Aul	136297	0	0	1	6	0	24
160	Kendrapara	Derabis	129532	0	0	1	5	0	24
161	Kendrapara	Garadpur	98297	0	0	1	4	0	19
162	Kendrapara	Kendrapara	137512	1	0	1	4	0	25
163	Kendrapara	Mahakalpada	191745	0	0	1	7	0	32
164	Kendrapara	Marsaghai	115103	0	0	1	5	0	22
165	Kendrapara	Pattamundai	147194	0	0	1	6	0	32
166	Kendrapara	Rajakanika	126887	0	0	1	3	1	24
167	Kendrapara	Rajnagar	145301	0	0	1	5	0	25
168	Keonjhar	Anandapur	96574	0	1	1	6	0	19
169	Keonjhar	Banspal	85845	0	0	1	6	0	25
170	Keonjhar	Champua	100485	0	1	1	6	0	34
171	Keonjhar	Ghasipura	133672	0	0	2	7	0	23
172	Keonjhar	Ghatagaon	102117	0	0	1	3	0	26
173	Keonjhar	Harichandanpur	122362	0	0	2	5	0	38
174	Keonjhar	Hatadihi	147996	0	0	1	5	2	22
175	Keonjhar	Jhumpura	97725	0	0	1	3	1	28
176	Keonjhar	Joda	102379	0	0	3	3	0	34
177	Keonjhar	Keonjhar	136567	1	0	1	5	0	30

178	Keonjhar	Patna	92513	0	0	1	4	1	25
179	Keonjhar	Saharapada	79048	0	0	1	4	0	23
180	Keonjhar	Telkoi	86498	0	0	1	4	2	24
181	Khurda	Balianta	100557	0	0	1	3	0	21
182	Khurda	Balipatna	106908	0	0	1	3	1	19
183	Khurda	Banapur	106148	0	0	2	3	0	19
184	Khurda	Begunia	114691	0	0	1	10	0	21
185	Khurda	Bhubaneswar	105992	1	0	2	3	15	21
186	Khurda	Bolagarh	117783	0	0	2	6	0	23
187	Khurda	Chilika	107867	0	0	1	4	0	20
188	Khurda	Jatni	84875	0	0	1	4	2	13
189	Khurda	Khurda	120117	1	0	1	5	0	21
190	Khurda	Tangi	139823	0	0	1	5	1	24
191	Koraput	Bandhugan	50000	0	0	1	3	0	16
192	Koraput	Boipariguda	91621	0	0	1	3	0	27
193	Koraput	Boriguma	126728	0	0	1	6	0	40
194	Koraput	Dasmanthapur	70946	0	0	2	4	0	23
195	Koraput	Jeypore	99694	0	1	1	5	0	26
196	Koraput	Koraput	66047	1	0	1	3	0	21
197	Koraput	Kotapad	81040	0	0	1	4	0	23
198	Koraput	Kundra	59028	0	0	1	3	0	19
199	Koraput	Lamtaput	54683	0	0	1	2	0	18
200	Koraput	Laxmipur	55268	0	0	1	3	0	16
201	Koraput	Nandapur	81654	0	0	1	4	0	26
202	Koraput	Narayanpatna	38117	0	0	1	1	0	13
203	Koraput	Pottangi	60300	0	0	1	4	0	18
204	Koraput	Semiliguda	55537	0	0	2	3	0	21
205	Malkangiri	Kalimela	101217	0	0	1	5	0	32
206	Malkangiri	Khairaput	34446	0	0	1	4	0	13
207	Malkangiri	Korukunda	104637	0	0	2	3	0	34
208	Malkangiri	Kudumuluguma	49938	0	0	1	3	0	15
209	Malkangiri	Malkangiri	53922	1	0	1	3	2	21
210	Malkangiri	Mathili	79814	0	0	1	5	0	25
211	Malkangiri	Podia	45608	0	0	1	2	1	18
212	Mayurbhanj	Badasahi	130850	0	0	1	4	1	38
213	Mayurbhanj	Bahalada	75842	0	0	2	1	0	26
214	Mayurbhanj	Bangiriposi	91603	0	0	1	5	0	24
215	Mayurbhanj	Baripada	60341	1	0	1	1	0	25
216	Mayurbhanj	Betnoti	128908	0	0	1	3	1	33
217	Mayurbhanj	Bijatala	58174	0	0	1	2	0	18
218	Mayurbhanj	Bisoi	66724	0	0	1	5	0	20
219	Mayurbhanj	Gopabandhunagar	66309	0	0	1	4	1	18
220	Mayurbhanj	Jamada	55801	0	0	1	2	0	16
221	Mayurbhanj	Jashipur	88845	0	0	2	3	0	25
222	Mayurbhanj	Kaptipada	126371	0	0	1	6	0	31

