



Report & Recommendations Of the Seventh Common Review Mission

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Abbreviations

ABER	Annual Blood Examination Rate
ACT	Artemisinin-based Combination Therapy
AES	Acute Encephalitis Syndrome
AFHS	Adolescent Friendly Health Services
ANC	Antenatal Care
AMG	Annual Maintenance Grant
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
APHC	Additional Primary Health Centre
API	Annual Parasite Incidence
ARC	ASHA Resource Centre
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric & Neonatal Care
BMO	Block Medical Officer
BMW	Bio-Medical Waste Management
BPHC	Block Primary Health Centre
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
BPL	Below Poverty Line
CBOs	Community Based Organizations
CBR	Crude Birth Rate
CEmONC	Comprehensive Emergency Obstetric & Neonatal Care
CHC	Community Health Centre
CMO	Chief Medical Officer
CMOH	Chief Medical Officer Health
CRM	Common Review Mission
CT Scan	Computed Tomography Scan
DEIC	District Early Intervention Center
DBT	Direct Benefit Transfer
DH	District Hospital
DHS	District Health Society
DHAP	District Health Action Plan
DLHS	District Level Household Survey
DOTS	Direct Observation Therapy, Short-course
DP	Development Partner
DPM	District Programme Manager
DPMU	District Programme Management Unit
DST	Drug-Susceptibility Testing
DTC	District Training Centre
DTCC	District Tobacco Control Cell
DWCD	Department of Women & Child Development
EDL	Essential Drug List
EmONC	Emergency Obstetric & Neonatal Care
EMRI	Emergency Management and Research Institute
ECP	Emergency Contraceptive Pill
FMG	Financial Management Group

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FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwife
HBNC	Home Based Newborn Care
HMIS	Health Management Information System
HMRI	Health Management & Research Institute
HR	Human Resource
HRMIS	Human Resources Management Information System
HRD	Human Resource Development
HSC	Health Sub-centre
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Project
IEC	Information, Education and Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In-Patient Department
IPHS	Indian Public Health Standards
IRL	Intermediate Reference Laboratory
ISO	International Organization for Standardization
IT	Information Technology
IUCD	Intrauterine Contraceptive Device
JE	Japanese Encephalitis
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KTS	Kala Azar Technical Supervisors
LBW	Low Birth Weight
LHV	Lady Health Visitor
LLIN	Long Lasting Insecticide Treated Nets
LR	Labour Room
LSAS	Life Saving Anaesthetic Skills
LT	Laboratory Technician
MB	Multi-bacillary Cases
MCV2	Measles 2 nd Dose
MCTS	Mother and Child Tracking System
MDA	Multi Drug Administration
MDR	Multi Drug Resistant
MIS	Management Information System
MHW	Male Health Worker
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MOIC	Medical Officer In-charge
MoU	Memorandum of Understanding
MPW	Multi-purpose Worker
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NNF	National Neonatology Forum
NBCC	Newborn Care Centre
NBSU	Newborn Stabilization Unit
NCD	Non-Communicable Disease
NE States	North Eastern States
NFHS	National Family Health Survey

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NGO	Non-Governmental Organization
NHSRC	National Health Systems Resource Centre
NICU	Neonatal Intensive Care Unit
NIHFW	National Institute of Health & Family Welfare
NIPI	Norway India Partnership Initiative
NPCB	National Programme for Control of Blindness
NPHCE	National Programme for Health Care of the Elderly
NPPF	National Programme for Prevention and Control for Fluorosis
NLEP	National Leprosy Eradication Programme
NPCDCS	National Programme for Prevention and Control of Cancers, Diabetes, Cardiovascular diseases and Stroke
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Suraksha Karyakram
NSV	Non-scalpel Vasectomy
NTCP	National Tobacco Control Programme
NVBDCP	National Vector Borne Disease Control Programme
OCP	Oral Contraceptive Pills
OOPE	Out of Pocket Expenditure
OPD	Out-Patient Department
OT	Operation Theater
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex- selection) Act - 1994
PHC	Primary Health Centre
PHN	Public Health Nurse
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPH	Postpartum Hemorrhage
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
PW	Pregnant Women
PWD	Public Works Department
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RHFWTC	Regional Health & Family Welfare Training Centre
RHP	Rural Health Practitioner
RKS	Rogi Kalyan Samiti
RMA	Rural Medical Assistant
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Reproductive Tract Infection
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SDH	Sub Divisional Hospital
SHC	Sub Health Centre
SHG	Self-Help Group
SHP	School Health Program
SHS	State Health Society
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SN	Staff Nurse
SNCU	Sick Newborn Care Unit

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SPMU	State Programme Management Unit
STG	Standard Treatment Guideline
TB	Tuberculosis
TNMSC	Tamil Nadu Medical Services Corporation Limited
ULB	Urban Local Body
USG	Ultrasonography
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
WIFS	Weekly Iron Folic Acid Supplementation

EXECUTIVE SUMMARY

BACKGROUND

The seventh Common Review Mission (CRM) of the NRHM was held from November 8 to November 15, 2013. It was the first review mission of the National Health Mission (NHM), which comprises the existing National Rural Health Mission (NRHM) and the new National Urban Health Mission (NUHM) as its two sub-missions. The CRM covered a total of 14 states - nine high focus (including three NE States) and five non-high focus states. A total of 197 members divided into fourteen teams comprising of government officials, public health experts, and representatives of development partners and civil society visited these states. Following a state level briefing on the status of NHM, the respective state teams visited two selected districts to review field level programmes. The teams then shared their findings and recommendations with key stakeholders at the state and submitted detailed reports. These formed the basis of the seventh CRM report.

KEY OBSERVATIONS

TOR 1 - Service Delivery

The population served per facility has improved across states of Jammu & Kashmir, Karnataka, Maharashtra, Arunachal Pradesh and Nagaland, but the development of new facilities based on a “time to care” standard is a new frontier that will now need to be addressed. Difficult terrain and scattered population continue to remain a hurdle in states like Himachal Pradesh, Arunachal Pradesh and Nagaland, further hampered by extreme weather conditions and lack of assured transport in these regions.

However, it is encouraging to note that states are taking special initiatives in high priority districts with additional resources in the form of incentives, financial motivation, infrastructure development and on-site mentoring to improve services.

Considerable investment has been made in improving infrastructure, particularly in facilities catering to institutional delivery services. Establishment of separate infrastructure wings has facilitated the quality and pace of construction as observed in Karnataka, Maharashtra and Madhya Pradesh. Increased pace of construction of additional MCH wings at high caseload facilities was observed in Himachal Pradesh, Maharashtra, Odisha and Meghalaya although in a few states, investment of infrastructure is not linked to caseloads. Construction of residential staff quarters fall short in a majority of the states, except Maharashtra where it is available in adequate numbers.

AYUSH facilities are co-located in many states except Jharkhand, Bihar and Uttar Pradesh. Good utilization of AYUSH services is seen in the states of Haryana, Maharashtra, Meghalaya and Nagaland. Increase in OPD is seen in Maharashtra where

efforts have been focused in building the capacity of AYUSH MOs. In many states, AYUSH MOs are also being utilized for providing OPD in places where there is no allopathic doctor, for monitoring and to serve on RBSK and school health teams.

Across the states, policy makers and programme officers are attempting to improve service quality. The pattern of quality of care has not improved in proportion to the demand for services, and is sporadic with few states showing progress in some dimensions. Quality assurance appears to be limited largely on forming quality assurance committees. The new approach, with its emphasis on being able to measure and certify quality and close quality gaps in a time bound manner is yet to be rolled out in the states. However, many states have built up capacity to do this through pilot programmes and show a willingness to scale up. Development partners are supporting the implementation of quality programmes for a limited set of services, such as Intra Natal Care, Immediate Post-Partum Care Standards, Facility Readiness Assessment and Accreditation of SNCUs, but this is yet to be scaled up by the public health system.

Biomedical Waste Management (BWM) and sanitation services have improved across all states except Arunachal Pradesh, Bihar, and Jammu & Kashmir. Outsourcing to third parties – for BWM and sanitation services, is the norm across all states visited. Provision of running water, electricity and power back up are good in all states except Arunachal Pradesh. On the other hand, implementation of Infection control Practices (IP) require stricter enforcement. It was notably poor in Himachal Pradesh, Bihar and Odisha. Adherence to Standard Treatment Protocols while showing signs of improvement in SNCU and NBSU continues to be a weak area in labour rooms and needs improvement across states. Grievance redressal mechanisms are yet to be established and where available, their effectiveness is limited.

Sub-contracting is also seen in the areas of security and diet. There have been definite improvements in cleanliness, laundry services and security. Sub-contracting is greater at the District Hospital level and the sub-district facilities rely on in-house capacities for providing ancillary services. Diet is most commonly outsourced in many states such as to self-help groups in Odisha.

Most states, except Jharkhand and Madhya Pradesh, report a mix of Dial 102 & 108 models for patient transport ambulances, with good standardization of the 108 model and good services in all areas, irrespective of provider. All states have inter-facility transfers in place and often 102 services play this role. Most ambulances are linked with centralized call centres, though in some states, reports on 102 services are mixed for e.g., GPS is not fixed or functional, call-centres have varying degrees of functionality, EM technicians do not have the necessary training and support, and the rates of pick up are poor. Both are a challenge in all areas with dispersed populations and hilly terrains, but there are positive reports of partnerships with private local vehicles from these areas such as *Mamta Vahans* of Jharkhand and the *Janani Express* in Odisha. Given the multiple models of ambulances and an increasing trend of assured referral transport, some gaps remain in enabling assured referral services. There were reports of out of pocket expenditure on account of paying for diesel or cost per km in some states such as, Meghalaya and Arunachal Pradesh.

MMUs have added value in terms of making services available to remote areas. In a few states, MMUs have been outsourced to NGOs such as in Jharkhand, or are operated in a PPP model as in Maharashtra, although monitoring needs to be strengthened. In states where MMUs are operational, remote areas have benefited, with an average of 70-80 patients per visit. The services are limited to general OPD, ANC/PNC checkups and basic laboratory services in some states for e.g. Jharkhand. While PPP models are claimed to be successful by the state, community discussions do not convey this. Some reports observe that there might be duplication of services and that states are yet to clearly demarcate the area and responsibility of MMU services.

In some states like Jharkhand and Odisha impressive progress has been made in developing a structured communication strategy relevant to their communities and local contexts, but other states still rely upon traditional methods of IEC/BCC. Capacity building for planning and implementing communication strategies is limited in most states.

TOR 2 - Reproductive and Child Health

States have shifted their strategic focus and attention to identifying facilities and prioritizing their functioning as delivery points. There is focus on strengthening quality parameters across these facilities. However, in areas where institutional delivery is low, systematic planning to increase the numbers of delivery points across districts and blocks is lacking. Some states have almost entirely excluded sub centres and the vast majority of PHCs perform the delivery function except in Haryana, Uttar Pradesh, Odisha and Jharkhand where the sub-centres serve as delivery points in the high focus districts.

There has been an increase in antenatal care provided across all states except Andhra Pradesh and Uttar Pradesh. Lack of diagnostics and stock out of IFA hamper provision of quality and complete antenatal care. ASHAs appear to be facilitating mobilization of women for antenatal care. Tracking of severe anemic and high risk pregnancies needs greater strengthening. Completion of MCP cards is still a challenge in most states except Karnataka and Andhra Pradesh.

HMIS reports also show increases in institutional deliveries in several states– Arunachal Pradesh, Nagaland, Meghalaya and Jharkhand, with low baselines, have recorded a faster change, but there is only a marginal increase in Bihar, Andhra Pradesh, Gujarat, Himachal Pradesh, Haryana and Uttar Pradesh. Uttar Pradesh shows a shift from the public to private sector. Home deliveries on the other hand remain a challenge and the situation is exacerbated by very few SBA deliveries and possibly significant under reporting from difficult terrains and tribal districts.

JSY is well established with increased awareness among the public and JSSK is also operational in all states, resulting in considerable reduction of OOP. However, benefits for entitlements for sick infants are still to be realized. Awareness of entitlements was low in some states. Out of pocket expenditures were also seen largely in the areas of drug, diagnostics and referral transport. Some aberrations were user fees levied on pregnant women in Pratapgarh district, Uttar Pradesh and cash reimbursements for diet

in Nagaland. JSY payments have become far more streamlined than previous CRM reports suggest. However, since the introduction of DBT, delays were reported from Himachal Pradesh and Nagaland. Reports suggest that opening a zero-balance bank account is a deterrent in some states. Conditionalities such as 48 hours stay post-delivery and demand for documents sometimes results in exclusion of beneficiaries, as in Himachal Pradesh and Odisha.

Reporting on MDR while showing improvement over time still does not exceed more than 50% of estimated deaths with cause of death analysis still being limited to the clinical causes and no programmatic linkage. Reporting of infant deaths although showing improvement continue to be weak. Implementation of maternal and infant death reviews are weakest in states with the highest mortality rates, although functional MDRs are in place in more states than earlier.

A majority of the states have ensured the provision of well-ventilated, clean labour rooms with necessary electricity back up and attached toilet facilities. SBA trained personnel are available at delivery points, but variations in skills were seen. A positive change from earlier CRMs is the operationalization of increasing number of CHCs into functional FRUs, thereby expanding access to Comprehensive Emergency Obstetric Care services. However, the lack of adequate numbers of functional blood banks/blood storage centres continue to limit the establishment of EmoNC services. C-section rates have improved across the states but are still inadequate in Bihar, Uttar Pradesh and optimal in Gujarat and Haryana. It is high in Andhra Pradesh and Karnataka where majority of the caseload come from the private sector.

In high focus states, BEmONC provision in 24X7 PHCs remains a matter of concern. Skills of staff in prevention and stabilization of complications like PPH have improved but are still weak in Odisha, Jharkhand and Uttar Pradesh.

Comprehensive abortion care and RTI/STI services are available mainly at Level III centres. Rational deployment of trained manpower to operationalize these services remains an issue. The non-availability of trained staff for safe abortion at CHCs and PHCs is cited in Arunachal Pradesh, Nagaland, Himachal Pradesh, Meghalaya and Odisha. Majority of the states also have shortage of Mifepristone and Misoprostol for medication abortion. In Arunachal Pradesh, Karnataka and Jharkhand lack of MVA equipment was observed.

There is an impressive rise in the number of Special Newborn Care Units, New Born Stabilization Units and New Born Care Corners established across all states. ASHAs are being trained in Home Base Newborn care in all states, except Himachal Pradesh where there are no ASHAs. An important priority in the tribal, difficult and remote districts with high newborn deaths is to ensure Home Based Newborn Care and facilities for stabilising newborns and the next priority should be establishment of SNCUs. This needs to be done particularly in the case of Sahibganj in Jharkhand, in both districts of Arunachal Pradesh, Dang in Gujarat and Kupwara in Jammu and Kashmir.

There is good compliance with infrastructural norms, quality care and availability of trained staff through adherence to standard treatment protocols in Andhra Pradesh, Haryana and Karnataka. There are positive reports of ASHA providing home based

newborn care and initiation of home visits for mothers and newborns across states. While good functionality of Nutrition Rehabilitation Centres are reported from Maharashtra, Odisha, Jharkhand, Andhra Pradesh, Karnataka and efforts are being made to improve community level linkages, the number of post discharge follow-up remains low. There is low utilization of NRCs in Gujarat and Uttar Pradesh indicating low detection and referrals by frontline staff.

The Rashtriya Bal Swasthya Karyakram (RBSK), is in its nascent stages in a majority of the states. They are in the early stages of recruitment of dedicated block school health teams, operationalizing of District Early Intervention Centres and undertaking school health level screening for illness with one-way referral. The School Health Programme in Pratapgarh district, Uttar Pradesh is doing well and holds lessons for RBSK.

Most states, except Uttar Pradesh and Arunachal Pradesh, have operationalized Adolescent Friendly Health Clinics (AFHC) at tertiary level facilities but there is no significant increase in the caseloads. Dedicated counsellors are present in Andhra Pradesh, Haryana and Himachal Pradesh while Integrated Counselling and Testing Centre (ICTC) counsellors provide services in Nagaland, Karnataka and Jharkhand. Community outreach and referral linkages remain weak, but a few states like Himachal Pradesh, Gujarat, Odisha, and Jharkhand have made efforts at assimilating this within the adolescent health care services.

Most states, except Jammu & Kashmir, have implemented the WIFS programme. In Jharkhand there is weak implementation of the programme. There is extensive promotional IEC contributing to the successful roll-out in states such as Haryana and Uttar Pradesh. The implementation of the Menstrual Hygiene scheme has stabilized and there is a wider acceptance of sanitary napkins amongst the adolescent girls.

Under the family planning programme, implementation of Post Partum Intrauterine Contraceptive Device (PPIUCD) is getting underway. Counsellors are posted in all states except Arunachal Pradesh, Jharkhand and Meghalaya. Home delivery of contraceptives by ASHAs has begun in all states and their effectiveness is affected by low supplies in Jharkhand, Arunachal Pradesh and Uttar Pradesh. The scheme for ensuring birth spacing by ASHAs has been implemented in most states.

Improvements in the cold chain and vaccine logistics continue. Strengthening is required to improve vaccine inventory management and conduct refresher and orientation trainings. Regular Village Health Nutrition Days (VHND) are conducted and some states like Odisha, Andhra Pradesh, Karnataka and Himachal Pradesh have delinked the immunization activity from VHNDs.

TOR 3 - Disease Control Programmes

Under Integrated Disease Surveillance Programme (IDSP), adequate IT infrastructure was reported from all visited states but lack of IT support and maintenance hampers functionality in many states. Data analysis is taking place at the district level but at sub-district level this is still not happening. District and state level rapid response teams are

available but functionality of block level rapid response teams is weak. The toll free number 1075 is available in many states except in Meghalaya but the utilization of this number needs to be strengthened. IDSP data is not being used for better planning and implementation.

A downward trend is observed in incidence of malaria cases in Gujarat, Himachal Pradesh, Jharkhand, Maharashtra, Jammu and Kashmir, Nagaland, Odisha, Uttar Pradesh and Meghalaya. Surveillance activities needs to be improved to increase the current Annual Blood Examination Rate (ABER) to a target of 10% in Himachal Pradesh, Jharkhand and Arunachal Pradesh. Odisha reported number of innovations like the “*Mo-Mashari*” and “*Nidhi Rath*” scheme to create awareness at community level. There is marked increase in dengue cases in Meghalaya, Himachal Pradesh, Jammu & Kashmir, Arunachal Pradesh and Odisha.

In the case of Tuberculosis (TB), there is improvement in case detection in Gujarat and Himachal Pradesh, but there is a decreasing trend observed in Maharashtra. Many states reported lower than the expected norm of 152 cases per lakh population per year. In addition to Integrated Reference Laboratory (IRL) and Drug-Susceptibility Testing(DST) labs, GeneXpert™ has been established to further strengthen the diagnosis of drug resistant TB in many states. Registration of TB cases under NIKSHYA varies from 59% in Nagaland to 80% in Jammu and Kashmir. Paediatric TB case detection rate is low in all visited states and this needs to improve by appropriate training of Medical Officers.

In the case of Leprosy, Himachal Pradesh, Maharashtra and Jharkhand report effective implementation of the programme with MDT drugs. Increasing trend of active cases are reported from Valsad in Gujarat and Nandurbar in Maharashtra. In Odisha, 19 districts report a prevalence rate of more than one and three districts report a prevalence rate more than three. However, there is concern of under-reporting in Maharashtra and the problem of ASHAs incentives not being paid on time in Meghalaya.

In the area of non-communicable diseases, National Programme for Control of Blindness (NPCB) is carried out through a network of public, private and NGO network in many states. The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) is ongoing in selected districts. Kupwara district of Jammu & Kashmir shows exemplary work in implementation of NPCDCS. The national programme for prevention and control of fluorosis was seen in Nayagarh, Nuapada and Angul districts of Odisha. Sickle Cell Anemia programme is being implemented in a phased manner in Maharashtra, and in Gujarat it is implemented in the tribal districts.

TOR 4 - Human Resources for Health and Training

Streamlining of the recruitment process, including innovative methods adopted by states like online application system and direct walk-in interviews, have led to an increase in the workforce pool. There is a substantial increase and improved functionality of AYUSH doctors. Regular posts under state governments are filled up. The sanctioned posts have not increased proportionately. Vacancies of specialists remain a critical issue. States such as Odisha and Himachal Pradesh are successfully

implementing incentive packages for staff in rural and remote areas, while states like Maharashtra, Haryana and Himachal Pradesh offer incentives such as PG reservations.

Remuneration disparity between contractual and regular staff is a cause of increased attrition rates and demotivation amongst contractual staff.

Online HR database has been established in Jharkhand and Odisha, while it is in progress in Bihar.

Training plans are in place but implementation is slow with little district level involvement in training need assessment and training planning. Training institutions are not engaged in the process of either selection or post training deployment in almost all states.

TOR 5 - Community Processes and Convergence

VHSNCs have been formed at all the states visited – at the Gram Panchayat level in Andhra Pradesh, Haryana, Bihar and Uttar Pradesh and at the village level in other states. The activities undertaken by the VHSNCs range from environmental sanitation, vector control measures to health promotion events. Participation of PRI members is reported from all states except Bihar, Uttar Pradesh, Karnataka, Arunachal Pradesh and Meghalaya. All states have conducted trainings for VHSNC members, although quality and content are variable. Regular meetings, minute records were available where there is active engagement of the PRI members. Community monitoring is implemented in Jharkhand, Bihar, Maharashtra, Meghalaya and Nagaland with greater community participation and improved health service delivery.

The ASHAs continue to act as a vibrant interface between the community and health system and their selection is near completion in all CRM states, except Himachal Pradesh, which has recently launched the programme. Selection gaps and shortfall is seen in poor performing districts and areas of marginalized populations. Support structures for ASHAs have been established at varying levels from district to below block levels in all states except Jammu & Kashmir where there is one nodal officer at the State level overseeing the programme. Bihar, Meghalaya and Uttar Pradesh with a support structure in place are unable to provide the requisite job mentoring and field based training for ASHAs due to shortages and poorly trained support staff.

ASHA training in Module 6 & 7 is in progress with slow pace of training in Uttar Pradesh, Bihar, Jammu & Kashmir and Haryana. Multiple refresher trainings and on the job mentoring are necessary to retain the acquired skills and knowledge. Frequent drug stock outs, poor quality and delays in distribution of HBNC equipment hamper the services provided by the ASHAs.

Although payments of ASHA incentives have been streamlined, delays continue to be reported. Cash payments are reported from Arunachal Pradesh, Meghalaya and Nagaland and delays of up to three to six months in Uttar Pradesh and Jharkhand respectively. The average incentives range from Rs.250 – Rs.4000, with the highest incentives reported from large populous states like Bihar and Uttar Pradesh. Non-monetary incentives are also provided by states like the insurance scheme for ASHAs in

Jharkhand, inclusion of ASHAs in the *Swalamban Yojana* in Odisha and educational support for ASHAs in Bihar. The ASHAs role in non-RCH activities, especially in less densely populated or low fertility areas needs to be emphasized.

The ten-indicator based performance monitoring of all ASHAs has been introduced in all states except Uttar Pradesh, Andhra Pradesh, Gujarat, Jammu & Kashmir and Arunachal Pradesh. Inter-departmental convergence, beyond VHNDs, is not evident in the field visits. While formal grievance redressal mechanisms have been established as per guidelines only in Bihar and Haryana, rudimentary grievance redressal mechanisms are in place in several states although their effectiveness is limited.

TOR 6 - Information and Knowledge

The quality of HMIS data has improved and all the states periodically upload facility wise data in the national HMIS web-portal, though contribution from the private facilities and medical colleges is still minimal. Poor design of primary register and lack of uniform registers across facilities are persisting concerns, which compromise the quality and flow of data, more so in tertiary level facilities with large caseloads. Many states have also adopted multiple IT systems for managing and analyzing data, however that is not effectively utilized for programme monitoring, planning and management.

MCTS registration is fair, but despite generation of work plans and due lists its use in tracking women and children is still weak in most states. The line listing of severely anemic women has not improved and requires monitoring and supportive supervision.

SHSRCs are functional in Haryana, Karnataka, Odisha and Maharashtra. SIHFWs are well established in Himachal Pradesh and Odisha, whereas RHFWTCS and ANMTCs where available show considerable gaps and constraints. While states have made budgetary provisions for studies and evaluations, almost no state reports utilization of this- or any major studies done

TOR 7 - Financial Management

Fund utilization is at the same level as in previous years but some of the earlier cited reasons – lack of staff, lack of e-transfers of funds, knowledge of accounting processes etc. are much less. Delays in reporting is noted where financial staff is inadequate. There are delays in reimbursement for outside agencies notably PWD, and to facilities with high unspent balance.

Human resource for accounting is available as per requirement in almost all states but accounts staff at PHC level is a problem in many states. Accounts staff reported lack of training on the use of Tally software. Closing of cash books on a daily basis is not taking place in many states and noncompliance to income tax was observed in states like Odisha and Arunachal Pradesh.

Electronic transfer of funds is taking place only up to the block level, and cheques are used for transferring funds, below the blocks. Bank reconciliation is another common issue reported across all the states.