223	Mayurbhanj	Karanjia	81390	0	1	1	3	0	22
224	Mayurbhanj	Khunta	68528	0	0	1	2	0	19
225	Mayurbhanj	Kuliana	88647	0	0	1	4	0	25
226	Mayurbhanj	Kusumi	82188	0	0	1	5	0	23
227	Mayurbhanj	Morada	94015	0	0	1	5	1	25
228	Mayurbhanj	Rairangpur	56056	0	1	1	2	0	16
229	Mayurbhanj	Raruan	59041	0	0	1	3	0	17
230	Mayurbhanj	Rasagovindapur	83632	0	0	1	4	0	24
231	Mayurbhanj	Samakhunta	70889	0	0	1	3	0	21
232	Mayurbhanj	Saraskana	89374	0	0	1	3	0	24
233	Mayurbhanj	Sukruli	52239	0	0	1	1	0	15
234	Mayurbhanj	Suliapada	92108	0	0	1	5	0	24
235	Mayurbhanj	Thakurmunda	90115	0	0	1	4	0	25
236	Mayurbhanj	Tiringi	48556	0	0	1	1	0	14
237	Mayurbhanj	Udala	66857	0	1	1	3	0	21
238	Nabarangapur	Chandahandi	61076	0	0	1	4	0	19
239	Nabarangapur	Dabugan	55639	0	0	1	2	0	18
240	Nabarangapur	Jharigaon	123860	0	0	1	4	0	34
241	Nabarangapur	Kosagumuda	134669	0	0	1	6	0	45
242	Nabarangapur	Nabarangapur	65698	1	0	1	2	0	24
243	Nabarangapur	Nandahandi	52277	0	0	1	2	0	17
244	Nabarangapur	Papadahandi	111179	0	0	1	4	0	30
245	Nabarangapur	Raighar	157346	0	0	1	7	0	44
246	Nabarangapur	Tentulikhunti	74419	0	0	1	4	0	20
247	Nabarangapur	Umarkote	126739	0	0	2	4	1	38
248	Nayagarh	Bhapur	93921	0	0	1	3	0	18
249	Nayagarh	Dasapala	92497	0	0	2	5	0	18
250	Nayagarh	Gania	34650	0	0	1	3	0	8
251	Nayagarh	Khandapada	99618	0	0	2	5	0	21
252	Nayagarh	Nayagarh	132644	1	0	1	5	0	25
253	Nayagarh	Nuagaon	84249	0	0	1	4	0	16
254	Nayagarh	Odagaon	153628	0	0	2	7	0	29
255	Nayagarh	Ranapur	150238	0	0	2	5	0	31
256	Nuapada	Boden	72056	0	0	1	3	0	14
257	Nuapada	Khariar	93018	0	0	1	3	0	17
258	Nuapada	Komana	117082	0	0	2	4	0	23
259	Nuapada	Nuapada	119830	1	0	1	4	0	24
260	Nuapada	Sinapalli	98666	0	0	1	3	0	17
261	Puri	Astaranga	78069	0	0	1	3	0	14
262	Puri	Brahmagiri	119224	0	0	1	4	0	20
263	Puri	Delanga	112476	0	0	1	5	0	22
264	Puri	Gop	153508	0	0	1	8	0	29
265	Puri	Kakatapur	98878	0	0	1	3	1	18
266	Puri	Kanas	122709	0	0	1	5	0	23
267	Puri	Krushnaprasad	78626	0	0	2	4	0	13

268	Puri	Nimapada	176304	0	0	2	3	1	34
269	Puri	Pipili	126801	0	0	3	4	0	25
270	Puri	Puri	129962	1	0	1	3	3	24
271	Puri	Satyabadi	102097	0	0	2	3	0	19
272	Rayagada	Bisamacuttack	82774	0	0	1	4	0	26
273	Rayagada	Chandrapur	32349	0	0	1	2	0	11
274	Rayagada	Gudari	35394	0	0	1	2	0	12
275	Rayagada	Gunupur	66046	0	1	1	2	1	21
276	Rayagada	Kalyansinghpur	57195	0	0	2	3	0	18
277	Rayagada	Kashipur	121086	0	0	1	6	0	36
278	Rayagada	Kolanara	66670	0	0	1	3	0	23
279	Rayagada	Muniguda	76166	0	0	1	3	1	22
280	Rayagada	Padmapur	49594	0	0	1	4	0	16
281	Rayagada	Ramanaguda	45699	0	0	1	2	0	17
282	Rayagada	Rayagada	112330	1	0	0	5	0	33
283	Sambalpur	Bamara	88459	0	0	2	5	0	29
284	Sambalpur	Sambalpur	88546	1	0	2	3	0	17
285	Sambalpur	Jamankira	86188	0	0	1	5	0	27
286	Sambalpur	Jujumura	77266	0	0	1	3	0	14
287	Sambalpur	Kuchinda	67126	0	1	1	4	0	26
288	Sambalpur	Maneswar	90288	0	0	1	4	0	19
289	Sambalpur	Naktideul	56913	0	0	1	2	0	11
290	Sambalpur	Rairakhol	51026	0	1	1	2	0	10
291	Sambalpur	Rengali	78114	0	0	1	3	0	14
292	Subarnapur	Binika	84463	0	0	1	2	1	17
293	Subarnapur	Biramaharajpur	82594	0	0	1	3	0	14
294	Subarnapur	Dunguripali	116002	0	0	1	5	0	19
295	Subarnapur	Subarnapur	70030	1	0	1	2	0	12
296	Subarnapur	Tarava	71016	0	0	1	3	1	14
297	Subarnapur	Ulunda	77662	0	0	1	3	0	13
298	Sundergarh	Balisankara	76759	0	0	1	4	1	28
299	Sundergarh	Baragaon	64676	0	0	2	3	0	17
300	Sundergarh	Bisra	76619	0	0	1	2	0	23
301	Sundergarh	Bonaigarh	62476	0	1	1	2	0	18
302	Sundergarh	Gurundia	57801	0	0	1	3	1	19
303	Sundergarh	Hemagiri	75694	0	0	1	4	1	21
304	Sundergarh	Koida	71705	0	0	1	3	0	24
305	Sundergarh	Kuarmunda	87342	0	0	2	3	0	27
306	Sundergarh	Kutra	71152	0	0	1	3	0	21
307	Sundergarh	Lahunipara	85019	0	0	1	3	0	27
308	Sundergarh	Lathikata	122756	0	0	1	5	0	33
309	Sundergarh	Lephripara	71605	0	0	1	6	0	24
310	Sundergarh	Nuagaon	91478	0	0	1	3	1	26
311	Sundergarh	Rajgangpur	90692	0	0	2	3	0	26
312	Sundergarh	Subdega	57420	0	0	1	2	0	20

313	Sundergarh	Sundergarh	63857	2	1	1	3	0	18
314	Sundergarh	Tangarapali	58284	0	0	1	4	0	17
Total			**3,16,44,866**	**32**	**26**	**377**	**1228**	**79**	**6688**

* Population as per 2001 census, as block wise population is not available according to 2011 census

B. Information on Progress of New Constructions taken up under NRHM in the State

(cumulative till 30th September 2011)