Diversion of funds from one program to another without approval was observed in all states, and is an area of concern. Fund utilization under Janani Suraksha Yojana (JSY), Untied Fund, Annual Maintenance Grant (AMG) and Rogi Kalyan Samiti (RKS) is very low across all states while zero utilization under Immunization was reported in Odisha.

TOR 8 - Medicine and Technology

Most states are now articulating a policy of free essential drugs in public facilities. This was particularly evident in Bihar, Himachal Pradesh, Maharashtra, Haryana and Gujarat.

Karnataka, Haryana and Gujarat have established a Medical Corporation for procurement of medical equipment and drugs while Bihar and Jammu & Kashmir have begun the process. Maharashtra, Odisha and Himachal Pradesh are committed to establishing such a system- but even as of now, there are substantial improvements in procurement and logistics.

CRM teams to Meghalaya and Nagaland and Arunachal Pradesh characterise the state level procurement systems as inadequate- and not coordinated with the demands and needs of the districts. In Jharkhand and Uttar Pradesh the state level rate contract with district level order placement system is introduced but its implementation is seriously flawed.

Some form of computerized drug inventory management system is in place for more states than in earlier CRMs. More states report improved and new warehouses. Drug inventory management at facilities is unsatisfactory in the states of Himachal Pradesh, Bihar, Jammu and Kashmir, Jharkhand and Nagaland.

Overall shortage of staff for drugs management was observed but there was effective deployment of the staff. Lack of cold-chain mechanics was noted in a few states. The availability, record-keeping and supply of drugs was found satisfactory in case of AYUSH drugs across all the states. However, in many states AYUSH drugs are not included in the drug inventory management system.

More states have put in place EDLs and many now display them in facilities. Standard Treatment Guidelines are less in evidence, but even where it is in place, observing their use is a challenge. Outsourcing Diagnostics is another developing trend, but there is insufficient information and mixed perceptions of whether it is working. This has been reported from Bihar, Himachal Pradesh and Gujarat.

Availability and maintenance of equipment is a mixed picture across states- and is currently an even greater challenge than with drugs. Guidelines for better management and maintenance of equipment is a much-required need.

TOR 9 - National Urban Health Mission

In every state, work has begun on NUHM. States are engaged with identification of slums, gaps in HR and facilities and developing PIPs. Many cities visited had functional

urban facilities in PPP mode and community health workers. There is a need to maintain continuity of these programmes as well as to upgrade them.

FGDs from the CRM visits present a picture of diverse needs. For example in Jharkhand KalaAzar, Malaria, Filariasis, RTIs, water borne ailments such as gastroenteritis, Jaundice etc. were highlighted. In most states, there was NCD and mental health issues.

Special strategies are needed to address the increasing prevalence of substance abuse and dependence in slum areas, alcohol abuse, and domestic violence.

Involvement of urban local bodies (ULB) is varied- with some states like Maharashtra having made a good effort and others yet to start so. Strengthening of convergence between ULB, State Health Department and related other departments such as Social and Women Welfare etc. is the need of the hour.

TOR 10 - Governance and Management

Across all states, the State Health Societies (SHS) and District Health Societies (DHS) are functional and much better coordinated with pre-existing structures of the Department and the Directorate. There are some states however, such as Meghalaya and Arunachal Pradesh where coordination is still seen as a problem.

The roles of the directorate are however, weak and strengthening of the directorate's role has not been significant. The level of governance exercised by the Governing Board is uncertain. Most decisions are taken at the level of the executive.

Most states have an adequate State Programme Management Unit in place- but the capacity of District Programme Management Units is more varied. The quality and functioning of block programme management is even weaker and many states do not have adequate staff in place.

It was a common finding that for officers working at peripheral level access to up-to-date guidelines is a challenge. Most often they do not receive them or the ones followed by them are not the latest guidelines, leading to confusion and non-implementation of the programmes.

All States have initiated mechanisms of supportive supervision but with different degrees of effectiveness. E-governance systems are yet to take off. Horizontal Accountability mechanisms within the State – like community monitoring or *Jan Sunwais* etc are few.

Steps are taken to implement Pre-Conception and Pre-natal diagnostics Act (PCPNDT) by the States and implementation of Clinical Establishments Act is just picking up.

RECOMMENDATIONS

TOR 1 - Service Delivery

- Each district must be able to document which habitations and what proportion of people have no access using time to care as the standard. It must also be able to document gaps in beds and facilities with respect to the norms, and plan to close the gaps in consonance with 2011 census.
- There is a need to ensure district health planning based on sound situational analysis. The plateau and even decline in utilization of services, in many districts—mostly for inpatients, requires more attention to understanding the match between the need for services, availability of services and the quality of services. While there is an understanding of this with regard to institutional deliveries—on all other healthcare issues—such information or planning is currently not evident.
- There is a need to match inputs – especially infrastructure, trained human resources and supplies to those facilities where caseloads are higher—and conversely to correlate additional inputs with increased services.
- There is an urgent need to address persistent gaps in blood banks (managed by NACO) and Blood Storage Centres with many districts still reporting the lack of these. There is also a need to understand why blood storage units as a concept are doing so poorly across all states. It would be worth mapping the current situation on blood availability by CHC/Block and then making a state level plan to close these gaps in a time-bound manner. While doing so, it would be advisable to start with needs for emergency obstetric care, but also go beyond it to estimate needs for blood transfusion more comprehensively.
- Quality of care though improving, is still in a fragmented manner and with inadequate space. There is an urgent need to roll out implementation of the new operational guidelines on quality assurance in a time-bound manner.
- Sub-contracting of supportive functions of the hospitals especially as related to sanitation, bio-waste management, diet is reported as having good results at least in terms of starting up attention in this area. However in Bio-Waste Management, the quality of services has mixed reports— with unsafe disposals reported from a few states. Implementation of Bio-medical waste management should be linked to the planning and practice of comprehensive infection prevention plans. On diagnostic outsourcing the reports are mixed, and we would need to study and learn from experiences on the ground.
- While access to drugs is better, and could be the reason for sustained increases in outpatient attendance, this does not apply for diagnostics where user fees and the physical lack of services are a major constraint.
- Out of pocket expenditures are an access barrier and contrary to NHM goals of social protection. Measurements of OOP would be important in order to monitor reduction and elimination.
- Regarding 102 and 108 the main message seems to be that in remote areas with dispersed populations, decentralised tie-ups through a call centre or even simpler means between facilities and local private transport providers, must be persisted with, since they are essential to ensure timely pick up and organise drop-back more

efficiently. Such tie-ups must be seen as necessary supplements to the 108 services- and not as an either-or option.

- Mobile Medical Units in some states are playing a very useful role- either supplementing sub-centre level services for non-communicable disease as in Andhra Pradesh and/or increasing access to sub-centre services by visiting smaller habitations as in Maharashtra. But this should be made uniform across states.
- The current approaches of IEC/BCC have inadequate penetration to the facility and the community level. There is a need for building district level institutional capacity for better planning and management and measurement of outcomes of IEC/BCC activity.

TOR 2 - Reproductive and Child Health

- The findings from the state seem to indicate that there appears to be a need to re-examine planning for delivery points. States need to ensure that delivery points are adequate to meet caseloads and time to care particularly where there are high home deliveries. The entire range of services including essential RCH components- like ARSH, family planning, and safe abortion, RTI /STI should automatically follow at least at level 2 facilities. Finally, the step would be to score the facility for quality of care and put in place commensurate improvements.
- Map the availability of blood with reference to FRUs and ask state to put in place a time bound plan to open necessary blood storage units or banks.
- The Nutrition Rehabilitation Centres (NRC) need to be optimally operationalised by improving linkages in the home/community setting and with facilities for referral and follow-up for comprehensive clinical examination of the children for morbidities and coordination with the WCD.
- Strengthen vaccine logistics management, temperature control, equipment maintenance, stock management and training of those working on the immunization programme.
- Decreasing the dropout rate and increasing the full immunization coverage needs strengthening by preparing due lists and tracking the beneficiaries and mobilizing them for vaccination.
- Facility based newborn care should be strengthened with focus on quality, adherence to protocols, prioritization and reorganization of the resources and building state capacities through partnerships with resource centres, medical colleges and other technical agencies. The referral link between home based and facility based newborn should be strengthened.
- There is a need to strengthen diarrhoea and ARI management in children- by better supply of drugs, and training/orientation support to front line workers for this task.
- Speed up the implementation of DEICs under the RBSK programme; make school level screening more comprehensive as proposed with good two-way referral systems. Other aspects of RBSK at newborn and the preschool child also need to be rolled out.
- Continue to support the implementation of home based newborn and sick infant/child care- with better access to drugs and support.

- Build on the maternal and infant death reviews with more skills on analysis and use of information for public health action.
- Focus on establishing MTP services in all FRUs aiming further to cover all 24X7 facilities, reorientation of providers on Comprehensive Abortion Care guidelines, focused extension of PPIUCD services to all delivery points with high client load and regular updating of the eligible couple register should be priority. Similarly, in all states, further promotion of Non-scalpel vasectomy (NSV), use of spacing methods and counselling should be the key focus.
- There is also an urgent need to follow up on the reasons why trained providers are not performing PPIUCD insertions.
- Minilap should be promoted and trained providers should be posted in PHCs where facilities exist thereby making these services more accessible to people across the states.

TOR 3- Disease Control Programmes

- As the number of disease control programmes multiply, the importance of district health planning for their integration gains importance. The plan should be based on disease epidemiology, and on current availability and utilisation of services. The plan should spell out which services would be available at what facility and how the continuity of care for Communicable Diseases and Non Communicable Diseases across facilities providing primary, secondary and tertiary levels of care would be organized.
- District/block action plan need to use IDSP data and data from the MIS of disease control programmes more rigorously for better and more effective planning and implementation of various disease control programmes. The data collected from IDSP needs to be reviewed on monthly and quarterly basis.
- Attention to infrastructural issues is required to make Edu-Sat and Inter Voice system functional and the system more responsive for IDSP.
- IEC/BCC for National Vector Borne Disease Control Programme needs strategies for engagement with migrant population, which will help in stemming the increase in number of cases. IEC activities in local language may be displayed at prominent public places in district and PHCs.
- All the vacant post to be filled on priority basis to implement the time bound activities for prevention and control of NVBDCPs. Reorientation/training may be given to LTs/ASHA etc.
- ASHA and ANM can be involved in all states for slide collection/use of RDKs in NVBDCP at field level and incentives for this purpose must be released on time.
- All health workers and MOs must be familiar with drug policy for malaria particularly for treatment with ACT. Adequate stock needs to be maintained for specific age group- which requires much better logistics management.
- Simple source reduction for elimination of breeding sources of vectors can be done within VHSNC activities.
- There is need for improving collaboration and engagement with private providers along with public sector for strengthening TB notification for better case detection.

- There is need to establish sputum collection and transportation mechanism in the PHCs where DMCs are not established under the supervision of MO/THO with maintenance of sputum transportation register.
- Under RNTCP, to make NIKSHAY real-time data, the data entry needs to be done at every PHC and block through Pharmacist /DEO /any staff available.
- There are major gaps in implementation of NCD programmes across districts. In most places, it has not yet gained importance as a public health problem and the most important step forward is for advocacy and demand generation for care of chronic illness.
- There should be a clear plan for establishment of primary care for NCDs- both the screening for diseases and the follow up on doctor/specialist initiated drugs. Access to drugs for chronic illness must be at PHC level or even at the sub-centre level and on a regular basis.
- Necessary infrastructural, logistics and HR supports should be provided to counter these silent killer diseases – but in an integrated manner. Thus the state should have a good drug logistics system, and one should ensure that such a system has all the drugs needed for NCDs.
- IEC/BCC activity addressing NCDs needs to be stepped up.

TOR 4 - Human Resources for health and Training

- Further increase in service providers is essential – and there is need for a clear policy articulation that states must be committed to achieving minimum levels of the regular public health workforce as per IPHS for carrying out core functions of facilities and this should go along with measured increase in service delivery. Targets need to be defined for both, prioritizing facilities with high caseloads.
- States need to devise policy for retention and motivation of staff by developing good performance based incentives including parity between regular and contractual staff.
- Decentralization of recruitment process for contractual appointments of all posts to district level with higher pay packages in the form of difficult area allowances for more difficult and remote districts should be considered, with state engagement when districts are unable to find candidates.
- Rational deployment of specialists such as obstetricians, anaesthetists, paediatricians and EmOC & LSAS trained M.O.s in designated FRUs should be ensured. All MOs with PG qualifications need to be posted in CHCs, block PHCs or higher centres.
- Establish and strengthen an HRH cell that undertakes all the “establishment” matters (recruitments, payments, training, career progression & grievance redressal) of all contractual staff exclusively. Frequent change of leadership at Mission Directorate office further raises the need of such a cell to maintain continuity.
- Online Human Resource Management Information System (HRMIS) should be scaled up in all states to facilitate decision-making process thereby ensuring better human resource planning and deployment. HRMIS should also be expanded to create

training database and in planning for training. Salary bills should be guaranteed through HRMIS to ensure regular updation of postings.

- Need to introduce separate cadres for clinical specialists and public health professionals with dedicated career progression pathways. It would help skilled human resources to gain expertise in their respective domains by gaining experience over the years.
- The health facilities must be categorized on the basis of degree of difficult-to-access, remoteness, and a package of measures put in place to encourage postings in these areas. These measures may include time-bound promotion linked with mandatory posting at all categories of workstations.
- Standardization of performance appraisal systems- both team and individual based- should be established in all states, with similar scoring systems applied for both contractual and regular employees.
- Standard Treatment Guidelines (STG) should be constituted by the states for each category of clinical service providers (Medical Officers, Rural Medical Assistants, AYUSH MOs, nurses and Paramedics) to address knowledge and skill gaps and improve their performance. Mentors from medical colleges and other centres of excellence should be involved for clinical mentorship.
- Managerial training needs to be continued up to district and block level officials for effective planning, monitoring and supervision under the programme.

TOR 5 - Community Processes and Convergence

- States should consider making the VHSNC more inclusive to ensure representation of the PRI, Community members, particularly women and the marginalized, and enable a central role for the ASHA in the committee. States need to build mechanisms to support VHSNCs to undertake the five tasks of: a) monitoring and facilitation of access to all health and health related public services- especially of marginalised groups within, b) organizing local collective action for health promotion, e.g. vector control, solid waste disposal, health camps etc. c) facilitating service delivery at village levels by service providers or ASHAs visit d) village health planning, and e) community monitoring of health care facilities. All this will necessitate funds at village levels.
- In addition, states should institutionalise training at both state and district levels, expanding the training cadres at district level to include trainers with a background in social mobilization so that the large numbers of VHSNC members are trained in the set of five tasks.
- Enable a realization of community engagement and ensure that VSHNC serve as an effective forum for addressing environmental and social determinants.
- In order to keep pace with the enthusiasm and commitment of the ASHA, states must build and strengthen the support structures so that a viable structure is created not just to support the ASHA but also the VHSNC and the community base planning and monitoring. Training of such support systems and ensuring regular performance appraisals is just as important as training and demanding accountability for ASHA. For states such as UP this is of critical importance given the scale of the programme, the very slow pace of implementation, and the associated nature of poor governance.

- In addition, medical officers and programme managers need to be sensitized to the ASHA programme so that they can provide a programmatic perspective.
- Ongoing refresher training of ASHA is another important area to ensure that her skills are reinforced. Certification of ASHA is an important step in assisting this process, but this needs to be buttressed by on the job mentoring, and using opportunities such as monthly review meetings and cluster meetings to build capacity.
- Grievance Redressal and planning for career opportunities for ASHA are large unfinished agendas for states.

TOR 6 - Information and Knowledge

- A huge effort is going into “facility based reporting on HMIS” and “MCTS reporting”. Both largely pertain to same data elements- but the consolidated figures vary widely. There are problems of data collection, flow and aggregation of information, which underlie this. A serious effort at integrating these systems is essential. It would also help remove the underlying problems that both systems face.
- States need to develop a culture of use of information for short and mid-term planning. This can be achieved by understanding the critical aspect of synthesizing data from multiple sources, and summarizing in view/context of the health situation and trends at local level.
- Most common data quality issues relate to poor primary records, data duplication and other process errors, which are easily identifiable and correctable. States need to systematically solve data quality issues to identify and remove sources of error.
- Health information systems are multiplying rapidly within each state- but they should be able to share data electronically with other databases for example, disease control programmes, MCTS, ICDS programme, civil registration systems etc. The Meta-Data and Data Standards fill an unmet need to provide semantic standardisation across the Health Domain and also provides solution needed for interoperability.
- There must be a clear set of guidelines for SHSRCs, which provides the institutional framework – in terms of governance, mandate, HR policy and financing. A similar framework is also required to make SIHFWs more functional.
- States also need institutional frameworks and capacity building to understand the importance of building knowledge partnerships and reduce dependence on externally funded technical assistance.

TOR 7 - Financial Management

- There is a need to further strengthen and create more regular posts in the area of financial management, as consistent with a long term strategy.
- The good progress made in shifting to electronic accounting and electronic transfer of funds should be continued, strengthened and expanded with special support to those states who are unable to achieve this on their own.
- There is a need to ensure regular annual training of about one week to all those at state, district and block level in charge of accounting and financial management functions. This is all the more essential since there is a high turnover in contractual staff. This requires a clear set of training sites and trainers and a training plan.

- There is a need to better understand the causes of delay in expenditure, even in those states where the first order of problems- related to accounting capacity has been clearly overcome.
- There is a need to simplify the process of resource allocation and accounting for resources such that it supports decentralised planning and management without reducing accountability and outcomes- if the efficiency of fund absorption has to increase.

TOR 8 - Health Care Technologies

- States may be encouraged to make a clear articulation of a policy for free drugs and diagnostics, wherein at least the conditions listed in the assured primary health care services are provided free of cost with access through primary care facilities, and most public hospitals up to and including the district hospital provide most drugs and diagnostics free for inpatients and outpatients.
- There is a need to ensure diagnostic services, which often constitutes the major part of the costs at the same time as planning for free drugs.
- The formation of an autonomous corporation for drug logistics is a necessary but not sufficient condition for solving the problems of responsive drug supplies and quality assurance and cost savings. There is a need to disseminate the process standards for procurement, storage and distribution of drugs and their rational use. These could also help evaluate state logistics.
- The procurement and logistics systems should integrate the needs of AYUSH.
- There is a need to examine and prepare guidelines and build capacity for states with regard to procuring, installing and maintaining bio-medical equipment.
- There is also a need to facilitate procurement of equipment (and if possible even for drugs) through central rate contracts- without diminishing the autonomy of states to follow their own tendering process.

TOR 9 - National Urban Health Mission

- Adequate capacity building to make city plans for NUHM.
- Ensure existing urban health care infrastructure and systems are seamlessly integrated with those that are being introduced with NUHM funding.
- Over all, existing Urban Health infrastructure particularly primary health care related, needs to be mainstreamed into NUHM and strengthened in terms of comprehensive, need-based coverage of services, delivery, staff/HR, drugs and equipment and at the same time enhancement of quality dimensions of health care needed.

TOR 10 - Governance and Management

- There is a need to disseminate the NHM Framework widely and invest in sensitising and orienting the entire leadership to this document as was done for the NRHM document in the year 2006-07. This would help the governance and accountability framework of the mission, (section 5.14.), its directions for improving public health management (section 5.9), its strategies monitoring and evaluation (chapter 7) all of which are essential to the success of the Mission.

- With the adoption of the new NHM framework for implementation, there is a need to renew the commitment to decentralization, integration and convergence and the single most important tool for this is the district health plan as elaborated in the NHM Framework for implementation (section 5.1)
- There is a requirement to strengthen the PMU staff, to orient them on the specific roles and support in relation to the existing governance structures, so that better output is possible at institutional/block/district and state level.
- State level sharing forums are a useful mechanism for sharing experiences and providing feedback.
- Encourage supportive supervision teams / programme officers in-charge to hold 'night-stays' or working with teams at the peripheral level facilities to understand the actual problems faced by the health staff posted there / community accessing services from such institutions.
- Encourage community monitoring of facilities and the participation of community representatives in the functioning of public health institutions.
- It is suggested that a mechanism to ensure access to guidelines at the periphery and ensuring that an 'indexing mechanism' is followed at the institutions, so that there is no confusion on 'which guidelines' to be followed.
- Expedite and support states for consultations on Clinical Establishments Act to actively consider a possible adaption/adoption.

MANDATE AND METHODOLOGY OF THE 7TH COMMON REVIEW MISSION

The Annual Common Review Mission is an important monitoring and in-built learning mechanism of NRHM. Each year since 2007, usually in the month of November, a multi-disciplinary team is assembled, briefed and undertake a visit to a sample of districts to understand the progress of the programme, identify the constraints and distil key learning from the experience. The Six Common Review Missions (CRMs) undertaken so far have provided valuable understanding of the strategies which were successful and have led to several significant mid-course policy adjustments.

This year's Common Review Mission- the seventh of the series- takes place in a new policy context. Most important of these is the launch of the National Health Mission (NHM) with existing National Rural Health Mission (NRHM) and the new National Urban Health Mission (NUHM) as its two sub-missions.

The Seventh Common Review Mission (CRM) of the NRHM and the First review mission of the National Health Mission (NHM) was held from 8th November 2013 to 15th November 2013 in 14 States.

Mandate of the 7th CRM

1. To critically review the functioning of NRHM/NHM vis-à-vis goals and objectives.
2. Review programme implementation in terms of accessibility, equity, affordability and quality of health care services delivered by public health systems including public private partnerships.
3. Review action taken on recommendations of earlier CRMs.
4. Identify constraints faced and issues related to each of the components outlined and possible solutions.
5. Document best practices, success stories and institutional innovations in the states.
6. To identify strategies and outcomes in the State in addition to the ones envisaged by the Mission, both positive and negative.
7. Make recommendations to improve programme management and design.

Geographical Coverage of 7th CRM

The 14 states selected for the CRM were Andhra Pradesh, Arunachal Pradesh, Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Maharashtra, Meghalaya, Nagaland, Odisha and Uttar Pradesh. The choice of states was partly by elimination. Six states were locked out by impending or on-going elections. Some states were facing special problems like Uttarakhand, which was recovering from a natural disaster, and the other southern states had been visited the previous year.

Within each state two districts were selected- usually one which was good performing and another which was poor performing – based on service delivery indicators. Logistics was also a consideration in some states.

Composition and Process

A 12-16 member team comprising of 3-5 Government Officials; 2 Public Health Experts, 1-2 representatives from Development Partners and 1-2 civil society representatives visited each State. In all, there were 14 teams with a total of 197 participants.

The terms of reference (TOR) for the 7th CRM were drawn up and the process began with a briefing of the teams by MOHFW and NHSRC on the 8th of November. The next day the teams reached the state capital where the Mission Director, NHM and the state team briefed the visiting CRM team on all the TORs. Each team was divided into two groups for respective district visits and the district visits began with an interaction with the district officials. In the subsequent four days, the team visited facilities and had interactions with the communities under the overall guidance of the team leader with the rapporteur being a point of contact for the team and co-ordinating the authoring of the report of the team. The teams concluded their visits on the 15th of November with a presentation of their findings to the NRHM state officials and finalised their report and recommendations.

The draft of the final report was circulated to all participants for inputs before publication and dissemination.

Terms of Reference for the 7th CRM

The observations and analysis of the 7th CRM is based on ten themes. These are-

1. Improvements in Service Delivery
2. Reproductive, Maternal, New born and Child Health Programmes
3. Disease Control Programmes
4. Human Resources for Health including Training
5. Community Processes and Convergence Issues
6. Information and Knowledge
7. Financial Management
8. Medicine and Technology
9. National Urban Health Mission
10. Governance and Management

A detailed term of reference was given to each of the team members, which listed a number of questions relating to each of these themes that the teams needed to study. In addition to specific comments on each of these themes, the report was expected to include information on outcomes achieved, against specific objectives as outlined in the Programme Implementation Plans. Reports were also expected to include photographs with appropriate captions and case study narratives.

What is presented in the following pages are the reports and recommendation on each of these 10 themes and a final concluding statement on outcomes followed by a summary of findings from each of the 14 states. While discussing each theme we first present the NHM mandate, then an analytic summing up of the observations from across all 14 states and the recommendations. This is followed by a brief summary of findings on that theme from each state. We note that due to constraints of space, many interesting observations from the 14 states have been left out in this document, but as is the custom, these state reports as summarized and presented by the state teams are made available in a CD that is enclosed with this publication.

Seventh CRM Report

While presenting this final report we begin with quotations from the Framework for Implementation of National Health Mission and the 12th plan to serve as a reference point of the policy direction and strategies set for the Mission in this Plan period.