Health Facility	New Construction sanctioned under NRHM so far		Progress of New Constructions						Remarks/ Shortcomings
			Completed		Under Construction		Sanctioned but Yet to start		
	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	
District Hospitals (DH)	1	2					1	2	
Sub-Divisional Hospitals and other hospitals above CHC	0	0	0	0	0	0	0	0	0
CHCs	3	7	1	1	1	4	0	3	
PHCs	58	40	29	27	29	13	0	0	
Other Health facilities above SC but below block level (may include APHC etc.)	0	0	0	0	0	0	0	0	
Sub-Centres	638	182	98	58	540	124	0	0	

C. Information on Progress of Up gradation of Health Facilities under NRHM in the State

(cumulative till September 2011)

Health Facility	Up gradation sanctioned under NRHM so far		Progress						Remarks/ Shortcomings
			Completed		Under Construction		Sanctioned but Yet to start		
	High Focus	Non High Focus	High Focus	Non High Focus	High Focus	Non High Focus	High Focus	Non High Focus	
District Hospitals (DH)	19	13	19	13	0	0	0	0	
Sub-Divisional Hospitals and other hospitals above CHC	16	10	16	10	0	0	0	0	
CHCs	110	96	75	78	35	18	0	0	
PHCs & Other Health facilities above SC but below block level (may include APHC etc.)	105	182	17	38	25	30	63	114	
Sub-Centres	1529		1529		0		0		

D. Status of Accommodation for Health Care Providers:

Facility Type	Availability and Shortage of Staff Quarters at all facilities								
	Doctors/ Specialists			Nurses and Paramedics			Other staff		
	Required (Sept 2011)	Available (Sept 2011)	Added during Mission period	Required (Sept 2011)	Available (Sept 2011)	Added during Mission period	Required (Sept 2011)	Available (Sept 2011)	Added during Mission period
District Hospitals (DH)	484	255	0	688	344	0	486	196	0
Sub-Divisional Hospitals and other hospitals above CHC	109	114	6	200	259	22	130	238	16
CHCs	340	550	87	909	1122	35	850	597	18
PHCs	80	179	0	411	460	0	297	207	0
Other Health facilities above SC but below block level (may include APHC etc.)	652	607	0	1410	875	0	1319	504	0
Sub-Centres	-	-	-	-	-	-	-	-	-

E. Sources of Funds for Health Care Infrastructure

(Rs in lakh)

Sl. No.	Sources of funds		2007-08	2008-09	2009-10	2010-11	2011-12
1	NRHM	2,860.00	4,655.00	7,205.75	5,956.00	6,820.25	6,223.88
2	Other Central Ministry Funds (AYUSH)	-	3,543.97	400.97	489.85	70.39	-
3	State Budget	1,487.99	561.98	2,182.31	2,587.95	3,123.00	3,696.11
4	Donor funds (Odisha Health Sector Plan funded by DFID and NIPI)	-	3,192.25	837.41	631.11	3,150.00	3,150.00
5	Finance Commission Grants	3,481.00	3,319.49	2,375.03	4,378.94	-	2,187.50
6	Other sources						
Total							

Note:	Total provision under TFC (2011-12 to 2014-15) is Rs.8750.00 lakhs. One fourth of the same is taken for 2011-12. However, funds are yet to be received.

F. Human Resources augmentation under NRHM at all facilities

Category	Required as per IPHS (March 2005)	Required as per IPHS (Sept 2011)	Sanctioned		In Position			
					Regular		Contractual	
							NRHM Funds	Other Sources
			Mar 2005	*Sept 2011*	*Mar 2005*	*Sept 2011*		
Doctors (Allopathic)			4259	4394	3459	3575	-	278
AYUSH doctors			0	1476	0	1273	-	-
Specialists			824	1819	673	1123	-	-
Paramedics			-	-	-	-	-	-
Staff Nurses		10760	2244	3522	2122	1775	884	6
MPW(M)		6718	4911	5727	4659	3083	602	-
MPW(F)		14985	7121	9237	6871	7072	1186	-
ANM		-	-	1630	-	1186	-	-
LHV		-	-	1128	-	1013	-	-
Lab Technician		2823	801	1639	728	653	110	271
Pharmacist		2676	2039	2114	1957	1812	134	5
AYUSH Paramedics			-	-	-	-	-	-
X-Ray Technician		918	162	235	123	115	-	-
Ward Staff			-	-	-	-	-	-
Cleaning Staff		-	-	-	-	-	-	Outsourced through agency
ASHA Facilitators			-	1	-	1	-	-
ASHA Co-ordinators			-	30		30	-	-

G. Training requirement and training institutions in the State

Sr. no	Category	Annual training require-emend in March 2005	Annual Training require-mint in Sept 2011	Institutions and Annual Intake capacity							
				Govt. (Sept 2011)		Govt. (added during Mission Period)		Private (Sept 2011)		Private if any - (added during Mission Period)	
				No	Intake	No	Intake	No	Intake	No	Intake
1	ANM Schools			16	640	2	160	50	1490	50+30 NOC to be given	1490
2	LHV Schools			1	30						
3	GNM Schools			5	270	1	40	41	948	36	693
4	MPHW Schools			3	120	-	-	-	-	-	-
5	Post Basic Bask(Nursing)-College			1	20	-	-	-	-	-	-
6	B.Sc. (Nursing)-College				20	-	-	11	-	-	-
7	M.Sc. (Nursing)-College				20	-	-	3	-	-	-
8	D.Pharm			1	60	-	-	32	1780	-	-
9	B.Pharm			NIL		-	-	-	-	-	-
10	Lab. Technician (DMLT)			3	110	-	-	Nil	0	-	-
11	Lab. Technician (Degree)			-	-	-	-	-	-	-	-
12	Others (Pl specify)			-	-	-	-	-	-	-	-

H. Achievements of training of Health Functionaries

Type of Training	*Cumulative number of functionaries trained (2005 to September 2011)*				
	MO	Specialists	ANM	Staff Nurse	LHV
IUCD	256	250	78	191	50
NSSK	944	-	577	1332	-
SBA	1237	559	3999	2450	200
IMNCI	608	-	3746	-	431
F-IMNCI	93	-	-	-	-
IUCD	-	-	-	-	-
BemOC	81	-	-	116	-
CemOC	38	-	-	-	-
LSAS	84	-	-	-	-
MTP/MVA	129	-	-	-	-
NSV	81	-	-	-	-
Minilap	184	-	-	-	-
CCSP	-	-	-	-	-
Laparoscopy	51	-	-	51	-
Communicable Diseases	-	-	-	-	-
Others *	-	-	-	-	-

I. Information on ASHA								
Sl. No.	Districts	Number of ASHA required	Number of ASHA Selected	Number of ASHAs dropped out	Number of ASHAs in place	Number of ASHA trained up to following Modules till date		Number of ASHAs with drug kits
						5th	*6th & 7th*	
1	Angul	1104	1104	0	1104	1104	180	72
2	Balasore	2019	1947	72	1947	1900	0	66
3	Baragarh	1474	1456	18	1456	1376	60	291
4	Bhadrak	1377	1367	10	1367	1364	0	181
5	Bolangir	1346	1346	0	1346	1346	60	0
6	Boudh	426	420	6	420	409	0	9
7	Cuttack	1917	1910	7	1910	1889	0	166
8	Deogarh	314	314	0	314	314	0	9
9	Dhenkanal	1122	1119	3	1119	1119	0	156
10	Gajapati	755	710	45	710	599	240	686
11	Ganjam	2939	2936	3	2936	2936	0	0
12	Jagatsinghpur	1046	1037	9	1037	1023	0	91
13	Jajpur	1861	1855	6	1855	1835	0	305
14	Jharsuguda	628	628	0	628	628	150	42
15	Kalahandi	1613	1566	47	1566	1187	180	865
16	Kandhamal	1092	1089	3	1089	1049	240	0
17	Kendrapara	1431	1420	11	1420	1407	0	0
18	Keonjhar	1895	1895	0	1,895	1,866	120	0
19	Khurda	1198	1190	8	1190	1161	0	0
20	Koraput	1488	1437	51	1437	1212	240	0
21	Malkanagiri	937	937	0	937	829	60	0
22	Mayurbhanj	3238	3232	6	3232	3232	0	144
23	Nawarangpur	1541	1541	0	1541	1541	120	0
24	Nayagarh	885	884	1	884	884	420	21
25	Nuapada	712	710	2	710	708	360	142
26	Puri	1555	1499	56	1499	1487	0	200
27	Rayagada	1397	1382	15	1382	1345	525	345
28	Sambalpur	969	968	1	968	964	180	52
29	Subarnapur	560	554	6	554	554	0	560
30	Sundargarh	2263	2261	2	2261	2085	180	338
TOTAL		**41102**	**40714**	**388**	**40,714**	**39,353**	**3,315**	**4,741**