TOR 1 IMPROVEMENTS IN SERVICE DELIVERY:

Guiding Principles/Strategies of the NHM¹:

- i. *“Build an integrated network of all primary, secondary and a substantial part of tertiary care, providing a continuum from community level to the district hospital, with robust referral linkages to tertiary care and a particular focus on strengthening the Primary Health Care System including outreach services in both rural areas and urban slums”*(Para 2.3.1)
- ii. *“Reduce out of pocket expenditure on health care, eliminate catastrophic health expenditures and provide social protection to the poor against the rising costs of health care, through cashless services delivered by public health care facilities, supplemented by contracted-in private sector facilities wherever necessary”*(Para 2.3.5)
- iii. *“Ensure that all public health care facilities or publicly financed private care facilities provide assured quality of health care services”* (Para 2.3.6)
- iv. *“Ensure increased access and utilisation of quality health services to minimise disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers”*(Para 2.3.7)

Key Observations

1. Adequacy of Facilities

a. In terms of population served per facility, many states have achieved the desired norm and this was confirmed at the district level in the states of Jammu & Kashmir, Karnataka, Maharashtra, Arunachal Pradesh and Nagaland. The state that was most deficient, in terms of even sanction of facilities was Jharkhand. No new facilities were created in Jharkhand since 2007, since the entire focus was on strengthening existing facilities and ensuring that buildings from rented centres began to function from government facilities. Facility planning was done based on 2001 population and now needs to be increased as per 2011 census.

b. Even for hilly, tribal and desert areas, the development of new facilities catering to the percentage, the proportion of population and the number of habitations outside the normative time to care are yet to be used to propose new facilities or identify areas which have a problem of physical access. While the population served per facility has improved across states of Jammu & Kashmir, Karnataka, Maharashtra, Arunachal Pradesh and Nagaland, but the development of new facilities based on a “time to care” standard is a new frontier that will now need to be addressed by the states. Difficult terrain and scattered population continue to remain a hurdle in states like Himachal Pradesh, Arunachal Pradesh and Nagaland. This is further hampered by extreme weather conditions

¹Framework for Implementation of National Health Mission 2012-17

and lack of assured transport in these regions with many habitations being outside the normative time to care.

c. In Himachal Pradesh, roads are good, but snow could be a limitation and travel takes time. In Jammu and Kashmir pockets of inaccessible areas are present where alternative modes of travel like *palki* are used. Meghalaya has identified and categorised facilities based on difficulty of access. Accessibility is also an issue in Jharkhand in form of geographic barriers, cultural factors, illiteracy and high prevalence of left wing extremism. As the system focuses on developing some functional facilities as “delivery points”, it is even more important to ensure that the entire population is brought within the time to care standard of a functional facility.

2. Infrastructure

- a. In terms of adequacy of health infrastructure there is considerable improvement, with many states reporting completion of work that has been ongoing for some time now. In Haryana, the completion rate of construction for SC, PHC and CHC is 58%, 53%, 37% respectively as against total sanctioned numbers since the start of NRHM. In hilly states progress in construction remains slow but there is steady improvement. The states where the reports are not as positive are Arunachal Pradesh and Jharkhand.
- b. One important observation is the large investment made in building up infrastructure to meet the growing caseloads of institutional delivery services. New MCH wings were reported to be under construction in Arunachal Pradesh, Himachal Pradesh, Maharashtra, Odisha, and Meghalaya. MCH wing was found in good clean condition in Jharkhand. Not all states have opted for MCH wings at the district hospitals.
- c. The construction of residential quarters for staff remains inadequate in most states visited. This includes Bihar, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir and Odisha. In Maharashtra alone staff quarters were available in adequate terms.
- d. As observed in earlier CRMs, where there are separate infrastructure wings, the quality and pace of construction is better- for example in Karnataka, Maharashtra and Madhya Pradesh. Haryana has developed an infrastructure development wing at state level and the district collector monitors this at the district level. On the other hand, comprehensive need based planning for infrastructure is missing in Arunachal Pradesh and Jharkhand. Further complicating the situation in Arunachal Pradesh is a random up-gradation of health facilities by political leaders, poorly designed facilities, multiple sources of funding, numerous implementation agencies with poor coordination amongst them and little or no coordination with the district health officer. Early handing over, commissioning and utilization however is good. However, in some states – notably Arunachal Pradesh and Haryana, investment in infrastructure has not been linked to caseloads. In Himachal Pradesh, a junior assistant is the nodal person for civil works in the state. In Jharkhand there is limited monitoring of such activities by the district health administration.
- e. There is a concern that there are no further new buildings being taken up, as resource envelopes are constrained and the funds are being prioritised for existing activities, leaving considerable

funds in the pipelines. The gaps in residential facilities and slowing down on new constructions points to how the resource crunch is beginning to adversely impact programme expansion.

3. Utilization of Facility Based Services:

- a. There has been continued increase in outpatient attendance – but the rates of increase are now declining in some states. The trend is more of a concern for in-patient admissions where despite a dramatic increase over the entire NRHM period, the last year or in some states the last two years- show a plateau or even decrease. Institutional deliveries have increased, but there could be considerable slowing down. These comments are made both based on HMIS figures and their validation in some of the districts visited. Given the fact that except for institutional deliveries, the outpatient and inpatient rates are far lower than what could be achieved, this slowing down or plateauing is a matter of concern.
- b. There are three possible reasons for this. First, there are no additional human resources sanctioned in the year under review, apart from specialists on a case-to-case basis - and as has been commented in earlier CRMs and the 11th Plan review, increase in HR deployed is perhaps the single factor most directly contributing to increased services. For a given density of HR, there is likely an increase of services due to increased performance, but the main determinant is the sheer numbers deployed. This tightening of HRH is due to funds constraints, concerns about rational deployment and more component specific allocations of additional HRH- such as for SNCU, RBSK etc. rather than to the general pool.
- c. The second possible reason is the decrease (rather than the expected increase) in number of facilities designated as delivery points. In conjunction with limiting facility-strengthening activities to just these delivery points, the problems of access to care could limit utilisation. The principle always was that for ensuring quality of delivery services, we persist with strengthening delivery points, while all other PHCs retain the rest of the services in full. Thus, typically in most states less than 10 % of all facilities are designated delivery points including few sub-centres and fewer than 30% of PHCs.
- d. A third factor is probably the limited range of services- with institutional delivery occupying most of the bed space, and infrastructure (in terms of number of beds) failing to advance in parallel with a lack of attention to all other in-patient care.
- e. Thus for example in Odisha only 11% PHCs and 2% SCs are designated as delivery points. In Gujarat, only 30% of the 24*7 PHCs and less than 1% SCs are so designated and other facilities are performing sub-optimally. In Arunachal Pradesh, facilities are present physically but functionally they are sub-optimal and services are available only at DHs.
- f. We however reiterate, that taken over a longer period, the rise is very significant, and whether this slowing down is a real trend or a data/sample aberration will need to be re-assessed.
- g. The limitation in range of services available could often be due to lack of drugs and diagnostics, forcing OOPE even for simple tests. Testing for Haemoglobin, Blood sugar and Urine are absent in

sub centres and PHCs in Jammu and Kashmir and Upper Subanshri district of Arunachal Pradesh. This raises issues of the quality of ANC services delivered. In Meghalaya, implementation of JSSK entitlements needs special attention.

- h. There is also a persistent problem with blood banks. There is a lack of blood banks even at the DH level, making for a no-blood situation as reported from a number of districts- in Bihar, Haryana and in Arunachal Pradesh. Even more worrying is the limited numbers of blood storage centres reported to be functional. There is a need to study this further and understand why cutting across states, blood storage facility as a concept does not appear to work.
- i. AYUSH facilities are co-located in Arunachal Pradesh, Gujarat, Karnataka, Haryana, Jammu & Kashmir, Maharashtra, Meghalaya and Nagaland. No co-location of facilities is seen in Jharkhand. Good utilization of AYUSH is seen in the states of Haryana, Maharashtra, Meghalaya and Nagaland. Increase in OPD is seen in Maharashtra where AYUSH MOs are also NSSK and SBA trained. In Meghalaya AYUSH OPD increased 22% in last 4 years from 2009-10 to 2012-13. The average AYUSH OPD in Nagaland is about 10-15 per day. There also exist AYUSH pharmacy and drug testing facility in Nagaland. Adequate human resources and medicine are available in Jammu & Kashmir and Nagaland. Arunachal Pradesh reports that in 44 facilities, AYUSH services are now co-located and functional.

4. Quality of Care

- a. The pattern in quality of care is isolated, with somewhat sporadic efforts across the states, showing progress in some dimensions, but no consistent pattern overall. Quality Assurance or Improvement systems relate to the earlier pattern, with many states relying on forming quality assurance committees without any clear plan of sustaining them or ensuring measurable outcomes. The new approach declared last year in August, with its emphasis on being able to measure and certify quality, and close quality gaps in a time bound manner, is still not rolled out in any of the states. However many states have built up capacity to do this through pilot programmes and show a willingness to scale up. Many states including Jharkhand have placed district hospital managers with an understanding that they would also serve as the drivers of quality assurance systems.
- b. Implementation of quality programmes covering a limited set of services is a feature of programmes aided by development partners – example Quality Intra Natal Care and Immediate Post-Partum Care Standards with MCHIP-USAID in Haryana, Facility Readiness Assessment & accreditation process of SNCU by NNF.
- c. The one area where there is some progress is in bio medical waste management where there is considerable improvement reported except from the states of Arunachal Pradesh, Bihar, and Jammu & Kashmir. This is outsourced to a third party in all States visited in 7th CRM. It was reported to be good in Haryana, Maharashtra, and Odisha, whereas more monitoring is required in Karnataka, Nagaland and Gujarat.
- d. Quality of sanitation services has improved in most states. The pattern is again of outsourcing. The CRM teams that visited Maharashtra, Odisha and Jammu & Kashmir filed positive reports. Poor hygiene was reported from the two states of Arunachal Pradesh and Bihar.

- e. Most facilities have running water, electric supply and power backup facilities are now available across all public facilities, though in Arunachal Pradesh and Nagaland it was still a problem in sub-district facilities.
- f. Progress in infection control is not satisfactory. Infection control practices were poor in Bihar, Himachal Pradesh and Odisha. In one CRM district of Gujarat, infection control practices were found deficient in OTs e.g. No post fumigation culture testing was done in the OT of DH. In Nagaland also there were problems in Labour Room and OT fumigations. In Haryana, autoclaving is highly compromised at all delivery points visited by the CRM team. In Bihar, inadequate sterile practices were observed below Block PHC level. Deep pit burial is the method used in Arunachal Pradesh, Jharkhand and Meghalaya.
- g. The availability and use of Standard Treatment Protocols remains more or less the same as earlier years - poorly followed with no mechanism of quality assurance to actively monitor or ensure this.
- h. No diet was provided for in-patients (including pregnant women) in one CRM district in Arunachal Pradesh. Odisha provides diet to patients with the help of women SHGs called Mission Shakti, which is functioning well in the State.
- i. Privacy concerns were reported from Arunachal Pradesh, Himachal Pradesh, Karnataka and Maharashtra while in Jammu & Kashmir the problem of admitting male and female patients in the same ward persists.
- j. Display of signage and citizen charter is absent in Arunachal Pradesh, Karnataka and Meghalaya, while in Bihar and Jharkhand it was well displayed. In Haryana, signages were well displayed but language was a problem in some places. In Himachal Pradesh, Jammu & Kashmir and Nagaland signage and citizen charter are displayed well. No mechanism for patient satisfaction assessment was observed in any State.
- k. No Grievance Redressal mechanisms were observed in Arunachal Pradesh, Bihar, Jharkhand, Karnataka, Nagaland and Meghalaya. In Himachal Pradesh, state level Grievance Redressal committees are set up and bilingual forms are being developed for employees and patients. Grievance redressal boxes were seen in health facilities but their effectiveness is questionable, as boxes were found open at some facilities. In Jammu and Kashmir, Grievance Redressal mechanism was poor in both districts. NRHM helpline has been recently launched for the benefit of the people as well as health workers but awareness of the helpline was low among health functionaries and beneficiaries.

5. Subcontracting:

- a. Range of services being subcontracted vary across States. Most common services that have been contracted out are a) Biomedical Waste Management, b) Security c) Diet and d) Sanitation services. Other ancillary and supportive services are mostly provided using in-house capacities.
- b. There has been definite improvement in areas of hospital cleanliness, laundry services and security wherever they have been contracted out. An area of concern is the BMW management services, where it has been observed that segregation, management and disposal of BMW is not

satisfactory, except in States like Himachal Pradesh. In other states there are issues pertaining to storage and timely collection of BMW from health facilities.

- c. Subcontracting is being done more at the level of District Hospitals as compared to sub-district facilities. For sub-district facilities states are relying on in-house capacities for providing ancillary services and the only service that is usually outsourced is provision of food for inpatients.
- d. Odisha has reported sub-contracting of almost all ancillary and supportive services, and has involved women Self Help Groups in provision of diet. Most States have mechanisms in place to ensure that services provided by subcontracted partners are of desired quality. For instance in Himachal Pradesh there are committees formed at health facility level to monitor quality of food provided.
- e. Experience with outsourcing of diagnostics is mixed and needs to be studied further. Himachal Pradesh and Bihar have done so amongst the states visited.

6. Ambulance & Referral Services:

- a. Most states report a mix of dial 102 & 108 models. However, 102 service does not exist in Himachal Pradesh, and 108 service in Jharkhand. There is good standardization of the 108 model with fairly good services in all areas, irrespective of provider. Maharashtra's more cost intensive version has not yet started up in the districts visited. On the other hand, the reports on 102 services are very mixed. For example, GPS is part of the 102 plan, but is often not fixed or not functional. Call-centres have varying degrees of functionality. EM technicians could be on board, but they do not have the necessary training and support. The rates of pick up are poor, though drop back rates are better.
- b. Arunachal Pradesh has 94 state owned ambulances attached to district hospitals and CHCs and not linked to a call centre. These get mostly used for inter-facility transfer but not as an entitlement, and there is almost no emergency rescue or even free drop back home (patients are charged for diesel). Call centre is a problem due to low connectivity in many areas.
- c. Inter-facility transfers – All states have inter-facility transfers in place and often 102 services play this role.
- d. Both 108 and 102 services have reported low effectiveness reports from all areas with dispersed populations and hilly terrains. On the other hand positive reports from these areas for partnerships with private local vehicles – (like the *Mamta Vahans* of Jharkhand or JE of Odisha) show that such private vehicles are definitely playing a positive role in pick up and drop back service under JSSK.
- e. Effectiveness of referral linkages – In spite of multiple models of ambulances being implemented in various States, there remains a considerable gap in ensuring assured referral services. For instance in Arunachal Pradesh, ambulances are not always 'free' even for pregnant women and in many cases they have to bear the cost of diesel. In states like Meghalaya, it was observed that ambulances are being used for administrative purposes whereas in Himachal Pradesh a fixed

amount is being reimbursed to pregnant women and postnatal mothers on basis of cost per kilometre approved by the State (and which often does not correspond with the actual cost demanded from patients.)

7. Medical Mobile Units (MMUs):

- a. All the CRM States that were visited report presence of MMUs except Himachal Pradesh. However, their utilization shows a mixed picture. While on one-hand states like Meghalaya, Nagaland, Jharkhand and Maharashtra have MMUs that visit peripheries and cater to patients; there are states like Arunachal Pradesh, Jammu and Kashmir where MMUs are yet to make an impact in improving the access to services.
- b. Across the CRM states that were visited, the average number of patients attended by MMUs range from 70-80/ visit. Most common range of services provided through MMUs include a) OPD, b) basic lab services (Jharkhand) and c) ANC/PNC check-ups.
- c. In states where MMUs are operational, provision for staff (1 MO, 1 Lab Tech, 1 Staff Nurse and 1 ANM) has been made. Supplies of drugs are more or less streamlined but stock-outs have been reported too. For instance in Nagaland it was observed that drugs were recently supplied to MMUs after a gap of two months.
- d. MMUs have added value in terms of making services available to remote areas. In Maharashtra, for example, an MMU serves 30 to 40 villages. One day before the scheduled visit of MMU, the ASHAs along with other frontline workers of the area inform communities, PRI members and pregnant women about the timing of the MMU. In Nagaland, the ANM of local area is associated with MMU for immunization services and the MMU visit schedule is synchronized with VHNDs. But the extent of such value addition is limited and not uniform.
- e. In a few states, MMUs have been outsourced to NGOs (Jharkhand) or are being operated with the help of private players under PPP model (Maharashtra). Both these states have reported a positive experience with their respective partners in terms of range of services that have been made available. However, at the same time interactions with the community did not substantiate claims made by respective states. For instance, in Jharkhand, although it was reported that X-rays are being done by a dedicated technician who travels with the vehicle, this could not be verified during community interaction. In the PPP model in Karnataka, diagnostics (X-ray) were not provided and limited OPD care was provided. However, it appears that patients with chronic diseases (Asthma, COPD, Osteoporosis arthritis etc.) do get the required treatment.
- f. Maharashtra has started Floating ambulances and MMUs in 5 sensitive districts out of the 15 tribal areas. In Gujarat special efforts are taken such as *Mobile Mamta Divas* and *Mamta Sandarbh* as outreach services to reach the marginalized communities

8. IEC/BCC:

- a. In the states of Jharkhand and Odisha impressive progress has been made in terms of moving towards a structured strategy for IEC and BCC that are relevant to their communities. Jharkhand, for instance, is now moving towards developing a life –cycle approach to IEC/BCC and Odisha has put in place a dedicated team of professionals led by the State Communication Manager and

comprising of Consultant IEC, Coordinator (Documentation Training and Research), Message Developer and a Programme Assistant, who implement the IEC activities of the state.

- b. Most states are following the traditional methods of IEC and BCC (radio jingles, posters, TV programs and pamphlets) and have invested maximum efforts on displaying various program components (JSY, JSSK, messages on specific diseases) at health facilities. However, it is encouraging to see that innovative measures are being used in States such as Odisha where local troupe dancers are used to convey IEC messages such as diarrhoea management, ANC Care and Family planning messages.
- c. Capacities at State level for planning and implementing IEC and BCC strategies was found to be limited in most of the States. No state has evaluated the impact of various IEC/BCC strategies nor have districts tried to assess behaviour indicators and plan strategies to address key behaviours. There is an urgent need to move from a generalist approach towards a more community specific approach.

Recommendations:

- a. Each district must be able to document which habitations and what proportion of people have no access using time to care as the standard. It must also be able to document gaps in beds and facilities with respect to the norms, and plan to close the gaps in consonance with 2011 census.
- b. There is a need to ensure district health planning based on sound situational analysis. The plateau and even decline in utilization of services, in many districts- mostly for inpatients, requires more attention to understanding the match between the need for services, availability of services and the quality of services. While there is an understanding of this with regard to institutional deliveries- on all other healthcare issues- such information or planning is currently not evident.
- c. There is a need to match inputs – especially infrastructure, trained human resources and supplies to those facilities where caseloads are higher—and conversely to correlate additional inputs with increased services.
- d. There is an urgent need to address persistent gaps in blood banks (managed by NACO) and Blood Storage Centres with many districts still reporting the lack of these. There is also a need to understand why blood storage units as a concept are doing so poorly across all states. It would be worth mapping the current situation on blood availability by CHC/Block and then making a state level plan to close these gaps in a time-bound manner. While doing so, it would be advisable to start with needs for emergency obstetric care, but also go beyond it to estimate needs for blood transfusion more comprehensively.
- e. Quality of care though improving, is still in a fragmented manner and with inadequate space. There is an urgent need to roll out implementation of the new operational guidelines on quality assurance in a time-bound manner.
- f. Sub-contracting of supportive functions of the hospitals especially as related to sanitation, bio-waste management, diet is reported as having good results at least in terms of starting up attention in this area. However in Bio-Waste Management, the quality of services has mixed reports- with unsafe disposals reported from a few states. Implementation of Bio-medical waste management should be linked to the

planning and practice of comprehensive infection prevention plans. On diagnostic outsourcing the reports are mixed, and we would need to study and learn from experiences on the ground.

- g. While access to drugs is better, and could be the reason for sustained increases in outpatient attendance, this does not apply for diagnostics where user fees and the physical lack of services are a major constraint.
- h. Out of pocket expenditures are an access barrier and contrary to NHM goals of social protection. Measurements of OOP would be important in order to monitor reduction and elimination.
- i. Regarding 102 and 108 the main message seems to be that in remote areas with dispersed populations, decentralised tie-ups through a call centre or even simpler means between facilities and local private transport providers, must be persisted with, since they are essential to ensure timely pick up and organise drop-back more efficiently. Such tie-ups must be seen as necessary supplements to the 108 services- and not as an either-or option.
- j. Mobile Medical Units in some states are playing a very useful role- either supplementing sub-centre level services for non-communicable disease as in Andhra Pradesh and/or increasing access to sub-centre services by visiting smaller habitations as in Maharashtra. But this should be made uniform across states.
- k. The current approaches of IEC/BCC have inadequate penetration to the facility and the community level. There is a need for building district level institutional capacity for better planning and management and measurement of outcomes of IEC/BCC activity.

State Findings

Andhra Pradesh

- Required Number of facilities are in place – there has been a small but sustained annual increase in outpatient service utilization, since 2008, but a plateauing of inpatient numbers over the last two years. However, the incidence of C-sections and IUCD insertions have declined.
- MMUs are functional and used for providing treatment for chronic diseases at the sub-centre levels.
- “108” ambulances with 752 vehicles is functioning well but now face the problem of renewal of ambulances that have worn out.
- Reports on quality of care is positive but biomedical waste management requires urgent improvement.
- Display of entitlements are satisfactory.
- Infrastructure development is as per plan, except for AYUSH facilities, which require up-gradation and renovation.
- User charges for diagnostics are being levied in some facilities.

Arunachal Pradesh

- Adequate number of health facilities have been established by population norms, but very low level of functionality is reported with some which are completely non- functional, for e.g. in Upper Subansiri district only 44 out of 65 are functional.
- Substantial increase in both OPD and IPD in the recent year.
- Infrastructure development does not commensurate with caseload or range of services provided.
- Health staff are not consulted in planning.
- Focus is on provision of RCH services and overall utilization has been limited.
- Major OOPS is on transport, drugs and diagnostics.
- Work on Quality of services needs to begin on all dimensions. However, in most parameters West Kameng district performs much better than the Upper Subansiri district.
- Referral transport and patient transport system is weak and not compliant with the national guidelines.
- Utilization of MMUs is also sub optimal.

Bihar

- Significant increase in number of all public health facilities under NRHM, but still CHCs, additional PHCs and health sub centres fall short of what is required and even what is sanctioned. Block PHCs and district hospitals are adequate in numbers.
- Rate of completion of civil works is slow (1200 out of 4192), Bihar medical services infrastructure corporation (BMSICL) was established in 2010 to take-over from PWD, but is not yet fully functional.
- Substantial improvement and good functioning in all the block PHCs visited as per reports.
- Out patients and in patient numbers continue to increase, but at a much slower pace than in the last two years. There is an increase in admission of RCH, fever and trauma cases.
- Drug supply shows remarkable improvement than earlier visits. Access to diagnostics and x ray services also shows improvement.
- AYUSH services are also functioning well but shortage of AYUSH drugs has been reported.
- Growth in Inpatient service is limited by inadequate infrastructure and limited range of services.
- Only 8.04 per cent of all facilities are designated as delivery points and focus is on strengthening these preferentially, which leaves huge gaps when considering high population density and high BPL population.
- 102 ambulances are in poor condition and services are sub-optimally utilized.
- Numbers of 108 ambulances are sub critical and used largely for inter district transfer and utilized almost exclusively for transporting pregnant women.
- MMUs are functional and operate as per tour plan, but there is considerable room for improvement.

Gujarat

- Numbers of facilities show moderate gaps in PHCs of Valsad district but otherwise are as per norms, however only 1 percent of SC and 30% of PHCs function as DPs. Dang has no FRU or CMOC centre and no private sector presence either.

- Outpatient numbers have continued to increase but inpatients admissions have not shown satisfactory improvement.
- Majority of the institutional deliveries are in private sector although many of these are not under the Chiranjeevi programme.
- There is a need to improve Bio medical waste management, ensure standard treatment protocols and infection control practices.
- Ambulance services are satisfactory in Valsad but poorly functioning in Dang, where the requirement for this service is much higher.

Haryana

- Number of health facilities in Palwal district are 30-50 percent less than required for each level. Bed population ratio is also very low, with only 192 bed for entire district and 30 beds at the district hospitals level. About 50 per cent of health facilities taken up for construction have been completed. However, there is a clear plan of infrastructure improvement, which is ongoing, although at a slow pace.
- Substantial increase in institutional deliveries, outpatient and inpatient services have been reported since start of NRHM but the numbers of the OPD and IPD have plateaued in last one year.
- Cleanliness, use of standard protocols and other quality parameters were positively reported.
- Bio medical waste management is outsourced but the quality of services is weak.
- Dial 102 service is working in Ambala but majority do not have an EMT on board, GPS is not functional and branding as NAS is not done. Where EMTs are on board training is not adequate and there is no refresher training available.

Himachal Pradesh

- Annual OPD visit per capita has been increasing with 1.5 OPD visits per capita in Kangra and 1.2 OPD in Chamba. Inpatient services however, which have increased well over NRHM show a minor increase over the previous year.
- Bio medical waste management systems are outsourced and satisfactory in one of the two districts. Infection prevention practices are weak.
- Efforts at grievance redressal mechanism has been initiated.
- Lab services also outsourced.
- 108 services are functioning satisfactorily. 102 services were not yet operationalized. However, percentage of pick up rate of pregnancies is as low as 10-20 per cent range and needs improvement. There are no MMUs in the state.
- IEC/BCC programs are sub optimal.