ii. Please specify reasons for drop outs in the report based on interaction with ASHA coordinator, Ex ASHAs, staff at district and facility level and villagers.

Reasons for Dropout of ASHAs

Sl. No.	Reasons	No. of ASHAs
1	Resignation	198
2	Joined as AWW	160
3	Death	22
4	De-recognition	8
Total		388

J. Mother and Child Tracking System

	Sub-centres	Other Health facilities above SC but below block level	PHCs	Other than CHC at or above block level but below District Level (SDH)	CHCs	Area Hospitals / General Hospitals (OH)	DHHs
No. of Data Entry Points	-	-	-	-	314	-	79
No. of facilities reporting on MCTS portal	6688	-	-	-	-	-	79
No. of facilities where DEOs are deployed for data entry	-	-	-	-	120	-	-
No. of facilities where ANMs/ DEOs are trained for data capturing on MCTS formats and uploading on MCTS portal	6688	-	-	-	120	-	-
No. of facilities where computers with internet connectivity available	-	-	-	-	314	-	30
No. of facilities using CSC (Common Service Centre) SWAN centres for data entry on MCTS portal	N.A	-	-	-	-	-	-
No. of facilities generating and using work-plan of MCTS	1105	-	-	-	-	-	5
No. of facilities doing verification of data to reduce errors and anomalies occurred at the time of data capturing and entry	1105	-	-	-	-	-	5

K. Information on Programme Management Units				
Level	No. of Regular Staff	No. of contractual Staff in important positions like Programme managers and Consultants who have been employed for their technical expertise	No. of contractual support staff such as programme assistants/ DEOs/ typists/ peons	Total Number of Staff in SPMU
SPMU	6	109	159	274
DPMU	-	307	2301	2608
BPMU	-	314	798	1112
Total	6	730	3258	3994

L. Information on Delivery Points

S.No	Indicator	Number
1	Total No. of SCs	6688
a	No. of SCs conducting >3 deliveries/month	358
2	Total No. of 24X7 PHCs	121
a	No. of 24X7 PHCs conducting > 10 deliveries /month	65
3	Total No. of any other PHCs	1107
a	No. of any other PHCs conducting > 10 deliveries/ month	86
4	Total No. of CHCs (Non- FRU)	289
a	No. of CHCs (Non- FRU) conducting > 10 deliveries /month	237
5	Total No. of CHCs (FRU)	88
a	No. of CHCs (FRU) conducting > 20 deliveries /month	85
b	No. of CHCs (FRU) conducting C-sections	13
6	Total No. of any other FRUs (excluding CHC-FRUs)	26
a	No. of any other FRUs (excluding CHC-FRUs) conducting > 20 deliveries /month	26
b	No. of any other FRUs (excluding CHC-FRUs) conducting C-sections	15
7	Total No. of DH	32
a	No. of DH conducting > 50 deliveries /month	32
b	No. of DH conducting C-section	32
8	Total No. of District Women And Children hospital (if separate from DH)	1
a	No. of District Women And Children hospital (if separate from DH) conducting > 50 deliveries /month	1
b	No. of District Women And Children hospital (if separate from DH) conducting C-section	0
9	Total No. of Medical colleges	3
a	No. of Medical colleges conducting > 50 deliveries per month	3
b	No. of Medical colleges conducting C-section	3
10	Total No. of Accredited PHF	17
a	No. of Accredited PHF conducting > 10 deliveries per month	17
b	No. of Accredited PHF conducting C-sections	17