Jammu and Kashmir

- Most facilities visited had good infrastructure. Work on further infrastructure development is ongoing. The numbers are enough to meet the need, however, more sub centres are desirable.

- Male and female patients continue to be admitted in the same ward, in order to save heating cost. The quality of residential accommodation for staff is very poor. Cleanliness was good. Bio medical waste management is outsourced but quality of services is poor.
- There is no grievance redressal mechanism
- Overall increase in number of outpatient, inpatient and diagnostic services is reported.
- Except for JSSK patients user fees charged for outpatients and inpatients.
- 102 ambulance services established in Kathua district, but at present utilization is limited (133 calls received and 236 women dropped back in 2nd quarter of 2013).
- No MMUs were present in districts visited.
- Blood availability is a problem at CHCs and FRUs and the blood storage units are not functional.

Jharkhand

- Number of facilities created are substantially lower than required. 77 of 139 SCs in Sahibganj cover a population of more than 5000 and 21 cover more than 10,000 population each. Population covered by each PHC varies widely. There are areas with marginalized populations, which are presently out of reach in these districts. Districts will need help in careful planning and innovation to reach out to these remote areas and communities.
- There is slow but steady progress in public health infrastructure development and much can be done to expedite construction and handing over.
- Sub-centres with high delivery loads need special attention.
- There is a steady increase in number of outpatients in both districts and in inpatients in Sahibganj district. Inpatients are primarily in CHCs and District hospitals.
- Drug availability was a problem in Sahibganj but not as acute in Bokaro. In both places outside prescriptions was the norm.
- There is improvement in cleanliness, signage, security and availability of guidelines.
- “*Mamata Vahans*” have improved access for institutional deliveries. Linking of local vehicles in a PPP mode with district level call centre is working well.
- MMUs made functional by outsourcing to local NGO, but size and design of vehicles makes it difficult to reach remote and rural areas.

Karnataka

- Adequate number of facilities are in place. Infrastructure development is satisfactory though staff quarters are still insufficient.
- Co-location of AYUSH doctors has increased access to AYUSH facilities and OPD attendance.
- Blood bank facilities are not available at the district level.
- Many dimensions of quality show improvement. However, lack of segregation of male and female in patient wards and patient amenities was a concern.
- “108” ambulance service is functioning well and drop back home is done by hospital ambulances. State is now adding a fleet of 102 type vehicles to strengthen drop backs.
- MMU services are provided by KHSDRP in PPP mode.
- Karnataka Guarantee of Services to Citizens Act 2011 is displayed in all the health facilities
- Grievance Redressal mechanism, dial 104, exists but utilization is poor.
- Availability of drugs and diagnostics is good, but user fees is prevalent for diagnostics.

Maharashtra

- About 28 per cent of PHCs and 54 per cent of CHCs are delivery points and infrastructure development has been focused on these. Public health state management cell for updating land records for health facilities is established so that land for new public hospital constructions can be identified.
- State reports an increase in OPD and IPD in 2012-13 as compared to 2007-08. However, OPD per 10000 population has declined from 4831 in 2011-12 to 4528 in 2012-13 in Nandurbar district. IPD per 10000 population has declined in both districts as compared to the last year.
- Institutional deliveries have increased to 96 per cent and the public share has increased to 50 per cent.
- Most support services are outsourced at district and sub divisional hospitals.
- Sub-contracting has helped greatly improve cleanliness of health facilities.
- Citizen's charter is in place in larger hospitals.
- Currently ambulances are available on the 102 model but 108 will be introduced soon.
- MMUs operated by local NGOs serves 30-40 villages on an agreed upon tour plan with outreach to inaccessible areas on foot.
- IEC/BCC activities have received a very positive appraisal.

Meghalaya

- State has achieved considerable progress in the area of infrastructure development under NRHM. More than 70% of sanctioned infrastructure projects have been completed over a period of three years and the quality and pace of the construction is satisfactory.
- Inadequate health facilities as per population norms for a tribal and hilly area. An almost complete doubling of number of facilities is required.
- Good increase in utilisation over entire NHM period though marked slowdown in preceding year
- Lab and diagnostic facilities are available, but shortage of drugs and consumables was reported in both the districts visited.
- Three districts, East Khasi Hills, Jaintia Hills, and West Garo Hills are catering to the needs of complicated pregnancies that need blood transfusion.
- Biomedical waste management systems observed by colour coding of bio-waste segregation at all levels in Ri Bhoi district
- 41 EMRI (108) ambulance, which include 31 BLS and 10 ALS with fully functional GPS system and centralized call centre, are available in the state. National Ambulance Service guidelines are not strictly followed in the state. Facility based ambulances are primarily being used for administrative (staff) purpose rather than for patients. Facilities charge money for referral transportation of beneficiaries, excluding pregnant women.
- Every district has 3 MMUs, except Jaintia hills and West Khasi. Low utilization of MMU services observed and these MMUs are not well equipped to provide diagnostic services and no GPS system installed. Staff and supplies were inadequate.
- IEC material was sparsely available across all health facilities in the district
- Outreach communication is outsourced to an agency and the focus is mainly on street plays and announcement through public address systems.

Nagaland

- Overall infrastructure in the State is quite good and well maintained. The pace of construction in the state was also found to be good. The major gap in both the districts is relative shortage of Staff quarters.
- Good co-location and utilisation of AYUSH services was seen.
- Dimapur DH has a model blood bank but no Blood Storage unit or Blood bank in District Peren. BSU infrastructure and equipment are in place in the DH and CHC in Peren for nearly 2 years, but the facilities are yet to get their licences.
- Biomedical waste management was found to be poor. Despite substantial number of providers having undergone training, knowledge and practices related to waste segregation at point of source and waste disposal was an issue.
- State has 76 level ambulances linked to 102 call centre. Ambulances are GPS fitted and vehicle tracking system is installed but not functioning. Average trip made is approximately 1 trip/ambulance/day. Call centre is established with 10 lines; however, no call has been received by the State control room since 2011. Few test calls made were not picked up by drivers, as the numbers of drivers were not updated.
- MMUs visited was not functioning satisfactorily- especially on essential quality parameters.
- State specific posters on different thematic areas and disease control programme and RCH are adequately displayed in all the facilities. Citizen Charter, IEC and BCC activities in all facilities are well maintained.
- JSSK implementation has issues related to payment of flat rates paid to pregnant mothers for diet and referral transport (in cases where hospital ambulance not used) and limited awareness among both providers and community about rights and entitlements under JSSK
- Quality of ANC at VHND and Sub Health Centres lacks robust supportive supervision and feedback mechanism.
- There is good convergence with the NACP, especially in universal screening of HIV, training and use of ICTC counsellors for adolescent counselling, and pooling of laboratory technicians.
- Inter-sectoral convergence with government departments such as Social Welfare and Public Health Engineering Department (PHED) is weak

Odisha

- All the DHs in all districts are functional as delivery points whereas there are 4% SDH and 12% CHCs that are yet to be operationalized as Delivery points. On the other hand, only 11% PHCs (136) and 2% of sub-centres are functional as Delivery points.
- Shortage in the number of sub-centres and poor infrastructure for existing ones.
- District Hospital is catering to unusually high delivery load due to poor functionality and underutilization of the peripheral institutions.
- There is a mismatch between the designation and functionality status in many facilities. Hence, where on one hand, in Koraput only 2 out of 5 designated FRUs are functional and conducting C-sections, on the other hand, in Jajpur, many CHCs apart from designated FRUs are catering to High caseloads. The status of the designated FRUs in the two districts shows that availability of blood storage facility is one constraint hindering the operationalization of these FRUs.

- There are insufficient residential quarters, however, they are all in a habitable condition and have been built by IAP funds. There are no staff quarters for Staff nurses and they reside in rented accommodation.
- There are 466 *Janani Express* vehicles that are run through local NGOs. The existing fleet of government ambulances is mobilized and '108' service, under PPP model, is available in 15 districts. The *Janani Express* is well utilised despite potential availability of alternatives.
- Quality of care in terms of infection control, biomedical waste management, cleaning, security, diet and laundry are all good. The latter three are outsourced to the third party agencies.
- Diet provision in District Koraput was outsourced to a women self-help group, Mission Shakti that provides good quality, free diet to the pregnant women and inpatients.
- At the state level, SIHFW acts as the nodal agency, which plans and strategizes all sorts of IEC activities in the state. Innovative IEC appropriate to the tribal community is used. Good district capacity is reflected in availability of guidelines at district level, and appropriate choice of methods for key messages regarding JSSK entitlements, Family Planning services, DOTS etc. Signages and citizen charter were displayed at higher facilities.

Uttar Pradesh

- All levels the facilities visited were neat, clean and had a good upkeep.
- 26.25% (Pratapgarh) and 18% (Mathura) facilities currently function as delivery points. It was observed that number of delivery points were inadequate and not uniformly distributed in both the districts.
- There was a gross mismatch between service demand and availability of beds at Pratapgarh and a significant underutilization at Mathura.
- Client perspective and attention to dignity & privacy was missing at all delivery points, including labor room and OT (at Pratapgarh), with no restriction to entry of the attendants accompanying the patients in the wards and labor room. However, the situation was fairly good at Mathura.
- Referral transport (108 Ambulances) were well functioning and the state is under process of introducing more vehicles for ensuring drop back facilities to the JSSK beneficiaries. The ambulances transport approximately 6 patients per day and till date, approx. 15 lakh patients have benefited from the service.
- Central Sterile Service Department guidelines have been shared by state. The guidelines have directed the district to take up housekeeping service on a fixed uniform rate, due to which the districts are facing difficulty to engage agencies for facilities with varying caseloads.
- Infection prevention & bio-medical waste management services are outsourced and available at both places but adherence to protocols was missing in Pratapgarh.
- A statewide IEC/BCC campaign "*Hausla*" has been planned; however, no specific BCC strategy or plan was visible at district level during the visit. There were no specific monitoring plans, indicators and outcomes for communication interventions either. Moreover, there is lack of understanding among programme managers on demand-side issues (which can be addressed through effective communication by service providers, for improved utilization of services).

TOR 2

REPRODUCTIVE, MATERNAL, NEW BORN AND CHILD HEALTH:

Guiding Principles/Strategies of the NHM:

- i. *“Prioritize achievement of universal coverage for Reproductive Maternal, Newborn, Child Health +Adolescent (RMNCH+A), National Communicable Disease Control and Non Communicable Diseases programmes” (Para 2.4.2.7)*
- ii. *“Expand focus from child survival to child development of all children 0-18 years through a mix of Community, Anganwadi and School based health services. The focus of such services will be on prevention and early identification of diseases through periodic screening, health education and promotion of good health practices and values during these formative years and timely management including assured referral for secondary and tertiary level care as appropriate”(Para 2.4.2.8)*
- iii. *“Achieve the goals of safe motherhood and transition to addressing the broader reproductive health needs of women” (Para 2.4.2.9)*
- iv. *“Focus on adolescents and their health needs”(Para 2.4.2.10)*

Key Findings:

1. Delivery Points:

- a. On the positive side, almost all states have undertaken identification of health facilities to prioritise as “delivery points” and have paid more attention to ensuring quality in these facilities.
- b. However, there is a concern that the number of delivery points are restricted and in areas where institutional delivery rates are low- the drive to systematically increase the number of delivery points is missing.
- c. While all states have designated higher facilities as delivery points, some states have almost entirely excluded sub centres and the vast majority of PHCs from this function, thus their rates remain stagnant.
- d. Differential planning is seen in Odisha, and here HSCs serve as delivery points only in high priority areas. The non-high focus states on the other hand as a consequence of better health seeking behaviour and fewer home deliveries have very few outreach centres as delivery points.
- e. A non-uniform spatial distribution of delivery points within the districts has been reported from Uttar Pradesh and in Dang district of Gujarat, where few blocks do not

have even a single facility designated as delivery point and a substantial number of women remain without access to safe institutional delivery.

- f. Andhra Pradesh, Maharashtra, Gujarat and Karnataka are making efforts for provision of comprehensive RMNCH+ A services at the centres designated as delivery points. However, in most states the term is being interpreted too literally. In high focus states, barring district hospitals and few CHCs it is delivery care that is being emphasized and districts all across are yet to strengthen all levels of facilities to provide comprehensive package of new born, safe abortion, RTI/STI and adolescent health services.

2. Ante-Natal Care:

- a. As regards three ANC achievement, a steady increase ranging between 2-23% is observed in nine out of fourteen states, being largest for Jammu and Kashmir. It is consistent for Gujarat and has decreased for Andhra Pradesh, Arunachal Pradesh and Uttar Pradesh.
- b. Lack of diagnostics is a problem in many states. The basic laboratory tests for anaemia, urinary protein and BP measurements are being done in a number of states but non-availability of diagnostic kits, reagents and urine dip sticks is an issue for Andhra Pradesh, Arunachal Pradesh, Jharkhand and Odisha. Inaccurate reporting and maintenance of records reduce the effectiveness of ANC services in Nagaland, Karnataka, Himachal Pradesh and Gujarat. Stock outs of Iron and Folic Acid have been reported from Jharkhand and Arunachal Pradesh.
- c. The reports make little connection between quality of ANC and implementation of MCTS- the latter being more perceived as a stand-alone activity. Tracking of severe anaemia and other high risk pregnancies remains a challenge and hampers the management of pregnancy complications- the only exception being Haryana- where there is a separate scheme to do just this.
- d. No experiences on skill-gaps of ANM for provision of ANC care have been reported from almost all the states except Odisha.

3. Institutional Delivery Rates:

- a. HMIS reports of the last two years show an increase in institutional delivery in several states. Four of these- Arunachal Pradesh, Jharkhand, Meghalaya and Nagaland are low performing, had very low baselines and are now showing a trend of faster change. The other set of states like, Karnataka and Maharashtra have little room for further improvement since they are in the nineties. Jammu and Kashmir reports a significant increase of 9%. Marginal increases are seen in Bihar, Andhra Pradesh, Gujarat, Himachal Pradesh, Haryana and Uttar Pradesh. Only UP shows a shift from public facility to private facility. Gujarat already had built a private preponderance.

4. Quality of Care:

- a. Most states have posted SBA trained personnel at the delivery points. Though issues of training and subsequent use of skills vary across states, the trend is positive. Use of standard protocols seem to be deficient across states- especially at peripheral centres.
- b. A positive finding across most states is the progress in ensuring that labour rooms with adequate provision of light, ventilation, privacy, electricity back up, attached toilet facility and infection control measures as noted in Andhra Pradesh, Karnataka and Odisha at all service delivery points up to the PHC.
- c. Adequacy of critical drugs such as magnesium sulphate, oxytocin and essential equipment is noted in most facilities but frequent stock outs of drugs and non-availability of equipment is a serious gap observed for Arunachal Pradesh and Jharkhand.
- d. Duration of stay by post-natal mothers for 48 hours as per the recommended norms continues to be a challenge for high focus states of Bihar, Uttar Pradesh and Jharkhand. Provision of *Mamta Kit*, *Mamta Gruha* –birth waiting homes for expectant mothers in Gujarat are some state specific measures that have been taken to improve intra partum care. However, the utilization of *Mamta Gruha* needs to be strengthened.

5. Emergency Obstetric Care:

- a. A change from the previous CRMs is that states are making efforts to add more CHCs to function as FRUs, and as a result comprehensive emergency care is not limited to just district or sub-divisional hospital in many states. This holds true for Andhra Pradesh, Maharashtra, Bihar, Jharkhand, Odisha, Uttar Pradesh and Nagaland.
- b. One exception to the above finding is the Dang district of Gujarat, which has no FRU, and emergency cases are referred to the neighbouring district. Himachal Pradesh and Arunachal Pradesh have very few CHCs serving as FRUs. In Jharkhand, Meghalaya, Uttar Pradesh and Arunachal Pradesh issues of unavailability of specialist, LSAS or EmONC trained HR, irrational deployment and limited contracting of these services to private sector continue to restrict the operationalization of FRUs.
- c. In the last two years, C-section rates (both in public and private health facilities) have increased in most states except in Bihar, where it remains unchanged at an inadequate level of 1% and Uttar Pradesh, where it actually shows a progressive decline of one percent for the last three years, is currently at 4%. C-sections in Odisha have increased in public health facilities during the last two years reaching 7% and are linked to good functionality of its FRUs. Jharkhand shows 2% increase but mainly from the private sector. Meghalaya and Nagaland in the North East states show comparatively high C-section rates of 14-15% but mostly in the private sector. Amongst the non-high focus states Gujarat and Haryana report optimal C-section rates but Andhra Pradesh, Jammu and Kashmir and Karnataka show high C-section deliveries with the majority of the caseload coming from the private sector. In Jammu and Kashmir, it is higher than desirable at 32%.
- d. In high focus states, BEmONC provision in 24X7 PHCs remains a matter of concern. Skills of staff in prevention and stabilization of complications like PPH have been reported to be inadequate in Odisha, Jharkhand and Uttar Pradesh. Unavailability of trained staff,

unauthorized absenteeism and lack of adequate drugs further complicates the problem for Jharkhand.

6. Blood Bank and Blood Storage:

- a. There are still a number of states which lack blood banks at the district hospital level and lack blood storage units in all FRUs.
- b. In many states, blood storage units- are not functional- two important exceptions being Odisha and Himachal Pradesh - but even here the report points out that in other districts and FRUs this problem is high.
- c. This remains a serious limitation to establishing emergency obstetric care though there are some FRUs that maintain C-sections despite this gap.

7. Safe Abortion, RTI/STI:

- a. A common finding for all states is that comprehensive abortion and RTI/STI services have so far been strengthened only at Level III centres, though they should have been available at least at all level II if not level 1 delivery points as well.
- b. Majority of states reported shortage of Mifepristone and Misoprostol for Medical Abortion.
- c. Non-availability of trained staff for safe abortion at CHCs and PHCs is an issue reported from the districts of Arunachal Pradesh, Nagaland, Himachal Pradesh, Meghalaya and Odisha.
- d. Lack of MVA equipment is seen to limit provision of these services in Arunachal Pradesh Karnataka and Jharkhand.
- e. In a few areas, MOs have not been oriented on recent abortion guidelines and are continuing with older methods such as Dilatation and Curettage and do not use medical abortion even for pregnancies less than six weeks.

8. Care of the Sick New Born and Child:

- a. There is considerable increase in structures to enable continuum of care for the newborn from the community to the facility level in all the states. Thus, majority of states have in place the NBCCs, NBSUs and SNCUs for newborn care though functionality is variable. In particular, there is an impressive rise in the number of districts reporting a functional SNCU.
- b. One concern observed is with the placement of SNCUs, which is not commensurate with the need. An important priority in the tribal, difficult and remote districts with high newborn deaths is to ensure Home Based Newborn Care and facilities for stabilising newborns and the next priority should be establishment of SNCUs. This is missing in the case of Sahibganj in Jharkhand, in both districts of Arunachal Pradesh, Dang in Gujarat and Kupwara in Jammu and Kashmir.
- c. Strategic planning in this regard is seen in Odisha where out of eight high priority districts, six have established well functional SNCUs. However, even here there is a need for expanding the bed strength or add more centres to meet the high caseloads.

- d. Compliance with infrastructural norms, presence of trained staff, and quality care through adherence to standard protocols are significant positive findings from many states for e.g. Andhra Pradesh, Haryana and Karnataka. Other issues such as lack of infection control in these SNCUs have been noticed in some states.
- e. In the case of child health, care provision by ASHA at the community and health staff at level of facilities has led to a reduction in fatality due to diarrhoea. For example, in Odisha, in the difficult districts like Koraput, there have been no diarrhoeal deaths recorded in the last one year. Nevertheless, at 30%, ARI mortality forms a significant percentage of child mortality in Odisha. One possible cause identified for this is weak skills for ARI detection amongst frontline workers.
- f. Home based newborn care for early identification, home management and referral of the sick child and supporting the low birth weight baby is established in more states and there are positive reports from many states.
- g. Reports from various states highlight different issues related to child health that need to be addressed. Irrational use of antibiotics for diarrhoea has been reported from Odisha. Non -availability of Vitamin A for the last year is a challenge seen in Meghalaya. There are reports on inadequate supplies of paediatric drugs such as Cotrimoxazole, Zinc and IFA especially at the Sub-centres in Jammu and Kashmir and at all levels of facilities in Jharkhand.

9. Functioning of Nutrition Rehabilitation Centres (NRC):

- a. Good functionality of NRCs has been reported from Maharashtra, Odisha, Jharkhand, Andhra Pradesh and Karnataka.
- b. A positive development is that the functioning of NRCs is generally according to the guidelines, wage compensation is being provided to mothers and no OOP is observed.
- c. Effective community level linkage is seen to improve the functionality of NRCs and is best illustrated in case of Odisha, Jharkhand and Maharashtra.
- d. Plans for operationalization of NRCs are underway in Haryana and Himachal Pradesh. Low utilization of NRCs has been reported from Gujarat and Uttar Pradesh indicating low detection and referral by frontline staff.
- e. One persisting concern for NRCs is the low number of cases attending post discharge follow-up and holds true even for NRCs which otherwise show good functionality.

10. Rashtriya Bal Swasthya Karyakram (RBSK):

- a. In a majority of the states RBSK is still in its nascent stages.
- b. Those states which have begun implementation are in initial stages of recruiting dedicated block teams and undertaking school level screening for illness with one-way referrals. In this, it appears very similar to earlier school health programmes that it has replaced.

- c. Some states have begun modalities for operationalizing District Early Intervention Centres (DEICs), but so far there is none on the ground. There are reports of early pilots in Haryana.
- d. Amongst these states only Himachal Pradesh is seen to have expanded the package of services covered and is actually attempting screening of school going children for “four Ds” and 30 identified conditions seen in children of this age group.

11. Adolescent Reproductive and Sexual Health (ARSH):

- a. Majority of the states except Uttar Pradesh and Arunachal Pradesh have been able to operationalize ARSH clinics at the district hospitals and CHCs. However to the extent that these could be visited the attendance was low- and the caseload, undifferentiated from the general OPD.
- b. Dedicated ARSH Counsellors have been posted in ARSH Clinics only in Andhra Pradesh, Haryana and Himachal Pradesh. Other states like Nagaland, Karnataka, and Jharkhand etc. continue to use the ICTC counsellors for this purpose. Districts in Nagaland have high prevalence of HIV and ICTC counsellors deal with high caseloads thus giving them limited time to attend to adolescent cases being referred.
- c. Efforts for community outreach continue to remain a weak area. Some states like Himachal Pradesh, Gujarat and Odisha have taken concerted action to build community linkages for adolescent health care. Gujarat has implemented *Mamta Taruni*, Himachal Pradesh extensively uses ANM, MPWs and AWWs and Odisha conducts *Kishori Melas* at Anganwadi Centres every quarter for adolescent health promotion and referral of cases needing counselling or health care support. To increase the scope of community participation in adolescent health, Jharkhand has recently selected peer educators through Nehru Yuva Kendras.
- d. Most states have implemented the WIFS programme. Extensive promotional IEC contributing to successful roll out has been reported from Haryana and Uttar Pradesh. Convergence with other departments is essential for this scheme and is best illustrated in the Kishori Swasthya Melas of Odisha being conducted in coordination with WCD for both school going and out of school adolescents. While Jammu and Kashmir is the only state that is yet to implement WIFS in all the districts, weak implementation is reported from Jharkhand.
- e. The Scheme for promotion of Menstrual Hygiene now seems to have stabilized wherever implemented. Reports highlight a wider acceptance of sanitary napkins amongst the adolescent girls now. The initial challenges of inappropriate selection of storage sites, adhoc distribution mechanisms and inadequate stock management have not been reported from any state. However, delays in supply have been mentioned for Odisha and concerns regarding quality of napkins persist in Jammu and Kashmir.

12. Community Level Arrangements:

- a. The reporting of home deliveries remains an area of concern with possibility of significant underreporting from areas with difficult terrains, such as the tribal districts of states like Maharashtra, Gujarat and selected northern districts of Karnataka. A very

small fraction of the home deliveries are actually conducted by SBA and remain a challenge for majority states.

- b. Home visits by ASHAs to provide community level care for the postnatal mothers and newborn have started in most states. Care provision shows an increase in districts that have completed training their ASHAs in first two or three rounds of Module 6 and 7. ASHAs in Bihar, Uttar Pradesh, Jharkhand, Odisha, Karnataka, and Haryana have started undertaking HBNC visits and reports from the latter four states show significant numbers of low birth weight, sick new born and high risk cases being detected and referred by ASHAs.
- c. Essential inputs needed for HBNC by ASHAs are- quality training, availability of equipment kits and regular monitoring through on the job supportive supervision. A clear change noticed from the previous CRM is that many states have now provided the first two inputs except Jammu & Kashmir, Maharashtra and Gujarat, which are yet to distribute HBNC kits to ASHAs.
- d. However, quality of supportive supervision of ASHAs differs across the states and explains their variable functionality. States such as Odisha and Jharkhand that show good functionality of ASHAs are also those states, which have trained support structures to undertake effective monitoring. Report from Nagaland highlights that home visits conducted by ASHAs are not as per the norms and is probably due to ineffective supervision and handholding.