Total Functional Delivery Points as per GoI mandate: 910

OTHER ANNEXURES

Annexure B: Detailed Up gradation of CHCs

Sl. No.	*Name of the District*	*No. of CHC*	*Taken Up*	*Completed & Handed over*	*Balance to be Taken Up*	*Remark*
HIGH FOCUSED DISTRICTS						
1	Angul	10	3	3	7	
2	Bargarh	14	7	5	7	
3	Bolangir	15	8	4	7	
4	Boudh	5	1	1	4	
5	Deogarh	4	2	2	2	
6	Gajapati	8	6	5	2	
7	Jharsuguda	6	3	3	3	
8	Kalahandi	16	11	8	5	
9	Kandhamal	14	8	6	6	
10	Keonjhar	17	12	7	5	
11	Koraput	16	11	4	5	
12	Malkangiri	8	4	2	4	
13	Nawarangpur	11	8	6	3	
14	Nayagarh	12	4	4	8	
15	Nuapada	6	4	4	2	
16	Rayagada	11	4	2	7	
17	Sambalpur	11	1	0	10	
18	Sundergarh	20	13	9	7	
	Sub Total	**204**	**110**	**75**	**94**	
NON HIGH FOCUSED DISTRICTS						
1	Balasore	15	6	6	9	
2	Bhadrak	7	3	3	4	
3	Cuttack	18	9	6	9	
4	Dhenkanal	10	5	5	5	
5	Ganjam	30	15	13	15	
6	Jagatsinghpur	9	6	6	3	
7	Jajpur	12	10	7	2	
8	Kendrapara	9	9	7	0	
9	Khurda	13	7	6	6	
10	Mayurbhanj	28	15	12	13	
11	Puri	16	7	3	9	
12	Sonepur	6	4	4	2	
Sub Total		**173**	**96**	**78**	**77**	
TOTAL		**377**	**206**	**153**	**171**	

Annexure C: Detailed Building Position of PHC(N)

Sl. No.	Name of the District	No. of PHC (N)	Having Govt. building	Having no Govt. building	Taken Up		Total	Completed & Handed over	Balance to be Taken Up	Remark
					State Plan	*TFC*				
HIGH FOCUSED DISTRICTS										
1	Angul	27	27	0	4		4	2	-4	New Bldgs were constructed at existing PHC (N) as the bldgs were fully damaged
2	Bargarh	45	44	1	4		4	4	-3	
3	Bolangir	40	23	17	3		3	2	14	
4	Boudh	12	7	5	4		4	1	1	
5	Deogarh	7	6	1	1		1		0	
6	Gajapati	20	20	0	1		1		-1	
7	Jharsuguda	15	15	0	2		2	1	-2	
8	Kalahandi	41	35	6	2	6	8	1	-2	
9	Kandhamal	36	35	1	3	1	4	2	-3	
10	Keonjhar	58	57	1	1		1		0	
11	Koraput	48	43	5	2	2	4	1	1	
12	Malkangiri	25	20	5	2	1	3	2	2	
13	Nawarangpur	39	25	14	1	3	4	1	10	
14	Nayagarh	33	32	1	1		1	1	0	
15	Nuapada	16	15	1	4		4	3	-3	
16	Rayagada	36	31	5	2		2	1	3	
17	Sambalpur	30	25	5	5		5	5	0	
18	Sundergarh	56	52	4	3		3	2	1	
Sub Total		584	512	72	45	13	58	29	14	
NON HIGH FOCUSED DISTRICTS										
1	Balasore	67	66	1	2		2	1	-1	
2	Bhadrak	50	48	2	4		4	3	-2	
3	Cuttack	54	54	0	2		2	1	-2	
4	Dhenkanal	32	30	2	4		4	3	-2	
5	Ganjam	84	79	5	2		2	2	3	
6	Jagatsinghpur	38	37	1	4		4	3	-3	
7	Jajpur	56	56	0	4		4	3	-4	
8	Kendrapara	45	44	1	2		2	2	-1	
9	Khurda	62	41	21	5		5	4	16	
10	Mayurbhanj	76	75	1	3		3	2	-2	
11	Puri	45	38	7	6		6	3	1	
12	Sonepur	19	19	0	2		2		-2	
	Sub Total	**628**	**587**	**41**	**40**	**0**	**40**	**27**	**1**	
	TOTAL	1212	1099	113	85	13	98	56	15	0