13. Family Planning:

- a. The CBR was around 21 per 1000 in 8 of the 14 states visited (Maharashtra, Arunachal Pradesh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Karnataka, Nagaland and Odisha).
- b. Counsellors have been posted in district hospitals of majority of the states except in Jharkhand, Arunachal Pradesh and Meghalaya where the full complement of approved positions have not been filled. The state reports highlight a need for building the skills of these counsellors for effective outcome although training for counsellors has been carried out in Uttar Pradesh and Bihar.
- c. Limiting methods for family planning continue to be the backbone in districts of all the states. Andhra Pradesh, Arunachal Pradesh, Himachal Pradesh, Jammu and Kashmir and Haryana are providing sterilization services on a fixed day basis. These states have also introduced fixed day services for IUCD insertions. However, due to paucity of trained providers in the high focus states of Jharkhand, Meghalaya, Uttar Pradesh and Bihar fixed day services below the district level is not optimal as one would have liked. Laparoscopic tubectomy appeared to be a challenge, seen especially in Jharkhand.
- d. PPIUCD is being implemented in most states, with states like Haryana, Bihar and Uttar Pradesh starting to perform well and in spite of being a new programme it is expanding satisfactorily across the states. The Odisha report demonstrates a higher number of post-caesarean insertions in comparison to normal deliveries.
- e. Home delivery of contraceptives through ASHAs has begun in all the states. Skills of ASHAs in the use of Nishchay kits have been reported to be good in all the states.

Effectiveness of ASHAs on this task is seen to be affected and related to supply issues as in case of Sahibganj in Jharkhand, Arunachal Pradesh and Uttar Pradesh. The supply side constraints with a lack or irregular supplies of ECPs have also been reported from Chittoor district of Andhra Pradesh, Jajpur district of Odisha and both districts of Meghalaya, Nagaland, Bihar, Arunachal Pradesh and Jharkhand. A stock out of all three commodities has been reported from Pratapgarh district of Uttar Pradesh. Successful implementation of this scheme has been reported from Odisha where ASHAs are proactive and maintain a calendar for OCP users to ensure regular supply and prevent any discontinuation of the pills during each cycle. ANMs from Odisha shared a concern that many beneficiaries continue to approach them for contraceptives but due to lack of stock, they refer the cases to ASHAs. Thus on few occasions when they cannot find the ASHA, the need of beneficiaries goes unmet. This builds a case for allowing some adjunct stock of these commodities at the health centres as well.

- f. Most states have implemented the scheme for ensuring birth spacing by ASHAs. While Odisha has emerged as a better performer in this regard and shows exceptional implementation, scope for improvement remains in other states. Adherence to the norm of producing the marriage certificate of couple or birth certificate of the first child by ASHAs before incentivizing is observed in some states. However, responses from states such as Haryana and Bihar have been positive.

14. Janani Surakhsha Yojana (JSY)

- a. JSY is now a well-established scheme in all the states, with good awareness among public, low awareness was noted only in Mehboobnagar district of Andhra Pradesh. State of Meghalaya has introduced Maternal Benefit Scheme (MMBS), which has given an additional thrust to JSY by providing an additional Rs. 4000 to women with up to two children.
- b. Payment of JSY is much better in most states though there are delays in many states.
- c. Since the introduction of Direct Bank transfers as the mode of payment, increased delays in payments were reported from Chamba district of Himachal Pradesh and Kathua district of Jammu & Kashmir while denials were noted in the visited districts of Gujarat and Haryana. The difficulty in opening a zero balance bank account, despite ASHA and ANM involvement, is a major deterrent as observed in these states.
- d. The conditionality of 48 hours stay at the health facility after delivery for JSY payments also resulted in exclusion of beneficiaries in Kangra district of Himachal Pradesh. In the state of Odisha, the unavailability of required documents leads to denial of JSY entitlement for migrant population, thus leaving out the most vulnerable group. Cash payments of JSY incentive to mothers were reported only from Arunachal Pradesh.

15. Janani Shishu Suraksha Karyakram (JSSK)

- a. JSSK is operational across all states. Though most beneficiaries are aware of 'free delivery' in the government hospitals, in comparison to JSY, the awareness in the community about all entitlements of JSSK scheme was found to be low. In terms of display of entitlements, more focus has been given to entitlements for pregnant women with little or no emphasis on

entitlements for newborn and infants. Inadequate IEC for JSSK was noted in Dang district of Gujarat.

- b. JSSK has no doubt led to reduction in the OOP expenditure incurred, but they continue to persist. While no OOP expenditure was reported from beneficiaries in the states of Maharashtra, Odisha and Valsad district of Gujarat in all other districts some OOP, usually in the Rs 400 range remain. This relates to issues of drug logistics, availability of diagnostics, referral transport for pick up or drop back and most often to matching resource allocation to caseloads so that these expenditures could be reimbursed. In Pratapgarh district of Uttar Pradesh alone, beneficiaries including pregnant women had to pay user fees in addition to expenses of drugs, diet, blood, consumables and diagnostics.
- c. In Nagaland rather than provision of free services, cash reimbursements are being given to beneficiaries for e.g. - cash re-imburement of Rs.1300/- (Rs. 650/- each) for pick up and drop back (at a flat rate irrespective of distance), Rs. 100/day for diet in case of normal delivery and Rs. 700/- for C-section.

State	Expenditure On					
	Transport	Drugs	Diagnostics	Diet	Blood Transfusion	Consumables
Andhra Pradesh	Y		Y			
Arunachal Pradesh	Y				Y	
Bihar	No OOP reported					
Gujarat	Y					
Haryana	Y		Y			
Himachal Pradesh	Y	Y				
J & K	No OOP reported					
Jharkhand	Y	Y				
Karnataka	Y		Y			
Maharashtra	No OOP reported					
Meghalaya	Y	Y				
Nagaland		Y	Y			
Odisha	No OOP reported					
UP	Y	Y	Y	Y	Y	Y

- d. Some positive developments relate to SHGs or NGOs taking over the diet provision. In Ahtihbung PHC (Peren district) of Nagaland, a small community kitchen has been set up and with the cash provided for diet, the family members of the pregnant woman can cook in the community kitchen.
- e. Appropriate mechanisms for Grievance Redressal require strengthening across all states. While help desks were available in Gujarat, there were no registered complaints or action taken reports available.

16. Maternal & Infant Death Review

- a. More states report a functional MDR in place, but states which have some of the highest mortality rates are weakest in implementation of this. Community based reporting is

weak in most states. State of Haryana has a very good system of web based reporting for maternal and infant deaths – MIDRS and the counterfoils of all the reported cases were available with the ANMs and across facilities.

17. Immunization Services and VHND

- a. The progress made in improving cold chain and vaccine logistics reported in the previous CRM persists. There are additional measures to strengthen it through field volunteers for monitoring, and stronger alternative vaccine delivery systems etc. However the generation of due lists to identify those left out, as was done for pulse polio, is not yet in place in many states. Since MCTS is operational across the states, there needs to be a thrust in using the data available for efficient tracking of due beneficiaries.
- b. Better vaccine inventory management and refresher and orientation trainings are required in a number of states.
- c. Regular VHND sessions are being conducted across the states. Some states have opted to delink the immunization activity from the VHNDs, these include – Odisha, Andhra Pradesh, Karnataka. In most states, VHND is synchronous to immunization day/session. The challenge of comprehensive delivery of ANC, immunization, nutrition related services, health education and counselling in outreach sessions, remains unresolved across the states owing to issues of either lack of adequate equipment / materials or effective convergence.
- d. In Karnataka, districts give vaccine to private paediatric clinics/hospitals and collect the data which is incorporated in their reporting, but it is not uniform and consistent. Quality of cold chain maintenance, and data capture are areas that need attention in the private sector.

Recommendations:

- e. The findings from the state seem to indicate that there appears to be a need to re-examine planning for delivery points. States need to ensure that delivery points are adequate to meet caseloads and time to care particularly where there are high home deliveries. The entire range of services including essential RCH components- like ARSH, family planning, and safe abortion, RTI /STI should automatically follow at least at level 2 facilities. Finally, the step would be to score the facility for quality of care and put in place commensurate improvements.
- f. Map the availability of blood with reference to FRUs and ask state to put in place a time bound plan to open necessary blood storage units or banks.
- g. The Nutrition Rehabilitation Centres (NRC) need to be optimally operationalised by improving linkages in the home/community setting and with facilities for referral and follow-up for comprehensive clinical examination of the children for morbidities and coordination with the WCD.

- h. Strengthen vaccine logistics management, temperature control, equipment maintenance, stock management and training of those working on the immunization programme.
- i. Decreasing the dropout rate and increasing the full immunization coverage needs strengthening by preparing due lists and tracking the beneficiaries and mobilizing them for vaccination.
- j. Facility based newborn care should be strengthened with focus on quality, adherence to protocols, prioritization and reorganization of the resources and building state capacities through partnerships with resource centres, medical colleges and other technical agencies. The referral link between home based and facility based newborn should be strengthened.
- k. There is a need to strengthen diarrhoea and ARI management in children- by better supply of drugs, and training/orientation support to front line workers for this task.
- l. Speed up the implementation of DEICs under the RBSK programme; make school level screening more comprehensive as proposed with good two-way referral systems. Other aspects of RBSK at newborn and the preschool child also need to be rolled out.
- m. Continue to support the implementation of home based newborn and sick infant/child care- with better access to drugs and support.
- n. Build on the maternal and infant death reviews with more skills on analysis and use of information for public health action.
- o. Focus on establishing MTP services in all FRUs aiming further to cover all 24X7 facilities, reorientation of providers on Comprehensive Abortion Care guidelines, focused extension of PPIUCD services to all delivery points with high client load and regular updating of the eligible couple register should be priority. Similarly, in all states, further promotion of Non-scalpel vasectomy (NSV), use of spacing methods and counselling should be the key focus.
- p. There is also an urgent need to follow up on the reasons why trained providers are not performing PPIUCD insertions.
- q. Minilap should be promoted and trained providers should be posted in PHCs where facilities exist thereby making these services more accessible to people across the states.

State wise summary

Andhra Pradesh

- Uptake of RCH services has improved. Full range of maternal and child health services including quality facility based newborn care and NRC is available. In addition, SNCU, NBSU and NBCC were well established as per the norms and were providing good quality services.
- Under Family Planning, PPIUCD and NSV services needs strengthening. State needs to focus on promotion of spacing methods.
- Line listing of the high-risk mothers and eligible couples is done through the MCTS. Skype based video conferencing method for follow-up of MCTS that is being implemented in Mahboobnagar should also be initiated in Chittoor district.

- Out of pocket expenses for the patient seen for certain services such as ultra sound and CT scan. The basic laboratory investigations for ANC like haemoglobin estimation, urine examination for protein and sugar were not being done at many facilities in Chittoor due to non-availability of kits and reagents .At some places some of these services were not being offered despite the presence of an LT due to non-availability of strips etc.
- District level maternal deaths review sub-committees have been formed in both districts. However, in-depth analysis and usage of data is not adequate.
- Regular Infant death audits are also being conducted with adequate record maintenance. Community based verbal autopsy is being done in Chittoor.
- Implementation of JSSK in the district is good at district level hospital but needs improvement at the PHC level in terms of being able to pay for diagnostics, free diet and transportation. JSY funds disbursed, but with excessive formalities.
- Training programmes for SBA have to be focussed on those conducting deliveries and adherence to protocols have to be supported.
- NRCs functional, but linkages of the community with the NRC need to be improved to ensure follow up and desired outcomes.

Arunachal Pradesh

- Space for ANC OPD is not present in the hospitals. ANC check-up is done mainly in the labour rooms.
- All the labour rooms and attached toilets were found to be neat and clean. However, there were was a lack of power back up and gaps in essential instruments and drugs.
- Basic diagnostics are not in place below district level in one of the two districts visited- but adequate in the other. There are problems of equipment and of lab technicians recruited under NVBDCP program not performing any other test except examining slides for malarial parasite.
- Blood Bank is functional only in the district hospital Naharlagon (in the capital city of Itanagar). The state has two private blood banks. Blood storage not functional.
- RBSK implementation has begun with 34 dedicated teams constituted – with staff of 1 MO (AYUSH/ Dental), 1 ANM, 1 (HA/ Ophthalmic Assistant) per team. DEICs are not yet initiated. Outcomes of programme are not yet measurable.
- Fixed day service provided for IUCD insertion and OCP distribution at facilities. PPICUD is not done in both the districts.
- JSY incentives disbursement good, albeit with some delays.
- No further improvements in implementation of JSSK with persistent out of pocket costs. Free referral transport and free blood are not provided, though drop back home is usually available. Referral transport provided includes drop back to home and referral to higher facilities but no pick up facility. Some facilities charge for diet. Out of pocket expenditure on drugs and diagnostics persists although it is less.
- Under reporting of maternal deaths. Facility level MDR communities are investigating the facility level deaths. However, community level reporting of female deaths in the age group of 15-45 as well as Community based maternal death review is not carried out.
- Immunization supply chain and services appears adequate- but due lists and efforts at closing the last mile not adequate.

Bihar

- Institutional delivery levels have remained constant last year. No detailed facility/block/district level plans for ensuring further increases in availability, accessibility and adequacy of quality RCH services. Numbers of delivery points are not expanding.
- Mechanisms to ensure quality of care in institutional delivery and EmOC were found to be very weak. Functional radiant warmers were seen at most of the delivery points.
- Nutritional Rehabilitation Centre (NRC) are established in both districts and it is managed by an NGO. Adequate beds and space, but no Paediatrician available at NRC. The designated staff at NRC needs training as there is knowledge gap in treating the child admitted.
- Line listing of severely anaemic pregnant women and low birth weight babies was not found.
- RBSK is rolled out largely as a school level health screening campaign with referrals to health facilities. Though DEICs are planned, work on these is yet to begin.
- Postnatal check- up at the community level is not done specially after home deliveries.
- IEC and community level family planning activities weak.
- Though JSY had led to a dramatic increase over the NRHM period, in the last two years the percentage of institutional delivery in HMIS has remained constant. Direct Benefit Transfer (DBT) implementation for JSY initiated in the first three districts of Arwal, Sheohar and Sheikhpura have recorded very few payments so far.
- JSSK seems to have picked up for all the in-hospital services. The beneficiaries told the teams that they were satisfied with the services as the out of pocket expenditure is nil.
- However assured referral is an issue in the State due to shortage/lack of optimal utilization of dedicated ambulances for JSSK at block level. Only one ambulance is provided to each block to cater all the pregnant women, trauma, complicated, neonatal cases.
- No Maternal Death Reviews or Child Death Reviews are being currently conducted in Vaishali district. In Purnea, only few deaths are being reviewed.
- Immunization activities are being conducted at regular interval in all health institutions and VHNDs. However, at places, microplans could not be seen.

Gujarat

- Delivery points are few and their distribution is skewed.
- Human resource is the main challenge for expansion of the services in both districts. Staff Nurse Posts are not sanctioned in many PHCs, sanctioned posts of MOs are not filled and trainings for those posted are not completed.
- To fill the gaps in specialists at FRUs (Dist. Valsad), doctors are being hired under the CM Setu programme for specialist services @Rs600/hr with a maximum of weekly 18 hrs.
- Quality of ANC service delivery was found to be suboptimal.
- JSY payment is pending in all the delivery units that were visited. At some places, there was no formal mechanism to record all details of JSY payments made to beneficiary. The

main hurdle in payment of beneficiaries was reported to be unavailability of bank accounts.

- JSSK is preventing out of pocket expenditures at the facility.
- SNCUs are in place in Valsad, but not in Dang - mortality was 21.2%. Need to improve quality of care.
- Both districts had NRCs with 60% bed occupancy in Valsad and about 50% in district Dang.
- Maternal death review at State level shows most of the maternal deaths occur at the time of referral to the facility.
- 108 service running in State is found to be satisfactory in Valsad but inadequate to reach and pick up from remote areas in Dang.
- Poor/non-availability of blood- and no blood bank or storage capacity in district hospitals or FRUs was reported.
- Immunization services good, but many health facilities do not provide birth dose of Hepatitis B, zero OPV and BCG as a routine practice.
- Poor attendance at ARSH clinics, even where they are present.

Haryana

- Institutional deliveries have been recorded as improving in the districts visited- over the NHM period with stagnation in the previous year. Most deliveries are concentrated in the higher facilities.
- In Palwal, rate of institutional delivery is 63% (2013-14, April-Oct), which is observed to be low in comparison to other districts in the State. In the last five years, the number of beneficiaries receiving benefits of JSY has come down from 3810 beneficiaries in the year 2009-10 to 2573 in the year 2012-13. The officers appointed in the facilities have clarified that, as per instructions, payments by cash/bearer cheque were stopped and payment through Account payee cheque or Direct Benefit Transfer was initiated. During this financial year, only 212 beneficiaries have received JSY benefits until October 2013. There are problems in opening zero balance bank accounts.
- Under JSSK, free diet is provided; dry meal (tea, biscuits, half litre milk and an apple) is given to any women admitted (costing Rs.30 and register entries as Rs.100), there are no user fees, and drugs are available and free. Diagnostic tests are however, a high cost centre leading to out of pocket expenditure at facilities where availability of lab technicians is a constraint. Ultrasound, though available at DH, is done from outside due to non-availability of sonologists, frequent power cuts and long waiting time.
- Reporting of maternal and infant deaths and stillbirths has improved considerably. Bleeding is a major cause of maternal deaths (12.4% and 37.5 % in the two districts).
- Anemia Tracking Module (MIS) has been in place to track anemia in pregnant women. Establishment of web-based Maternal Death, Infant Death and Still Birth Reporting System (MIDRS)
- There is an SNCU in each of the districts visited- one of which is functioning well below capacity. Accreditation process of SNCU by NNF has been initiated and self-assessment scores are being used.
- RBSK was launched in July 2013 with initiation of activities in 3 districts – but in CRM districts only at level of training of district teams.

- State has launched a number of measures to address anaemia in women- for adolescents, in antenatal period and what is called a reverse tracking system in the post-partum period.
- Training of HBPNC for ASHAs for five days at block level completed in most districts where 11432 ASHAs were trained and their home visits are being monitored.
- Pentavalent vaccination, Measles surveillance started in 21 district and 2nd dose measles initiated in the state. Cold chain facilities in the district are well maintained in both districts. Most facilities have adequate power back up. No stock-outs for vaccines were found in the district but vitamin A was not found at Qurbanpur sub-centre.
- Family planning services are adequate though more could be done to promote spacing contraceptives. The RTI/STI management is limited to the DH, Palwal and facility has effective cross referrals with ICTC.
- Dedicated ARSH /Mitrata clinics established at District Hospital (21) and on fixed hours at CHCs and PHCs. However, attendance was minimal in facilities visited.

Himachal Pradesh

- The state has chosen 62 of 78 CHCs as delivery points, only 8 of 475 PHCs and none of the sub-centres. This must be correlated with the institutional deliveries rate increasing modestly from 71 to 75 % in the previous year.
- Dial 108 emergency services are good, but not for more remote areas- and there are not many local tie-ups with private vehicles for these villages.
- Blood storage units are functional at about half the designated FRUs- and there is a blood bank at Chamba.
- Facility based newborn care is improving with 8 SNCUs and 59 NBCCs in the state.
- Yuva Pramars Kendra (ARSH clinics), have been established across all the District Hospitals in the state and staff are trained. ANM and MPW are aware about the programme and conduct outreach at schools and Anganwadis. The WIFS programme has been rolled out across the state. Menstrual Hygiene programme is in place in 4 districts.
- RBSK has revived the school health programme with systematic screening of children in place, but DEICs are yet to be established.
- Post-partum visits of the mother and newborn are an area of concern and the quality of these services is a concern as the Anganwadi worker who is given this task has received limited inputs or no for the same.
- Family planning programmes have good planning and utilization. Fixed day IUCD services are available across the facilities from the DH down to the SC level.
- Both JSY and JSSK are fully operational in the state. There is good awareness among the beneficiaries in Kangra, while this was low in Chamba district. Payment through DBT has been operationalized in 6 districts of the state. There is a backlog of JSY payments. Interactions with the home delivery cases revealed that they do not receive the JSY benefits.
- JSSK entitlements are listed out at all the facilities visited, and diet is provided for. Reimbursement for transportation is done and 108 is utilized for pick up. Separate Grievance Redressal mechanism is not available in the state.

- Facility based maternal and infant death reviews are being conducted. There were 35 maternal deaths reported in 2011-12 and 24 deaths in 2012-13, all of which had been reviewed.
- Immunization programmes are doing well on all aspects.

Jammu and Kashmir

- Delivery points are well-equipped and trained manpower is available. 18% of PHCs and 1% of sub-centres are delivery points. Most deliveries happen at DH and SDH levels.
- EmOC services are available at FRUs and C-sections were being done.
- The high caseload hospitals require more beds – perhaps in the form of a MCH wing.
- JSSK- is being implemented throughout the State. Beneficiaries are getting cashless services at public hospitals. Interviews with patients confirmed that no out-of-pocket expenses were incurred except payment for transport was given to the vehicle operators.
- Newborn Care: 12-bedded SNCU is functional at DH Kupwara with an average load of 3-4 admissions per day – staffed with 5 SNs, one pediatrician, and 5 MOs available for the SNCU and pediatric ward. In Kathua, SNCU is underutilized. NBSU is functional at SDH/CHC and NBCCs are functioning in PHCs but considering the delivery load and admissions there is a need of SNCU with a full time pediatrician at SDH Kupwara.
- ARSH Clinic: functional at DH level with dedicated counselor providing average 150 counseling sessions per month.
- Sanitary Napkin Program is being implemented at both the districts and in general, there is good acceptability amongst adolescent girls however there are issues regarding quality of napkins.
- Family Planning: 1062 IUCD insertions have been done at CHC, PHC and SC but not at the DH level in the last 6 months in district Kupwara. However, PPIUCD insertion was not seen in either district and this needs to be prioritized.
- Nishchay kit and contraceptives was available with ASHAs and there is good acceptability in the community.
- Adequate stock of vaccines at cold chain points was found but buffer stocks were not maintained at district vaccine store Kupwara.
- NRCs are not established in both districts despite the burden of malnutrition as evidenced from the growth charts at AWCs.
- National Iron + Initiative/WIFS is not yet implemented in the State. IFA tablets are not available in most of the facilities visited.
- Immunization services are available at all levels and birth doses of Hepatitis B and zero dose of OPV are given for institutional delivery, however, BCG is not provided to the newborn. Inadequate implementation of open-vial policy.

Jharkhand

- The number of public sector delivery points has increased from 705 to 909 and FRUs have increased from mere 17 to 48. In the districts visited also, there are a higher proportion of PHCs and sub-centres that are delivery points. There has also been a substantial increase in institutional deliveries in the last year.

- There has been emphasis on strengthening HSCs, as access to higher centres is actually difficult on account of problems of left wing extremism or geographic dispersion. Efforts for provision of ANM accommodations have been made and have contributed to the high functionality of HSCs. However, there remains a huge scope of improvement in all inputs- manpower, training, infrastructure and ensuring a regular supply of equipment and drugs.
- The Level-II PHCs do not have capacity of BEmOC, do not function as 24x7 and in clinical capacity they are effectively Level I.
- Persistent HR shortage remains a major challenge in improving effectiveness of RCH care at the facilities.
- Slow progress on facility based care for new born is noted. Status of HBNC by Sahiyas was noted to be reasonable with checklist filling and all protocols being followed. However, Sahiyas informed that their payment is pending since last six months.
- Delay in JSY payments to beneficiaries are reported from Sahibganj due to difficulty in opening of bank accounts on account of unavailability of bank services in remote villages.
- JSSK is in place but after lowering costs to about Rs.400 it stagnates at that level due to periodic shortage of drugs, diagnostics and transport gaps. In comparison to JSY, awareness about JSSK in the community was low and highlights a need to more focussed IEC/BCC.
- Fixed day services for NSV and tubectomy are not being provided in Level 2 and 3 facilities, and PPIUCD implementation is weak due to unavailability of trained staff in all maternity centres.
- Malnutrition treatment Centres have been established across all the districts and a need based planning has been done in terms of placing NRCs in high prevalence areas. Sahiyas have been trained in identifying malnourished children and has improved referrals.
- Safe abortion services need to be increased through deployment of trained staff and increased attention to supply of necessary equipment and drugs.
- Maternal and infant death review is a weak area. Community reporting is almost non-existent and facility based reporting is neither closely monitored nor effectively analysed.

Karnataka

- Continued efforts to increase the number of delivery points and functional first referral units is seen in the state. There has been an increase from 54 FRUs in 2007 to 166 in 2013 and 389 PHC's (24*7) in 2007 to 1018 in 2013.
- Better quality of care in all sites of institutional delivery with protocols and partographs in place are being followed. Institutional delivery now reaches 98% which has increased from 63% in 2005-06.
- Apart from JSY and JSSK, state has initiated the following: *Thayi Bhagya*, *Thayi plus* (accreditation of private and public institution with incentives for institution and personnel), *Madilu* (a kit for mother and new born consisting of 19 items), Extended *Thayi Bhagya* (cash assistance to BPL/SC/ST for delivery in private institutions), *Prasooti Araiike* (State incentive for nutrition and medical care), *Samooha Seemantha* programme (Community bangle ceremony to promote institutional delivery).
- In both Gulbarga and Haveri, most PHCs are delivery points and only a few fail to meet the caseload criteria.
- Facilities for sterilization and IUCD are available through fixed day approach once in a month at PHC level and on a weekly basis at FRU's. PPIUCD are not implemented as yet.

- Facility based newborn care was functional in the districts visited. Adolescent health counselling services is being provided in the district with the honorarium given to ICTC counsellors for ARSH activities.
- Recruitment of RBSK mobile health teams for screening teams is partial and setting up of District Early Intervention Centres (DEIC) is still to be conceptualized.
- The quality of ANC was poor; Line listing of high-risk mothers especially for hypertension, gestational diabetes needs to be monitored by the immediate supervisors.
- There is poor awareness of JSSK and payments for diagnostics persists.
- Immunization programme is positively reported upon except for concern due to measles outbreaks in the northern districts and MCV2 coverage is only 48%. Immunization field volunteers being introduced. EVM study shows high equipment sickness rate of 23% which needs attention from the state.
- Processes for Maternal Death Review, quality of documentation and reviews conducted and the corrective action on the health systems gaps need improvement.

Maharashtra

- Out of a total 12,880 public health facilities in the State, adequate deliveries are being conducted in 1997 delivery points- of which 1226 sub-centres, 393 PHCs, 192 CHCs. There are 133 hospitals that do C-sections. There are also 3700 accredited private health facilities.
- The public share of total deliveries which was low to begin with has consistently increased and now 50% happen in the public sector.
- Major issue is regarding observance of standard treatment protocols particularly in labour rooms, SNCU and in the Post Natal and Post-Operative wards. Progress of labour is not being monitored using partograph despite availability of digital Doppler at most of health facilities, including the sub centre.
- Special New Born Care Units (SNCU) for sick neonates are established in 23 Civil Hospitals, 8 Women Hospital and Sub-Districts Hospitals in the State
- The SAM/MAM Children who do not have medical problem are admitted in Village Child Development Center for 30 days. The treatment is given by Medical Officer of Primary Health Center and Nutritious diet is provided by Anganwadi.
- Moderately malnourished children (MAM) and Severely malnourished children (SAM) having medical complications are admitted in selected Primary Health Centres, Rural Hospitals and Sub District Hospitals for 21 days. Admitted malnourished children are examined and treated by a medical officer. Nutritious diet is given to the children and mother/caretaker and loss of daily wages is given to the mother.
- NRCs are established in 15 tribal districts at district hospital/sub district hospital level. Sick and severely malnourished children (SAM) are admitted in Nutrition Rehabilitation Centres. At NRC treatment and nutritious diet for 14 days is given to the children. In addition, the mother of the child is given nutritious diet and is taught recipes for preparation of Nutritious diet at home.
- Awareness amongst the beneficiaries regarding JSY was good as was seen in Nandurbar District and ASHAs involvement in mobilizing the pregnant women was good. Most of the deliveries except those from Gujarat were accompanied by ASHA.

Seventh CRM Report

- JSSK implementation is good and achievements under JSSK for 2012-13 is-Free Drugs-49%, Free Diet-49%, Free Diagnostic-45%, Home to facility(pregnant woman)-20%, Drop Back-40%.
- All components of family planning programme are in place- except for PPIUCD.
- Immunization programme had gaps in preparation of due lists, temperature monitoring in vaccine inventory management etc.

Meghalaya

- The density of delivery points is thinly spread and partially functional in terms of SBA and EmOC. All PHC and CHCs are providing only Level 1 service delivery care. Both districts have more than 70% home deliveries (with less than 5% assisted by SBA) and around 30% institutional deliveries.
- No line listing of high-risk pregnant women, eligible couple and no follow up were maintained.
- NBCCs were functional but in 50 % facilities ANM/SN was unable to operate the baby warmer. NBSU and SNCU Functional in MCH Hospital but with staff shortage.
- No blood storage facility in MCH hospital and district hospitals (Tura and Ri Bhoi). Vital drugs viz. Inj. Mag. Sulphate and Tab. Misoprostol not available at 90% of facilities across districts.
- Despite functional equipment, USG facility was not available in Ri Bhoi district due to lack of radiologist/trained gynaecologist. NRC has recently been established in MCH and district hospital Ri Bhoi.
- In Ri Bhoi district, dedicated AFHS centre at district hospital and CHC levels are well staffed and equipped with IEC tools and appropriate, records are being maintained. Around 40 functional adolescent clinics established in all CHCs and DHs and a model ARSH clinic established in Ganesh Das hospital in Shillong.
- Home deliveries are not attended by SBA. It appears that adequate number of SBA are not trained and selection preference is given to regular staff nurse and ANMs over the contractual ones for training.
- The religious beliefs and social norms are major challenges in achieving family planning goal in the state. All staff members are trained in IUCD but still no PPS at the CHCs and no PPIUCD, except in CHC-Ampati.
- Meghalaya Maternal Benefit Scheme (MMBS) has given an additional thrust to JSY in the state, which provides additional Rs.4000 up to 2 children. However, home delivery incentive disbursement was negligible as SBA attendance of home delivery is only 5% in the state.
- No pickup facility available due to lack of a centralized number, 108 is not reachable due to network problem. The vehicle at the PHC is not used for drop back, instead beneficiary are given an estimated amount depending upon their home distance from the facility.
- Only 2% of maternal deaths are reviewed as against to reported maternal deaths in the state.

Nagaland

- In Dimapur district, only the DH is providing C-section services, while in Peren district, the DH and a CHC are conducting C-sections.
- Delays in JSY payment due to account payee cheque system. State has recently issued an order that in areas where banking services are not available, cash payments can be made under JSY to the beneficiaries and ASHAs, however such areas need to be notified.
- JSSK being implemented – but State/ district have misunderstood it to be a cash reimbursement scheme instead of free entitlement. Cash is being given to pregnant women for provision of diet and Referral transport, instead of making available these entitlements. The achievement of the State under JSSK is reported as Free Drug-26%; Free Diet-35%; Free Diagnostic-26%; Free RT-33%; Free Drop back-31%. However, Out of pocket expenses are still being incurred on drugs, blood (for screening tests), and diagnostics. There was poor awareness of free entitlements among staff at all levels, and ASHAs.
- State has around 49 MOs trained in MTP; however, essential MTP drugs like Mifepristone and Misoprostol were not available. None of the facilities at CHC and PHC level is providing Safe abortion services.
- Under-reporting of maternal deaths was noted in DH Dimapur (only 1 death was reported out of the 8 deaths that occurred between Jan-Oct 2013). Further, no facility level review was conducted.
- RTI/STI Clinics have been established at district hospitals but pace of decentralization of STI services below sub-district level has been sluggish. Drug kits were not available in both the districts visited. Partner notification and follow-up remains a challenge. Concerns around partner notification include possible discrimination, violence or other harm due to partner reactions, and relationship termination or risks of breaching confidentiality.
- There has been significant progress in setting up of facility based newborn care services, since the last CRM. In District Dimapur, 2-bedded NBSU was available at the DH. NBSU was not appropriately located as it was almost 500 feet from the labour room. Newborn care corners were available at all visited sub-centre/ PHCs / CHC delivery points. Provider knowledge and skills however are weak.
- The programme on prevention or management of malnutrition is deficient.
- RBSK has not yet begun. However, there is an active school health programme that is on-going.
- Immunization services had a considerable number of process gaps that needs to be urgently attended to, including micro-planning, alternate vaccine delivery, and mechanisms for follow up of missed cases. Further, poor knowledge and practices related to immunisation schedule, inventory management, and cold chain maintenance were noted. Record keeping was not streamlined, leading to data mismatches.
- Family Planning Service availability and uptake was very poor in the State- both for spacing and for limiting methods.
- ARSH Clinics are initiated in a number of facilities, but in the clinic visited – most were general cases of fever/cough/diarrhoea etc.; few RTI/STI cases are reported. No IEC materials targeting adolescents was seen at the facilities. In Dimapur district, high HIV case load for ICTC counsellor leading to lesser attention on ARSH issues.

Odisha

- Quality of care especially with regard to standard protocols, and the irrational use of uterotonics and antibiotics was a problem. Stillbirths are high.
- Lack of blood banking or storage facility is limiting provision of C-sections in 2 DH and 4 SDH. Only 21 of 308 facilities have a blood storage unit. 6 DHs and 5 SDHs do not have either a blood bank or storage facility. Both visited districts had blood storage units in their FRUs.
- JSSK is well implemented and most care is free. Drug availability is good.
- Maternal death review is well implemented both in terms of better reporting and better analysis and use of information- but lot of cases are listed as “other” under causes of death.
- Facility Based Newborn care: All the delivery points have Newborn care corners. SNCU is functioning well at Koraput with dedicated trained staff and good bed occupancy, but none at Jajpur. NBSUs at CHC level not in place.
- RBSK is yet to take off.
- ASHAs make regular home visits in post-partum period for post natal and newborn care and are involved in home delivery of contraceptives. HBNC is well practiced and implemented.
- Most components of Family Planning programme are implemented. However, there is low uptake of PPIUCD in both the districts, despite availability of trained providers. There is no monitoring of the trained providers in both districts. Interval IUCD uptake is also poor with only MOs inserting IUCDs. There is no focus on NSV and there are few trained providers for NSV. Minilap is not provided in PHC (N), Koraput district, despite being more accessible to people and trained manpower being posted.

Uttar Pradesh

- In the districts visited, facilities currently functioning as delivery points are 26.25% (Pratapgarh) and 18% (Mathura) as compared to total facilities in the district. Delivery points were inadequate and not uniformly distributed in both the districts.
- There was a gross mismatch between service demand and availability of beds at Pratapgarh and a significant underutilization at Mathura
- User perspectives and attention to dignity & privacy was missing at all delivery points , including labor room and OT at Pratapgarh. There is no restriction to entry of the attendants accompanying the patients in the wards and labor room and bedside blinds and curtains are not in place especially in facilities with high caseload. Although, the situation is fairly good at Mathura
- Adherence to standard protocols is poor. In the facilities visited, Labor rooms and NBCC are not adhering to technical protocols, except at District Women Hospital and Combined Hospital at Mathura. SHCs continue to use 200-Watt bulbs as newborn care corner.
- No line listing of severely anaemic women and identification of high-risk pregnancies being done at SHC/PHC
- Fixed day family planning services are not available in both districts; however fixed day camp services for sterilization is available at both places. PPIUCD not initiated in Pratapgarh; available at District Women Hospital and Combined Hospital in Mathura.

Seventh CRM Report

- Nischay Kits mostly available, however expired stock found in 1 ASHA kit in Mathura
- Only 1 functional and well maintained NRC at DH Pratapgarh, however admission through outreach referrals was only 14% indicating poor detection and referral by frontline workers.
- Community Level HBNC not yet implemented - ASHA training module (1st round, 6th module) underway
- Well maintained cold chain, vaccines available, micro plan are being generated and available
- ARSH clinics and menstrual hygiene programmes not yet implemented in both districts.
- WIFS is being implemented in school going children so far; it is yet to be extended for out-of-school children
- Under RBSK record keeping and screening activity was good, but treatment and referral of deformities and disability and the follow-up of identified cases needs to be strengthened. No DEIC in place as yet.
- JSSK implementation is very weak. Entitlements for infants require strengthening. At Pratapgarh, user fees were being charged from everyone including pregnant women.
- 108 services generally used for bringing women to delivery points in Pratapgarh; only 10-20% women availed services in Mathura. The drop back facility is very poor in both the districts visited.

TOR 3

DISEASE CONTROL PROGRAMMES:

Guiding Principles/Strategies of the NHM:

1. *“Ensure the control of communicable disease which includes prompt response to epidemics and effective surveillance”*(Para 2.4.2.11)
2. *“Use primary health care delivery platforms to address the rising burden of Non-Communicable Diseases”*(Para 2.4.2.12)

Key Findings

1. Integrated Disease Surveillance Programme

- a. State and district surveillance units have been established in all the districts and states. Adequate IT infrastructure available in all visited states but many of the installed systems are non-functional due to lack of IT support and maintenance. Connectivity and communication is a major challenge for effective implementation of IDSP in many states. Data Analysis is done at the district level, which is an improvement, however it is still not being done at sub-district level even though infrastructure and data entry operators are available. State and district needs to develop a mechanism to support sub-district level analysis and provide feedback from the district level, which will help respond to and prevent local outbreaks.
- b. District and state level rapid response teams are available but functionality of block level rapid response teams was weak. Many newly joined IDSP contractual staff were not trained.
- c. IDSP linkages with medical colleges and ICMR laboratories was established in Odisha. The same was not established in Jharkhand, where the post of state microbiologist is vacant. There is however a need to establish and strengthen referral labs across all states to confirm outbreak of an epidemic.
- d. IDSP data is not being used for better planning and implementation of various disease control programmes. The toll free number 1075 is available in many states (but not in Meghalaya) however, the utilization of this number needs to be strengthened.

2. National Vector Borne Disease Control Programme (NVBDCP)

- a. Downward trend observed in incidence of malaria cases in Himachal Pradesh, Jharkhand, Maharashtra, Jammu and Kashmir, Nagaland, Odisha, Uttar Pradesh and Meghalaya. Similarly, deaths due to malaria also reduced considerably in all these states. Availability of reagents and stains is good in Himachal Pradesh, but there is a shortage in Haryana. Surveillance activities needs to be improved to increase the

current Annual Blood Examination Rate (AEBR) to a target of 10% in Himachal Pradesh, Jharkhand and Arunachal Pradesh.

- b. There is marked increase in Dengue cases in Meghalaya, Himachal Pradesh, Jharkhand, Maharashtra, Jammu and Kashmir, Arunachal Pradesh and Odisha.
- c. Chikungunya and JE cases not reported in Himachal Pradesh but Jharkhand state reported JE cases in 13 out of 24 districts with three medical colleges of the state as sentinel surveillance sites. Shortage and erratic distribution of LLINs observed in many states. Drug policy charts are not available in visited labs in many states. Many sanctioned post from district malaria officer to multipurpose health worker are vacant in many states, and filling these is essential to gear-up the work as per annual plans. Around 2000 Kala-azar cases reported in Jharkhand. Similarly, numerous scrub typhus and cutaneous Leishmaniasis cases were reported in Himachal Pradesh.
- d. Odisha reports a number of innovations like the “*Mo- Mashari*” scheme to promote mosquito nets for pregnant women and children in tribal pockets. Another is the “*Nidhi Rath*” campaign to create awareness about benefits of mosquito nets at community level. These innovations have yielded good results in control of vector borne diseases in the state.
- e. In states of Meghalaya and Jammu & Kashmir, ASHAs are not involved in vector borne disease related activities nor do they have RDT kits. There is need to strengthen coordination between different directorates to successfully implement various national disease control programme.
- f. ACT packs have been procured from NRHM flexi pool in Jharkhand but not in other states. In Arunachal Pradesh, due to non-availability of ACT there is high out of pocket spending of patients.

3. Revised National Tuberculosis Control Programme (RNTCP)

- a. Case detection rate has improved over the period since 2005 in Gujarat and Himachal Pradesh, but there is a decreasing trend observed in Maharashtra. Many states reported lower than the norm of 152 cases per lakh population per year.
- b. Diagnosis of MDR TB through Intermediary Reference Lab (IRL) and DST lab is established in all states. GeneXpert™ has been established to further strengthen the diagnosis of drug resistant TB in many states in the country. In Jharkhand, three drug resistance centres are functional at Dhanbad, Ranchi and Dumka. DOT Plus and MDR suspect criteria – A, B and C is implemented in Gujarat and Himachal Pradesh. C criteria is not implemented in Jammu and Kashmir.
- c. Due to lack of paediatrician in health facilities, paediatric TB case detection rate is low in all visited states. This needs to be improved by appropriate training to MOs. Laboratory consumables are available in all visited microscopy centres.
- d. Registration of TB cases under NIKSHYA is being done in all visited states. Reported achievement varies from 59% in Nagaland to 80% in Jammu and Kashmir.
- e. Supervision at Treatment Unit (TU) and Designated Microscopy Centre (DMC) needs improvement. HIV-TB cross referrals observed, but need further supervision at district level.

4. National Leprosy Eradication Programme (NLEP)

- a. In Himachal Pradesh, implementation is good with MDT medicines and equipment available at the facilities. However, state needs to address training of district programme officers for NLEP.
- b. In Maharashtra, the case detection, management and follow up activities are in place at PHC, Sub Centre and community level. However there is still non-detection of cases in time, which results in deformity. In Nandurbar, number of cases are increasing year upon year from 2009-10.
- c. In Jharkhand, Annual New Case Detection Rate (ANCDR) of leprosy has reduced from 16.7 to 10.8 / 100,000 between 2009 and 2012. The overall treatment completion rate is 95%. Sahiyas are given monetary incentive to keep track of patients.
- d. In Haryana, only one district Panipat is endemic. Around 663 leprosy-affected patients are on MDT treatment in 21 districts. In Gujarat, Valsad district reported an increased leprosy case detection from 783 in 2010-11 to 1009 2012-13. In Karnataka, 3368 new leprosy cases were detected with a 95.5% treatment completion rates in 2012-13.
- e. In Odisha, 247 high endemic blocks have been identified. The leprosy prevalence rate is reported to be 1.25/10,000 as on September 2013 but 19 districts are reporting a prevalence rate more than 1 and three districts report a prevalence rate more than 3. Case detection work has improved with involvement of ASHA.
- f. In Meghalaya, leprosy indicators show reduction from 2011, but there is concern of under-reporting and problems of ASHAs incentives not being paid on time. Providing instruments and training to eligible Medical Officers can help start up reconstructive surgery.

5. National Program for Control of Blindness (NPCB)

- a. NPCB is being implemented in all states covered under CRM. Camps were organized for Cataract surgery at health facilities where functional Operation Theatres are available. Transport facility is being provided for operated patients. NGOs and private sector plays very active role in conducting cataract surgeries in Haryana. Some states reported a shortage of manpower under this programme, especially of paramedical Ophthalmic Assistant (PMOA) positions.
- b. Himachal Pradesh achieved more than its target for cataract surgery and intra-ocular lens implantation at 61% and 67% respectively. In Karnataka Cataract surgery carried out through a network of public, private (6) and NGO (9) network. Out of 9,277 IOL target about 5,000 was carried out. In Odisha total only 539 cataract operations were done against the target of 7243. IOL are being procured at the district level itself.
- c. States had Eye Donation centres; however, Eye Donation is very low.
- d. The NPCB programme has been linked with School Health Programme. School children are being screened for refractive errors and free spectacles are being provided, if

required. In Uttar Pradesh, School health camps for detecting visual errors now merged with school health program under RBSK.

6. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS)

- a. This is ongoing in select districts in the states. Jammu and Kashmir shows exemplary work in Kupwara district – DH at Handwara is equipped with 4-bedded CCU, Geriatric ward and day care chemotherapy centre and a physiotherapy unit as well as OPD services. Over 4 lakh people have been screened for diabetes and hypertension in the districts till September 2013 with prevalence of 9.35% hypertension and 6.75% diabetes. Himachal Pradesh established Critical Care Units at district level facilities and screening for Diabetes and Hypertension of those coming to facilities are available at sub centres and PHCs. In Jharkhand, four districts were covered. The estimated prevalence of high blood sugar was found greater than for hypertension.
- b. In other states, these NCD activities were not observed. Meghalaya has not implemented NCD programmes yet and in Nagaland it has just been initiated.

7. Other NCD Programmes:

- a. The District Tobacco Control Cell under the National Tobacco Control Programme is functioning in selected districts. The national programme for prevention and control of fluorosis was present in Nayagarh, Nuapada and Angul districts of Odisha. In Maharashtra, Sickle Cell Anaemia programme is being implemented in a phase wise manner since 2008 and has now covered 19 districts. In Gujarat, Valsad district is implementing the sickle cell anaemia project in the tribal population. Maharashtra State has taken the initiative to provide palliative care to the patients suffering from chronic diseases like malignancies and debilitating /old age diseases. In Nagaland under the Mental Health Programme – Drug de-addiction programme is going on but there is no rehabilitation centre. With respect to iodine deficiency disorder control, salt testing kits are not available since 2009, in the vulnerable districts of Himachal Pradesh, Jammu and Kashmir. However, these states are promoting the use of iodized salt in the district.

Recommendations

- As the number of disease control programmes multiply, the importance of district health planning for their integration gains importance. The plan should be based on disease epidemiology, and on current availability and utilisation of services. The plan should spell out which services would be available at what facility and how the continuity of care for Communicable Diseases and Non Communicable Diseases across facilities providing primary, secondary and tertiary levels of care would be organized.
- District/block action plan need to use IDSP data and data from the MIS of disease control programmes more rigorously for better and more effective planning and implementation of various disease control programmes. The data collected from IDSP needs to be reviewed on monthly and quarterly basis.

- Attention to infrastructural issues is required to make Edu-Sat and Inter Voice system functional and the system more responsive for IDSP.

Recommendations under NVBDCPs

- IEC/BCC for National Vector Borne Disease Control Programme needs strategies for engagement with migrant population, which will help in stemming the increase in number of cases. IEC activities in local language may be displayed at prominent public places in district and PHCs.
- All the vacant post to be filled on priority basis to implement the time bound activities for prevention and control of NVBDCPs. Reorientation/training may be given to LTs/ASHA etc.
- ASHA and ANM can be involved in all states for slide collection/use of RDKs in NVBDCP at field level and incentives for this purpose must be released on time.
- All health workers and MOs must be familiar with drug policy for malaria particularly for treatment with ACT. Adequate stock needs to be maintained for specific age group- which requires much better logistics management.
- Simple source reduction for elimination of breeding sources of vectors can be done within VHSNC activities.

Recommendations under RNTCP

- There is need for improving collaboration and engagement with private providers along with public sector for strengthening TB notification for better case detection.
- There is need to establish sputum collection and transportation mechanism in the PHCs where DMCs are not established under the supervision of MO/THO with maintenance of sputum transportation register.
- Under RNTCP, to make NIKSHAY real-time data, the data entry needs to be done at every PHC and block through Pharmacist /DEO /any staff available.

Recommendations under Non-Communicable Diseases:

- There are major gaps in implementation of NCD programmes across districts. In most places, it has not yet gained importance as a public health problem and the most important step forward is for advocacy and demand generation for care of chronic illness.
- There should be a clear plan for establishment of primary care for NCDs- both the screening for diseases and the follow up on doctor/specialist initiated drugs. Access to drugs for chronic illness must be at PHC level or even at the sub-centre level and on a regular basis.
- Necessary infrastructural, logistics and HR supports should be provided to counter these silent killer diseases – but in an integrated manner. Thus the state should have a good drug logistics system, and one should ensure that such a system has all the drugs needed for NCDs.
- IEC/BCC activity addressing NCDs needs to be stepped up.

State Findings:

Andhra Pradesh

- Post of 20 LTs is vacant in Chittoor district and no record of training on VBDs could be provided by the district. ASHAs are playing only the role of activists and are not trained in RDT testing and administration of drug.
- RNTCP treatment cards are well maintained and DOTS are provided as per guidelines. Though the state/districts have achieved the NSP case detection and cure rate targets, they are yet to achieve the universal access in terms of total TB case notification.
- The diagnostic services for the MDR TB have increased substantially in recent period. Andhra Pradesh is one of the leading states in implementing PMDT successfully and is one of the training centres for National Level training on PMDT.
- DRTB centre in Mahboobnagar is yet to start and the sudden closure of DRTB centre in AP Chest Hospital is affecting the treatment initiation of DRTB cases in the district. The DRTB centre at the DH in Chittoor lacks adequate beds and needs partition between beds for male and female patients.
- The NPCDCS was started in Vizianagaram and Nellore Districts. Subsequently the program was extended to six more districts in 2011-12 - Srikakulam, Krishna, Prakasam, Kurnool, Kadapa and Chittoor.
- Screening programme was launched to screen people above 30 years and pregnant women for diabetes and hypertension in eight identified districts and nearly 84 Lakh persons were screened so far at sub centres, villages and CHCs. There were 7.12% diabetic and 7.32% hypertensive among the screened.

Arunachal Pradesh

- Malaria and Dengue are most prominent public health issues of the state. Recently few JE cases have been reported from the State. Due to non-availability of adequate diagnostic facility as well as drugs like ACT for Pf positive cases, malaria patient has to bear out of pocket expenditure.
- ASHAs are not involved in malaria activity nor provided RDTs/anti-malarial drug. Active collection is nil as the DHB (Domiciliary health Visitors), RFW(Regular Field worker) including MSI(Malaria Surveillance Inspector) are not at all involved for collection blood slide in the community, rather they were observed to be involved in office /hospital activities.
- The Annual Blood Slide Examination (ABER) of State is >10%; however it has been declining over the years. In the West Kameng District, surveillance is found to be very poor, as the ABER was only 1.88 to 2.58% since 2009 against the national norm of 10%. In Upper Subansiri district, the ABER has declined from 17.5 in 2011 to only 4.65 in 2013 till September.
- New Sputum Positive (NSP) case detection rate in the state is 87% by the end of September 2013. It is 82% in West Kameng and 60% in Upper Subansiri district. Treatment Success rate in the state is 85% however, the success rate in West Kameng

and Upper Subansiri is 98% and 93% respectively in 2013. Default rate is below the expected rate of 5%.