Annexure D: Detail positions of Sub Centre Buildings

SL NO	District	Sanctioned	Building Available As on 2005-06	Building Required (New)	*Under taken out of different scheme*											Completed	Balance to be taken up	Remarks
					05-06	06-07	07-08	08-09	09-10	10-11	11-12	Total (NRHM)	10-11 OHSP	11-12 State Budget OHSP	Total			
HIGH FOCUSED DISTRICTS																		
1	Angul	166	85	81	3		3	4				10			10	3	71	
2	Bargarh	204	122	82			3	4			6	13			13	4	69	
3	Bolangir	226	90	136	2	4	3	5	2	5	5	26	14	51	91	1	45	
4	Boudh	67	34	33			3	3		3		9		12	21	3	12	
5	Deogarh	42	30	12			3	3			4	10			10	3	2	
6	Gajapati	136	105	31	6		3	4		3		16	7	8	31	4	0	
7	Jharsuguda	66	51	15		4	3	4				11			11	11	4	
8	Kalahandi	242	185	57	6		3	4	1	4		18	10	4	32	16	25	
9	Kandhamal	172	144	28			3	5		4		12	12		24	6	4	
10	Keonjhar	351	278	73		4	3	4			21	32			32	2	41	

11	Koraput	307	126	181			3	4	2	5		14	14	53	81	14	100	
12	Malkangiri	158	99	59		6	4	5	2	5		22	7	30	59	6	0	
13	Nawarangpur	289	129	160			3	4	2		4	13	14	37	64	5	96	
14	Nayagarh	166	77	89			3	4		6	10	23		18	41	4	48	
15	Nuapada	95	57	38			3	4	1	3	3	14	5		19	4	19	
16	Rayagada	235	69	166			4	4		4		12	11	53	76	0	90	
17	Sambalpur	167	81	86			3	4				7			7	2	79	
18	Sundargarh	390	262	128		3	6	7				16			16	10	112	
	Total	**3479**	**2024**	**1455**	**17**	**21**	**59**	**76**	**10**	**42**	**53**	**278**	**94**	**266**	**638**	**98**	**817**	
NON HIGH FOCUSED DISTRICTS																		
1	Balasore	275	102	173			3	4				7			7	2	166	
2	Bhadrak	178	76	102	3		3	4				10			10	0	92	
3	Cuttack	332	119	213		4	4	4				12			12	1	201	
4	Dhenkanal	167	97	70			3	4			1	8			8	4	62	
5	Ganjam	460	272	188	2		5	7				14		34	48	10	140	
6	Jagatsinghpur	189	95	94	3		3	4				10			10	10	84	
7	Jajpur	260	80	180			3	4				7			7	5	173	
8	Kendrapara	227	65	162	4		3	4			3	14			14	2	148	

9	Khurda	202	89	113			3	4			5	12			12	0	101	
10	Mayurbhanj	589	292	297	2		5	7				14		16	30	6	267	
11	Puri	241	124	117			3	4			1	8			8	2	109	
12	Sonepur	89	28	61			3	4		3		10	6		16	16	45	
	Total	**3209**	**1439**	**1770**	**14**	**4**	**41**	**54**	**0**	**3**	**10**	**126**	**6**	**50**	**182**	**58**	**1588**	
GRAND TOTAL		**6688**	**3463**	**3225**	**31**	**25**	**100**	**130**	**10**	**45**	**63**	**404**	**100**	**316**	**820**	**156**	**2405**	