Bihar

- Among NVBDCP diseases, Kala- azar is a major problem in the state. Dengue and AES/JE have emerged as problems in recent years. While malaria cases seem to be under control, filariasis has wider presence (with low endemic) in the State.
- Across State, 33 districts are endemic, among them 425 are endemic blocks and out of these five blocks are having more than 10 cases per lakh population.
- In place of 36 DMCs, as per Population norms of RNTCP, only 17 DMCs are functional. Sub optimal involvement of the ANMs observed in the supervisory activities and there is no plan exists for the alignment of the TU at the block level.
- Under Nikshay, only 33 cases were entered out of 1811 TB Cases registered in 2013. Not a single TB Case was notified. Treatment cards are not regularly updated and patients do not get informed about scheduled follow-up visits.
- Under NPCDCS, 7 districts were chosen as pilots i.e. Muzaffarpur, E. Champaran, West Champaran and Kaimur started the work and Vaishali and Rohtas are under process to start. Except diabetic screening, screening for Cancer, Cardiovascular disease and stroke is yet to be initiated in the State. Procurement of equipment and consumables as per NPCDCS is to be initiated. Cardiac care units are yet to start under the pilot program in the 7 districts.

Gujarat

- Guidelines and treatment protocols of vector borne diseases are adhered to and efforts are made to prevent vector borne diseases in focused areas. All the required facilities for diagnosis and treatment of the diseases are available as per need and level of care.
- The trend of total TB case detection rate is improving over the years from 2005, yet it is much below the norm of 152 per lakh population per year. Registration of TB patients through NIKSHAY is being done. The overall program performance of the state is satisfactory.
- TB-Diabetes collaborative activities are being undertaken in 6 districts. State achieved 95% entry of the diagnosed and treatment initiated TB cases in the Nikshay web portal. More than 8000 TB cases were notified from the private sector (highest in the country).
- National Programme for prevention and control of cancer, diabetes, cardiovascular diseases and stroke (NPCDCS) has not yet been rolled out in the States. However, patients are treated at the facility or referred to District Hospital for treatment.
- Sickle Cell Anaemia Control project in Valsad screened 3,78,379 and the incidence of sickle trait is around 15.45%.

Haryana

- A total 10,419 cases of Malaria with 95 cases of *P. Falciparum* were reported during 2013 till September. Post of State Entomologist (1), Zonal Entomologist (2) are lying vacant for last many years. As a result surveillance for vector borne diseases are not adequately and properly monitored to control vector borne diseases, particularly Malaria and Dengue.
- During the visit, the recent drug policy chart was not displayed. Laboratory of district hospital Palwal, CHC Hodal and CHC Hathin were ill maintained.
- There was no district level HIV- TB co-ordination committee meeting to ensure effective co-ordination of HIV-TB activities in Palwal. The ICTC counsellors were unaware of such meetings.
- Knowledge of paramedical staff in newer initiatives under RNTCP like TB notification, PMDT and TB/HIV is sub optimal. No state level training of MO and para medical staff has been done since 2010.

Himachal Pradesh

- Incidence of Malaria including *P.vivax* shows a decreasing trend after 2011. API in the state was 0.1 in 2012 and is 0.02 for 2013 (till Sep.). However, surveillance activities needs to be improved so as to increase the current ABER rate from 7.4% to a target rate of 10%.
- The cause of concern are diseases like scrub typhus and cutaneous Leishmaniasis. Since May 2013, 3027 cases of Scrub typhus have been suspected, out of which about 1/3 were confirmed cases. Diagnostic facility for it was available only at the two medical colleges at Shimla and Kangra respectively.
- RNTCP program objectives of case detection and treatment success rate are being achieved by the State since the last 7 years. There is provision of free diagnostic services through 180 DMTCs and free of cost treatment through DOTS centres in all health facilities including Ayurveda facilities, Anganwadi Workers and community volunteers.
- State achieved more than its target for cataract surgery and intra-ocular lens implantation under National Program for Control of Blindness (NPCB). 61% more than expected for cataract surgery and 67% for IOL was achieved in the state for the financial year of 2012-13. However, the respective numbers have decreased in year 2013-14.
- First phase of NPCDCS was introduced in three districts Chamba, Kinnaur and Lahaul and Spiti in 2010. It is observed that screening facilities for Diabetes and Hypertension were available even at sub-centres, PHC level, and critical care units have been established at district level facilities. Facility for cancer screening and treatment needs to be made available in the districts and speedier implementation of phase II of the programme is needed.

Jammu and Kashmir

- Slides, staining facilities are satisfactory in the visited facilities. Slides are examined/being sent for cross checking in stipulated time. Records were not maintained properly in Kathua district. Line-listing for malaria cases was incomplete. ASHA are not aware and not involved in NVBDCP activities nor have RDT kits for diagnosis of Malaria cases been provided.
- A total of 20 MDR patients are under treatment in district Kathua and 11 in Kupwara. There is no shortage of anti TB drugs and paediatric patient wise boxes and cat IV drugs are available. Nikshay entries are being done at both the districts. HIV testing of all TB patients are done.
- Camps are organized for cataract surgery at health facilities where functional operation theatres are available. Transport facility for the operated patients is available. Schoolchildren are being screened for refractive errors and free spectacles are being provided, if required.
- NPCDCS programme is being implemented in Kupwara district. Over 4 lakh people have been screened for diabetes and hypertension in the districts till September 2013 with 9.35% hypertension and 6.75% diabetes detected among the screened population.

Jharkhand

- Malaria mortality rates have come down from 0.10 to 0.02 in the last five years. API has marginally reduced from 3.70 last year to 2.38 this year (up to October); the ABER has further reduced from 7.40% to 6.39% till Oct. 2013. Involvement of Sahiyas was less in Malaria case detection and treatment, which is mainly viewed as responsibilities of MPWs.
- Strong vigilance and increased vector surveillance needs to be ensured to detect any future outbreak of dengue and Japanese Encephalitis.
- Kala-azar is endemic in four districts viz. Sahibganj, Godda, Pakur and Dumka. During January to September 2013, a total of 2013 cases with no death have been reported. Adequate stock of drug for six months is available and treatment completion rate is >95%. KTS are actively involved in tracking and ensuring drug compliance.
- Lymphatic Filariasis is endemic in 14 out of 24 districts. The state has observed MDA 2013 round during 11-13 November, 2013. 16 districts have achieved overall <1% Mf rate out of which six have achieved <1% Mf rate at each site. The state has a backlog of about 5000 hydrocele operation.
- The state reports an average of 40,000 TB cases per year. There are >8000 DOT centres in the State. Treatment completion rate of patients is >80%. The state has adequate supply of anti-TB drugs though supply of paediatric TB drugs was not there.
- NPCDCS programme was started in four districts (Bokaro, Dhanbad, Deoghar and Ranchi) of the state during 2012-13. Of the total cases that have been screened in Bokaro, about 6% were suspected for diabetes and 9.5% for hypertension.

Karnataka

- Malaria and JE cases have shown a declining trend in the state whereas Dengue & Chikungunya cases have shown an increasing trend during last two years. Total malaria cases detected in 2012 were 16466 whereas till October 2013, it is 10,613.
- Treatment rate of RNTCP shows an increasing trend with 83% success rate among new smear positive cases. However, default rate of 6-7% and death rate of 5-6% are the reasons for the state not reaching the minimal expected target of 85% success rate.
- In the year 2012-13, nearly 3,88,210 cataract surgeries have been conducted with over 22,766 free spectacles distributed.
- NPCDCS programme is implemented in five (Chikmagalur, Kolar, Shimoga, Tumkur and Udupi) out of 30 districts covering a population of 8.3 million. Three major hospitals have entered into a MoU to provide cancer screening.
- National Programme for Prevention and control of Fluorosis (NPPF) is implemented in 18 endemic districts of Karnataka with special focus on 6 high prevalent districts.
- National Programme for the Health Care of the Elderly (NPHCE) is operational in the 5 districts that have NPCDCS programme. Geriatric clinics have been established in these districts with OPD facilities with 10 bedded geriatric wards in 3 districts for in-patient care.

Maharashtra

- There is increase in Dengue and Chikungunya cases in 2012 as compared to 2011. In 2013 (till Oct 2013), 17 cases have been diagnosed by sentinel surveillance centre at Government Medical College, Dhule.
- The TB suspect examination in the state shows an increasing trend from 140 suspects per one lakh per quarter in 2011 to 167 suspects per lakh per quarter in 2012 as against the RNTCP norm of 220 suspects per lakh per quarter.
- There has been a gradual increase in the number of cataract surgeries in the district from 7,779 operations in 2008-09 to 13,988 in 2012-13. Cataract Surgery Rate (CSR) was 874 per lakh population during 2012-13 which is satisfactory.
- The sickle cell anaemia programme is implemented in 20 districts; services are being provided through 947 PHCs, 238 SDH/RH, 14 district hospitals, 4 Women's hospitals and 8 Medical Colleges. There are 153 electrophoresis and HPLC machines available.
- New Initiative for Palliative Care (Pilot) in Thane and Nashik districts have been introduced to provide palliative care to the patients suffering from chronic diseases like malignancies, debilitating /old age disease.

Meghalaya

- Deaths related to malaria shows a downward trend, from 197 deaths in 2009 to 52 deaths in 2012, which is a 73% change in death rate. ASHAs are neither aware, nor have RDT kit for diagnosis of malaria cases.

- The Annualized new smear positive case detection rate is 72% per lakh in 2012-13. A total of 220 drug resistance (MDR) TB cases have been registered for treatment, which include 191 MDR at Shillong DRT and 29 at Tura DRT centre.
- There is an overall shortage of Anti TB medicine in the State. As per directions from Central TB Division, some of the drugs are being managed locally by state level procurement.
- A total of 927 cataracts operations were performed, 924 IOL were supplied and 5592 children were checked for refractive errors in entire state. Four eye surgeon posts are vacant out of 5 sanctioned posts in the state.
- Almost all health facilities are co-located with AYUSH clinics which have consultation and dispensing rooms at CHCs and DHs level. Essential equipment's, instruments and furniture required for AYUSH are available, but medicines have not been supplied since 2009.

Nagaland

- Vector borne diseases are a major public health problem in the state. Malaria is endemic in all 11 districts; Japanese Encephalitis (JE) is confirmed in 8 districts and Dengue is endemic in 1 district. Recently Scrub typhus outbreaks were reported in all 11 districts
- The prevalence of all three vector borne diseases (Malaria, JE and Dengue) are declining from year 2011 to 2013. On an average 11 % ABER is maintained in both the district, although *API* is < 1 in Peren district and 2.26 in Dimapur district which is higher than the state goal. There is a need to reorient LTs, ASHAs and allied health workers on disease control programme.
- There are a total of 9721 patients in the state undergoing TB treatment, of which 3395 are new sputum positives. Of the total, 1949 patients completed their treatment and 3372 patients have been cured till date.
- Under National Mental Health Programme, drug de-addiction programme is going on but no rehabilitation centre has been established yet.
- The NPCDCS has started recently in the State.

Odisha

- The Incidence of malaria has decreased from 3.96 lakh in 2005 to 2.62 lakh in 2012 and the Annual Parasite Incidence (API) has declined from 10.1 in 2005 to 6.1 in 2012. Reported deaths due to malaria have also reduced from 255 to 79 during the same period.
- The annual new sputum positive case detection rate in 2012 was 61% against the norm of 70% and the treatment success rate was 86%, against the norm of 85%. The reported death rate during 2012 is 4.9% against the Norm of >5%. Paediatric cases range from 4 to 5%.
- The screening for diabetes and hypertension under NPCDCS in 5 districts shows that the prevalence of diabetes is 5.41% and Hypertension is 2.8%. It was observed that in Koraput all population under 30 years of age are being screened.

- NTCP is functioning in two Districts of Odisha namely Cuttack and Khurda and is centrally sponsored by Govt. of India.

Uttar Pradesh

- Disease burden of JE, Kala-Azar, dengue, chikungunya and filariasis in both districts is not high. UP is not an endemic area for malaria but the slide examination for fever cases are being prepared and examined.
- Under RNTCP, around 850 posts are laying vacant across the state. 76% of the TB cases is being reported through Nikshay. Detection of Paediatric TB cases show a declining trend (from 7-to 5%) against the national average (10-15%).
- Only 11% of facilities are co-located (DMC with ICTC). Proportion of TB-HIV co-infected patients receiving HIV care and support shows an increasing trend (2010- 24%, 2011- 44%, 2012 -50%, 2013- 61%)
- In Mathura, 4196 (out of 4206 cases) operated for cataract were IOL under NPCB while in Pratapgarh it was 2352 (out of 2751 cases). School health camps for detecting visual errors have now merged under RBSK.
- No other national program under NCD flexi pool is being implemented in both the districts.

TOR 4

Human Resources for Health & Training:

Guiding Principles/Strategies of the NHM:

1. *"Build environment of trust between people and providers of health services"*(Para 2.2)
2. *"Support States to develop a comprehensive strategy for human resources for health through*
 - a) *Policies to support improved recruitment, retention and motivation of health workers in rural, remote and underserved areas,*
 - b) *Improved workforce management*
 - c) *Numbers deployed as per IPHS norms.*
 - d) *Development of mid-level care providers*
 - e) *Creation of new cadres with appropriate skill sets*
 - f) *Appropriate in-service training"*(Para 2.4.2.20)
3. *"Strengthen the sub-centre/Urban Primary Health Centre (UPHC) with additional human resources and supplies to deliver a much larger range of preventive, promotive and curative care services- so that it becomes the first port of call for each family to access a full range of primary care services"*(para 2.4.2.6)
4. *"Incentivise good performance of both facilities and providers"*(Para 2.3.10)
5. *"Address shortages of skilled workers in remote, rural areas and other under-served pockets through appropriate monetary and non-monetary incentives"*(Para 2.3.11)

Key Findings

- a. Better organization of recruitment process - often using innovative methods of recruitment such as online application system, direct walk-in-interviews have helped most states increase the availability of skilled workforce across various categories, in particular MBBS doctors, AYUSH doctors, staff nurses, ANMs and paramedics. Regular vacancies under respective state governments are also filled up. However, there are no reports of any new sanction of positions either under NRHM or under the state government. There are no systematic efforts to create regular posts under the state government, so that contractual positions under NRHM can be withdrawn. This would mean increasing workload for existing staff in well-functioning facilities.
- b. Across the board, there is very little progress on filling up of vacancies of specialists, which still remains a critical issue.

- c. Jharkhand, which had been unable to fill up its regular posts in past years, finally got going, re-initiating regular recruitment in 2012. There have been two rounds of recruitments and 1561(53%) posts of MOs have been filled so far against the target of 2983. In the state of Haryana, regular recruitments, done twice a year since 2011 led to appointments of 2368 M.Os of which only 50% are retained.
- d. The CRM team to Himachal Pradesh observes that there have been no recruitments in this cadre and the last trainings for MPW (male) were conducted in the year 2002.
- e. There is a substantial increase in AYUSH doctors and their improved functionality. In some states like Odisha and Maharashtra, AYUSH MOs are providing AYUSH services while in Punjab and Haryana, AYUSH MOs are predominantly deployed as a substitute to MBBS MOs for the delivery of Maternal and Child Health care services.
- f. More states have now adopted with some success an incentive package for the staff posted in rural and remote areas. States like Himachal Pradesh and Odisha have come up with differential incentive packages. Educational Opportunity such as incentives like PG seat reservation in Medical colleges is provided in states of Himachal Pradesh, Maharashtra and Haryana.
- g. Online Human Resource Management Information System (HRMIS) has been established in Jharkhand, Bihar and Odisha. In these states, online HR database has been developed, which includes both regular and contractual staff, barring Odisha where only contractual staff is covered in the database. However, limited application of HRMIS in HR and Training planning and post training deployment was seen.
- h. Initiatives at Performance appraisal system on annual basis are reported from more states.
- i. Training Plan was in place in some states but the roll out is slow- with little district level involvement in training need assessment and training plans. Training institutions have little knowledge of selection and post training deployment in almost all states.

Recommendations:

- Further increase in service providers is essential – and there is need for a clear policy articulation that states must be committed to achieving minimum levels of the regular public health workforce as per IPHS for carrying out core functions of facilities and this should go along with measured increase in service delivery. Targets need to be defined for both, prioritizing facilities with high caseloads.
- States need to devise policy for retention and motivation of staff by developing good performance based incentives including parity between regular and contractual staff.
- Decentralization of recruitment process for contractual appointments of all posts to district level with higher pay packages in the form of difficult area allowances for more difficult and remote districts should be considered, with state engagement when districts are unable to find candidates.
- Rational deployment of specialists such as obstetricians, anaesthetists, paediatricians and EmOC & LSAS trained M.O.s in designated FRUs should be ensured. All MOs with PG qualifications need to be posted in CHCs, block PHCs or higher centres.

- Establish and strengthen an HRH cell that undertakes all the “establishment” matters (recruitments, payments, training, career progression & grievance redressal) of all contractual staff exclusively. Frequent change of leadership at Mission Directorate office further raises the need of such a cell to maintain continuity.
- Online Human Resource Management Information System (HRMIS) should be scaled up in all states to facilitate decision-making process thereby ensuring better human resource planning and deployment. HRMIS should also be expanded to create training database and in planning for training. Salary bills should be guaranteed through HRMIS to ensure regular updation of postings.
- Need to introduce separate cadres for clinical specialists and public health professionals with dedicated career progression pathways. It would help skilled human resources to gain expertise in their respective domains by gaining experience over the years.
- The health facilities must be categorized on the basis of degree of difficult-to-access, remoteness, and a package of measures put in place to encourage postings in these areas. These measures may include time-bound promotion linked with mandatory posting at all categories of workstations.
- Standardization of performance appraisal systems- both team and individual based- should be established in all states, with similar scoring systems applied for both contractual and regular employees.
- Standard Treatment Guidelines (STG) should be constituted by the states for each category of clinical service providers (Medical Officers, Rural Medical Assistants, AYUSH MOs, nurses and Paramedics) to address knowledge and skill gaps and improve their performance. Mentors from medical colleges and other centres of excellence should be involved for clinical mentorship.
- Managerial training needs to be continued up to district and block level officials for effective planning, monitoring and supervision under the programme.

State Findings

Andhra Pradesh

- Over the NRHM period, State has increased intake of medical students through the creation of 5 Medical Colleges in the Public Sector and 6 Private Colleges with an overall increase of 1000 medical seats.
- The dearth of Human Resources was observed across all facilities. State has vacancies of 337 Medical Officers, 1292 Specialists, 688 Paramedics, 1333 Lab Technicians, 2811 MPHWs, 3740 ANMs and 5873 ASHA facilitators.
- However, state has recently issued advertisements for recruitment of regular staff such as medical officers and specialists and this is a welcome step.
- Mismatch of skill and allocated work profile was observed. Despite the dearth of available specialists, Anesthetists and Gynecologists were posted as SPHOs in many facilities.
- Several modes of training including establishment of skill labs and skill van are being attempted, but there is no strategy for post training follow up and supervision. The baseline assessment of knowledge and skills of service providers like doctors and ANMs also needs to be carried out.

Arunachal Pradesh

- Naharlagun State Hospital is being upgraded to a 300-bedded facility and has been proposed as a Medical College.
- There is no specialist cadre in the state. As a result, various specialist doctors are working in many of the PHCs and CHCs as General Duty Medical Officers.
- Irrational posting of highly skilled staffs was seen in the state. For instance, the only Anaesthetist working at the DH Daporijo has been given the charge of DRCHO, which reduces his availability for clinical work.
- Performance appraisal systems for the Regular as well as Contractual Staff is not in place and consequently, blanket increments are done irrespective of differential outputs of the staff.
- Annual Training Plan is made at the state level and does not take into account the districts' needs. Nominations for LSAS, BEmOC, EmOC and SBA training are done at state level without looking at the actual requirements in the districts.
- State is undertaking a competency assessment test for the ANMs to identify their skill gaps.

Bihar

- NRHM has contributed vastly in increasing human resources for health, with contractual staff constituting more than 50% of the total available staff in the state.
- In parallel, the state has increased the sanctioned posts for Staff Nurses, ANMs, Doctors, etc. as per the IPHS norms. State has also initiated the process of absorbing contractual doctors and specialists into regular services.
- Decentralized system of recruitment at the district level is done for the appointment of contractual ANMs and SNs. The District Health Society is the recruiting authority for recruitment of all contractual staff within the district.
- Data on facility level performance in terms of OPD/IPD and delivery caseload from HMIS is analysed in correlation with the human resource status (generated through HRMIS) at the facilities that helps in identifying the issues of under- and over-utilization of the HR availability.
- Pace of training achievement against the targets is not up to the mark because of the lack of adequate training infrastructure in terms of HR (trainers) and facilities across the state.

Gujarat

- To address the shortages of specialists, walk-in interviews for contractual posts are conducted every Tuesday. There is also provision of contracting-in Specialists under C.M.'s SETU Yojana where private practitioners (Specialists) are paid at the rate of Rs. 600/- per hour for a maximum 72 hours a month for serving in government hospitals.
- In the State Hospital at Dharampur in District Valsad, 54 percent Specialist posts, 43 percent posts of nursing staff, 40 percent Class-III posts and 64 percent Class- IV posts are lying vacant.
- State has also conducted interviews outside the state for Class I and II posts at Indore, Nashik, Jaipur and Udaipur.
- There is no provision of incentives/rewards for HR posted in difficult-to-access areas such as remote, hilly, tribal and High Priority Talukas.

Haryana

- State has devised its own staffing norms for doctors, staff nurses and paramedical staff based on the delivery caseload at the facilities. HR gaps for FRUs and other facilities are calculated on the basis of these norms only.
- To expedite the recruitment process, a high-powered selection committee has been constituted under the chairmanship of Director General Health Services, which conducts interviews for selection of MOs twice in a year.
- There is no specialist cadre in the state. Specialist doctors join at the same rank as that of General Duty Medical Officers and sometimes, do not find the posting areas relevant to their areas of specialty.

- State has extended the retirement age of doctors from 58 to 60 years and is recommending engagement of specialists for 2 years post-superannuation.
- Educational incentives are given to the MOs serving in rural areas in the form of credit marks at the time of PG entrance examination.
- AYUSH MOs are being deployed at the PHCs with chronic vacancies of MBBS MOs for delivering basic Maternal and Child Health care services.

Himachal Pradesh

- On a quarterly basis, an exercise is undertaken to review trained HR vis-à-vis available posting areas. In the preceding month to the CRM visit, 21 employees were redeployed based on their skills and requirement at the facilities.
- There is improvement in retention of MOs and Specialists, due to introduction of several measures, viz.-
 - *Hardship allowances:* Incentives amounting to Rs 25,000 and Rs 40,000 (*in addition to the salary*) are given to the contractual MOs and Specialists working in the Hard Terrain areas.
 - Provision of giving *choice of posting* to the MOs after they successfully complete the mandatory years of service (*2-4 years*) in the select difficult areas.
 - *Educational Incentives:* 66% reservation is given in PG seats for Regular MOs after serving for 2 years in hard terrain and 5 years in other areas.
- There is an increasing felt need of imparting managerial training for effective planning, monitoring and supervision to the District & Block level officials.

Jammu and Kashmir

- Skilled human resource is evenly distributed in health facilities, and availability of doctor including MBBS MOs and basic staff has been ensured.
- In Kupwara district, overall 20 % of the positions are lying vacant (State regular + NRHM), though vacancies are much less under NRHM as compared to regular staff- 95% of positions under NRHM are filled, whereas 27% of regular positions are vacant – mainly specialists (72%), MOs (42%) and Staff Nurses (36%). Under NRHM the process of recruitment is faster with walk-in interviews and choice of posting offered to the successful candidates.
- Rational deployment of staff at different MCH levels and delivery points is required and needs to be emphasized in Kupwara district.
- There was a huge gap between the 'post sanctioned' and staff 'in position' which was cited as the main reason/concern for not rendering health services to the poorest of poor.
- Inadequate availability of specialists in DHs, SDHs & CHCs has affected the quality and range of services like Caesarean Sections, Specialized Newborn Care and Ultrasound

Services e.g. paediatric services are affected in SDH/CHC Kupwara due to non-availability of Paediatrician though the delivery load of this SDH/CHC is more than that of the District Hospital.

- The problem of shortage of health staff is inter-linked with the fewer numbers getting trained in district. For example, deputing an MO or SN or ANM for training from a health facility will cause stoppage of even the basic services being provided there.
- Performance appraisal system for HR is in place.
- Facility Based New Born Care (FBNC) training program has been initiated for the first time in the State for capacity building of SNCU staff.
- There are 38 Doctors and 50 Staff Nurses from functional SNCUs and G.B.Pant/SMGS Hospital who have been trained in FBNC training during 2012-13 in collaboration with National Collaborative Center for FBNC, at Kalawati Saran Children Hospital, New Delhi

Jharkhand

- The recruitment process of regular staff which was adjourned until 2009 has been re-initiated during 2012 wherein two rounds of recruitments have taken place and 1561 posts of MOs have been filled against the target of 2983.
- Decentralized system of recruitment is required at the district level and the state should only intervene in case of inability to find candidates in the districts.
- Under iHRIS, the state has established HR database of Medical Officers in all 24 districts with support of USAID supported IntraHealth project. The database captures personal, educational, training and service history of the medical officers posted across the districts, which is updated on a quarterly basis. However, the information generated is still not being effectively used for HR planning and rational deployment.
- Mismatch in skill and work profile was observed for some categories of staff. In DH Sahibganj, the O&G Specialist was posted as District TB officer and given the responsibility of the blood bank as well.
- Payment delays of as much as three months were reported by ANMs from Borio and Tallijhari Block in Sahibganj.
- There is no Transfer & Posting policy in the state, which leads to lack of motivation for doctors placed in the remote areas.

Karnataka

- Karnataka has taken up many systemic changes and innovations including enacting of new acts like the Karnataka State Civil Services Act 2011, the KPME (Karnataka Private Medical Establishments) Act 2007, development of Human Resource Management Systems (HRMS), Incentives for deployment & retention of HR, Pre-service and In-service training for HR and Human Resource Development Program. However, due to Article 371-J, which gives special status to Hyderabad-Karnataka region- filling up vacancies has been temporarily suspended.

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- Doctors, Nurses, and ANM are adequately trained but some of the MOs and Specialists need re-orientation for updating knowledge & skills on new technology and programmes.
- There are no MBBS doctors (GDMOs) at high case-load facilities especially in Taluk Hospitals to support the specialists in handling the workload.
- A good initiative has been the CPHN training of LHVs at SIHFW – to fill vacancies of District Nursing Officer/District Nursing Supervisor Post. From the inception of NRHM, a total of 70 doctors have been trained in EmONC and 74 in LSAS. Of these 21 and 26 respectively are conducting C-Section and administering lifesaving anaesthesia. However, only 35% LSAS/EmOC doctors practicing the skills learnt is a cause of concern.
- Physical Infrastructure of SIHFW is impressive. However there is a need to train and orient the consultants appointed by SIHFW on the latest strategies & interventions to enable them to effectively conduct training programs for service provider.
- A number of ANMTCs have been upgraded to GNMTCs, which would function under Medical Education Department. Selection of LHVs for training is based on certain criteria linked with seniority, service period left, willingness etc. The creation of a separate public health cadre is under process.

Maharashtra

- Specialists were not available as per IPHS standards.
- Laboratory technicians are not available at PHC level and laboratory tests are done outside the facilities.
- AYUSH doctors need to be imparted with multi skill training for better integration of AYUSH with the health system.
- The managerial training for effective planning, monitoring and supervision needs to be provided to all district and block level officials.
- 15 PHCs of Nandurbar District has been upgraded and labelled as IPHS facilities. The state has placed 2 MOs in all the PHCs. All the delivery point sub centres has 2 ANMs in place.

Meghalaya

- Contractual staff under NRHM has increased from 120 in 2005 to 1142 personnel in 2013.
- State finds it a challenge to rationally deploy HR despite the availability of more than required number of staff.
- Lack of coherence was observed between DHS and NRHM on HR issues viz. recruitment, training and deployment. All postings, be it regular or contractual are controlled by the DHS and as a result even though sufficient number of HR is available in the state, they are not appropriately deployed.

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- Lack of adequate training infrastructure both in terms of HR (Master Trainers) and facilities was observed in the state. The State has 2 GNM Schools and 1 ANMTC.
- The current incentives given to the MOs and SNs serving in the difficult and very difficult areas are not sufficient enough to motivate them.

Nagaland

- There is no Medical College in the state and only 1 GNM School is functional with an intake capacity of 40 seats. There are 4 ANM schools currently under construction.
- Training sites need to be reaccredited as per guidelines to improve the quality of training and service delivery.

Odisha

- Huge shortfall of staff exists in the categories of MPW (M), Staff Nurses, Radiographers and Specialists with respect to the population based IPHS norms. State needs to revise the sanctioned strengths for all these categories in order to keep up with the requirements.
- There is no specialist cadre in the state. MOs and Specialists join services at the same level as Assistant Surgeon and sometimes do not get posted at a facility where their skills are required.
- State has already achieved the training targets for LSAS, BSU and NSSK.
- ANMs placed at sub-centres are entrusted with a large population spread across vast geographical areas, which they find daunting to manage along with conducting daily sub-centre duties. State, however, has recruited MPWs to support ANMs in their duties but still many Sub-centres are being managed by single ANMs.
- Residential facilities for staff were not available even at the higher facilities like DH and CHCs in Jajpur and Koraput.

Uttar Pradesh

- 37% vacancies amongst regular staff is seen in Mathura District. For instance, vacancies of SNs (regular staff) are as high as 75% in Mathura and 72% in Pratapgarh. Majority of the staff nurses are hired on contractual basis and efforts for filling up regular positions need to be accelerated. Critical gaps are seen in rational deployment of HR. In Mathura, there is no provision for second ANM at the sub centre.
- It was mentioned during interaction at the district level that all cadres of medical officers (including specialists) have been merged into the general cadre. AYUSH doctors need to be more effectively utilized (e.g. for supportive supervision, Family Planning etc.) with clear demarcation of roles at the PHCs.
- Lack of rational plan for deployment of HR in critical areas like Labour Room, SNCU, family planning services etc. after being trained in these skills.
- No rationalization of load between laboratory technicians hired through various programs (e.g. RNTCP and NRHM). These LTs are not comprehensively oriented, and as a result the regular LTs doing routine tests are overburdened whereas LTs from vertical programmes are grossly underutilized.

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- Mismatch between skills and placement - for instance, multi-skilled doctors were not posted at EMoC facilities. Also, there appears to be no plan on how to fill these gaps through skill-based training. No performance related incentives for all categories of HR.
- A performance appraisal format is available for contractual staff. However, the same is not appropriately designed. Designated work of employees (FP counsellor & BF counsellor, HMIS & MCTS data entry operators, DPMs, DCMs and BPMs, HEOs and Computer/ARO) is not being monitored
- Information on the number of persons trained under various trainings was not readily available at district level and had to be computed on request. Moreover, no systems have been established either for any follow-up or monitoring performance of the trained personnel.

TOR 5

COMMUNITY PROCESSES AND CONVERGENCE:

Guiding Principles/Strategies of the NHM:

- i. *“Empower community to become active participants in the process of attainment of highest possible levels of health”*(Para 2.2)
- ii. *“Ensure coordinated inter-sectoral action to address issues of food security and nutrition, access to safe drinking water and sanitation, education particularly girls education, occupational and environmental health determinants, women’s rights and empowerment and different forms of marginalization and vulnerability”*(Para 2.3.2)
- iii. *“Encourage and enable the involvement of Panchayati Raj Institutions (PRIs) /Urban Local Bodies (ULBs) representatives in the governance and oversight of health services, and undertake proactive efforts for convergence and concerted action on social determinants of health such as food and nutrition, safe drinking water, sanitation and hygiene, housing, environment and waste management, education, child marriage, gender and social inequity”*(Para 2.3.14)
- iv. *“Establish an accountability and governance Framework that would include social audits through people’s bodies, community based monitoring and an effective mechanism of concurrent evaluation”*(Para 2.3.15)
- v. *“Empower the ASHAs to serve as a facilitator, mobiliser and provider of community level care”*(Para 2.4.2.14)
- vi. *“Strengthen people’s organizations such as the Village Health Sanitation and Nutrition Committees (VHSNC) and Mahila Arogya Samitis (MAS) for convergent inter-sectoral planning to address social determinants of health and increasing utilization of health and related public services at the community level”*(Para 2.4.2.15)

Key Findings:

1. Village Health, Sanitation and Nutrition Centre (VHSNC)

- a. The experience with VHSNC across states is mixed, with substantial variations in the levels at which the VHSNC were established (revenue village versus Gram Panchayat), composition of the committee (representation of the SC/ST, marginalized families, and women), involvement of the ASHA, leadership provided by representatives of the Panchayati Raj Institutions, activities undertaken and the extent of fund utilization.
- b. Most states are yet to put in place the new guidelines particularly as related to the composition and activities of VHSNC.
- c. All states have conducted some training of VHSNCs that ranges from a one-day orientation to two – three days training of VHSNC members. However, as the findings on functionality demonstrate, this is clearly insufficient.
- d. VHSNC have been formed at the Gram Panchayat level in Andhra Pradesh, Haryana, Bihar and Uttar Pradesh. In all other states VHSNC have been formed at the village level. In Bihar, while the committees have been formed at GP level, funds are sanctioned for every Nigrani Samiti formed at revenue village level under the VHSNC .

- e. Across the states visited there is a huge gamut of activities undertaken by VHSNC. These activities include environmental sanitation (cleaning and drainage of water tanks); vector control measures (spraying and fogging activities, chlorination, purchase of bleaching powder); health promotion events (hoardings, wall paintings, rallies, healthy baby shows etc. Some states also use the untied funds to purchase furniture and other equipment for the sub centres, to pay the ASHA a monthly sum of Rs.150, payment for the Ward member to attend the meeting, purchase sari for the ASHA etc. Some use it for helping transport a sick patient to the health institution. What does not clearly emerge from this pattern of expenditure, except in Odisha and Jharkhand, is whether the funds are being used in response to local gap analysis, or in an ad hoc manner. Until now VHSNCs have not undertaken any activities related to local level planning.
- f. As far as participation of PRI members is concerned, some form of engagement was reported from all states except in Bihar, Uttar Pradesh, Karnataka, Arunachal Pradesh and Meghalaya. In particular, active engagement was reported from the states of Jharkhand, Odisha, Nagaland and Kangra district of Himachal Pradesh. While low levels of PRI members engagement is evident from all states it is also important to note that efforts for orientation of PRI members were undertaken only in states of Odisha and Jharkhand.
- g. The pattern of VHSNC functionality that emerges in this review is that active engagement of PRI contributes to processes such as regular meetings, minute records, and to a certain extent fund utilization. However, VHSNC engagement in local planning, implementation and purposive action on environmental determinants, such as water, sanitation, vector control measures, rely on a strong community processes support structure and training of members of the VHSNC. This is clearly seen in states like Nagaland, Odisha and Jharkhand, where there are sufficient support structures at state, district and sub block levels. In the states of Andhra Pradesh, Karnataka, and Gujarat despite the lack of adequate support structures, a strong PRI system enables regular meetings but with little relationship to any health related outcomes.
- h. ASHA as a member secretary of VHSNC is seen only in states of Haryana, Arunachal Pradesh, Jharkhand, Maharashtra, and Nagaland (in some cases). The bank signatories to the VHSNC account also varies. In the states where she is member secretary she is likely to be one of the bank signatories. Where cooperation with the PRI exists, there is progress in productive use of funds. In the state of Odisha though ASHA is not a member secretary she is a facilitator and plays an active role in VHSNC.
- i. Poorly functional VHSNCs are seen in the states of Uttar Pradesh and Bihar. In Bihar, despite the existence of a strong support system for ASHA, the limited attention to VHSNCs could be partly because of a lack of commensurate management structure. In Uttar Pradesh, the support system is weak and fragmented, and this is reflected in the functionality of the community processes component, including ASHA training and support.
- j. VHSNC meetings are held regularly and minutes of proceedings are well maintained in the states of Andhra Pradesh, Karnataka, Jammu & Kashmir, Jharkhand, Odisha and Nagaland. However, even here there is inter-district variations. Thus, for instance in Andhra Pradesh,

we see that Mehboobnagar district has better meeting records than in Chittoor district, in Andhra Pradesh. In Bihar, need based meetings were reported while in the PHC areas of Vaishali district no meetings were held since last nine months because of non-fulfilment of quorum.

- k. The guidelines stipulate a release of Rs. 10,000 annually per VHSNC. States have interpreted this in various ways. Based on the status of fund utilization in previous year some states have released only part amount of the untied fund (Rs. 10,000). These include Bihar, Haryana, Arunachal Pradesh and Jammu and Kashmir; while in Jharkhand fund of Rs.10,000 was released to only those VHSNCs which reported over 70% utilization in the last fiscal year.

2. Community Monitoring:

- a. Community monitoring has been implemented in five out of 14 states - Jharkhand, Bihar, Maharashtra, Meghalaya and Nagaland. In Jharkhand, the process of CBM is led by the state CP team, with technical support from NGOs only for training while in other states the involvement of NGOs extends from state level to field level implementation of CBM. Positive outcomes in terms of greater community participation and improved health service delivery have been noted in the villages where the process of CBM has been rolled out. In the stated approach of CBM,VHSNC was to be facilitated to undertake CBM as a sustainable process. However, VHSNCs were involved in CBM only in the state of Jharkhand.

3. ASHA

- a. As with all CRMs the reports laud the ASHA as being 'vibrant', 'active', 'good interface between community and health system', 'motivators' and 'carriers of change'. The visibility of the ASHA is high with both community members and the officers in the public health system acknowledging her role in better service delivery outcomes.
- b. ASHA selection is near completion in all states except for the state of Himachal Pradesh where the ASHA programme was launched recently. The selection is complete in Odisha, Jharkhand, Andhra Pradesh, Maharashtra and Meghalaya. It is over 97% in Bihar, Arunachal Pradesh and Nagaland; and up to 90% in Gujarat, Haryana, Jammu and Kashmir and Uttar Pradesh. This gap, noticed in 7 states, is due to a revision in the target as per rural population of Census 2011 or attrition over last seven years. Thus a shortfall of 37,842 ASHAs was reported from Uttar Pradesh, 700 in Chittoor district of Andhra Pradesh, and 102 in Dang district of Gujarat. In Bokaro and Sahibganj in Jharkhand about 15% of villages and 286 villages in Ri Bhoi district of Meghalaya have no ASHAs. The gaps in ASHA selection in poor performing districts continue to exist and these are more likely to be areas with marginalized population or small habitations where mothers and children are more likely to require support.
- c. Thanks to a well maintained district database which is largely established across all districts it is now possible to track attrition which ranges from 3% -12% across all states. Odisha reported a very low attrition rate of only 0.67%. Attrition is mostly related to ASHAs getting selected in other programmes, voluntarily opting out or being dropped out

on account of non performance. Thus, for instance Haryana identified and replaced 3000 non performing ASHAs in last financial year. States are also showing progress on the speed with which ASHA selection is made to compensate for revised targets based on attrition.

- d. Another area of progress is the establishment of support structures for the ASHA programme. Support structures at all four levels i.e. state, district, block and sub block level are in place in Bihar, Odisha, and Jharkhand; at three levels in Haryana, Karnataka, Arunachal Pradesh, Meghalaya, Nagaland and Uttar Pradesh (selection of ASHA Facilitators is under way); at two levels in Andhra Pradesh, Maharashtra, and Gujarat. Only in Jammu and Kashmir the programme is managed by existing staff at all levels with one state nodal officer at the state level. The most critical link in the support structure i.e., ASHA facilitator has been put in place in ten states barring Andhra Pradesh, Karnataka, Jammu and Kashmir and Nagaland. However, poor functionality of ASHA facilitators was reported from Gujarat and Bihar. In Odisha, 1 ASHA facilitator is selected for every 25-35 ASHAs, at times increasing to 50 ASHAs, making consistent and high quality on-the-job field level support difficult. The existence of a support structure is not necessarily equivalent to effectiveness, as seen in states such as Bihar, Meghalaya and Uttar Pradesh. Poorly trained support staff are not able to provide adequate on the job mentoring and field based training of ASHAs.
- e. ASHA training in Module 6 &7 is underway in all the states and is at varying stages of completion. Training of Round 2 is near completion and Round 3 is underway in Jharkhand, Gujarat, Andhra Pradesh, Odisha and Meghalaya, while all three rounds have been completed in Arunachal Pradesh and Nagaland. Slow progress of training was reported from Uttar Pradesh, Bihar, Jammu and Kashmir and Haryana. Of these four states, the decision to roll out Module 6 &7 in Haryana and Uttar Pradesh was taken only in FY 2013-14. The state of Uttar Pradesh is hugely constrained by existing norms of procurement related to printing, recruitment of high quality trainers and the involvement of NGOs, making the pace of training extremely slow.
- f. Observations from the field however have highlighted skill gaps. Thus, ASHAs in Arunachal Pradesh, Nagaland and Bihar were not able to identify danger signs among sick newborns. Previous reports from these states have highlighted good quality training. Thus, it is clear that one time training is not sufficient. Constant reinforcement of training is necessary in order to improve retention of knowledge and skills. This can best be achieved through structured refresher training and on the job mentoring by ASHA facilitators.
- g. With the completion of Round 1 training of Module 6 & 7 in most states, Home based New Born care has emerged as a priority task for ASHAs. All states reported that ASHAs were making home visits to the newborns, but the quality of the visits are varied, and are linked to the level of support provided. Reports from Odisha show that 97,338 newborns, were visited by ASHAs, 3705 newborns and 1063 mothers were identified with danger signs and about 1963 newborns were referred. In the states of Bihar and Andhra Pradesh though visits are being undertaken, ASHAs have not been provided with HBNC equipment kit, which minimizes the effect of such visits.

- h. ASHA's effectiveness in the field is affected by frequent stock out of drugs and quality of the HBNC equipment provided to ASHAs. Delays in distribution of HBNC kit was reported from Jharkhand, Odisha and Arunachal Pradesh where the kit was distributed after a delay of 2-3 months post completion of training. The quality of the HBNC kit was found to be variable in Uttar Pradesh and Arunachal Pradesh. In both these states, district level procurement with no monitoring of technical specifications was undertaken. In Nagaland, the weighing scale did not conform to the specifications with a result that newborns are not being weighed by ASHAs. Unavailability of drugs with ASHAs emerges as a common finding and adhoc replenishment mechanism seems to be the norm in all states. During the visit adequate drugs in ASHA kit were found only in Jharkhand and Haryana. In Andhra Pradesh and Arunachal Pradesh, even a basic drug kit was not available with the ASHAs.
- i. Almost all states have taken cognizance of the delays in payments of ASHA incentives and have taken steps to streamline the payment process. Over 90% ASHAs have bank accounts across the states. Cash payments were reported from states of Arunachal Pradesh, Meghalaya and Nagaland because of difficult terrain and unavailability of accessible bank branches. Single window payment was observed in Odisha, Uttar Pradesh and Maharashtra. Odisha has been successful in reducing time delays through introduction of single window e- transfers on a fixed date of every month and has also launched CPSMS scheme in four districts. Delays of upto three months were observed in the state of Uttar Pradesh despite the payment being done through a single window mechanism. Huge delay of up to six months was observed in Jharkhand because of delay in release of funds at the block level.
- j. Average incentives earned by ASHAs ranged from Rs. 250-4000. The range is between Rs. 250-600 in the North Eastern states of Arunachal Pradesh and Nagaland with low CBR and sparse distribution of population. The highest incentives, within a range of Rs. 2500 to Rs. 4000 were reported from the states with large population and high fertility rates i.e, Bihar and Uttar Pradesh. In the states of Andhra Pradesh and Arunachal Pradesh, low awareness among ASHAs about their incentive entitlements was also observed. These findings emphasize the need for increasing ASHA's role in non RCH related activities specifically in areas with either low population density or with low fertility rates. The recent policy decision to provide all ASHA with incentives for a set of routine activities will also ensure a minimum amount that is not dependent on population coverage or fertility. Meghalaya has introduced an incentive scheme to give a matching amount of the incentives earned by the ASHAs on an annual basis.
- k. Considering the fact that ASHAs are not mandated to accompany pregnant women to institutions for delivery, in most states ASHAs are actually doing so, which is an expression of their agency and sense of responsibility in ensuring safe institutional delivery. Despite this, no provision of separate facilities like ASHA rest rooms / *Gruhas* were found at facilities except in Odisha and at some DHs and CHCs in Jammu and Kashmir.

- l. In terms of non-monetary incentives, Jharkhand has launched an Insurance scheme for ASHAs, Odisha has included ASHAs in Swalamban Yojana and Bihar supports ASHAs to pursue higher education - 472 ASHAs have enrolled in NIOS for 10th class in FY 2012-13.
- m. The performance monitoring of ASHAs based on ten indicators has been introduced in all states except Uttar Pradesh, Andhra Pradesh, Jammu and Kashmir and Arunachal Pradesh. Reports of performance monitoring for last quarter are available for all the other states. However, effective utilization of performance monitoring system with analysis of the ASHA functionality vis-a-vis health outcomes has been initiated only in the states of Odisha, Jharkhand and Meghalaya.
- n. Formal Grievance Redressal mechanisms as per the guidelines have been established only in two states i.e. Haryana and Bihar. Even in these states, these committees are yet to become fully functional. In Odisha, ASHAs have been provided with post cards for registering their complaints to CMO.
- o. Effective convergence with other departments beyond the scope of organizing VHNDs was not evident across any states. The onus of effective convergence between the ICDS and Health Department at field level seems to lie only with the field level functionaries like ASHAs, ANM and AWW with no inter departmental coordination at block level and above.

Recommendations

- States should consider making the VHSNC more inclusive to ensure representation of the PRI, Community members, particularly women and the marginalized, and enable a central role for the ASHA in the committee. States need to build mechanisms to support VHSNCs to undertake the five tasks of: a) monitoring and facilitation of access to all health and health related public services- especially of marginalised groups within, b) organizing local collective action for health promotion, e.g. vector control, solid waste disposal, health camps etc. c) facilitating service delivery at village levels by service providers or ASHAs visit d) village health planning, and e) community monitoring of health care facilities. All this will necessitate funds at village levels.
- In addition, states should institutionalise training at both state and district levels, expanding the training cadres at district level to include trainers with a background in social mobilization so that the large numbers of VHSNC members are trained in the set of five tasks.
- Enable a realization of community engagement and ensure that VSHNC serve as an effective forum for addressing environmental and social determinants.
- In order to keep pace with the enthusiasm and commitment of the ASHA, states must build and strengthen the support structures so that a viable structure is created not just to support the ASHA but also the VHSNC and the community base planning and monitoring. Training of such support systems and ensuring regular performance appraisals is just as important as training and demanding accountability for ASHA. For states such as UP this is of critical importance given the scale of the programme, the very slow pace of implementation, and the associated nature of poor governance.

- In addition, medical officers and programme managers need to be sensitized to the ASHA programme so that they can provide a programmatic perspective.
- Ongoing refresher training of ASHA is another important area to ensure that her skills are reinforced. Certification of ASHA is an important step in assisting this process, but this needs to be buttressed by on the job mentoring, and using opportunities such as monthly review meetings and cluster meetings to build capacity.
- Grievance Redressal and planning for career opportunities for ASHA are large unfinished agendas for states.

State Wise Findings

Andhra Pradesh

- ASHAs are a good interface between the community and the health centres. They are providing a wide range of services like Home visit; HBNC; Contraceptive distribution; VHSNC meeting; Support in VHNDs; due list preparation, promotion of institutional deliveries etc.
- MAARPU programme has been initiated in the State to improve convergence at the district level.
- Nutritional supplements like Milk, Rice, Pulses are being provided through “**Amrit Hastam**” programme to each pregnant and lactating women (up to 6 months post-delivery)
- ASHAs are getting incentives on a regular basis which is directly transferred to their respective bank accounts in Mahboobnagar. In Chittoor, the incentives are given through cheques currently and the process of online transfer will be operationalized soon.
- While there is a dedicated programme officer at State who holds the charge for ASHAs, there is no officer for overall management of community processes including untied grants, VHSNCs etc. Supportive structures for ASHAs namely ASHA Mentoring Group, ASHA Resource Centres etc are yet to be established.
- A shortfall of 700 ASHAs was reported from Chittoor district which needs to be filled immediately. ASHAs in Chittoor district have not been provided with ASHA drug kits although some medications are provided to them from the Sub centre level.
- Most of the ASHAs are unaware of the various schemes through which they can earn an income except for institutional deliveries and follow-up of pregnant and post natal women. On an average, ASHA earns around Rs. 800-1000 per month.
- VHSNCs have been formed at Gram Panchayat level with minimal engagement of the Panchayat members. ANMs and Village Revenue Officers are signatories of VHSNC bank accounts.

Arunachal Pradesh

- Despite the difficult geographic terrain, state has been able to maintain the pace of training. Thus out of 3862 selected ASHAs, 3643 ASHAs have been trained up to 5th Module and 3135 till round 2 of Module 6 and 7.
- However unavailability of residential training sites and a high dropout rate of trainers has affected the quality of training and there is an urgent need for refresher training in the state.

- State has also set up support structures for ASHAs at district level and sub block level for effective mentoring of the ASHAs.
- ASHAs were largely involved in RCH activities. However, due to a low density of population there were few ANCs to follow up and escort, leading to a meagre incentive generation i.e. average of Rs.600 to Rs.1200 per month. Some ASHAs, working for more than three years, are not aware about incentives and entitlements other than RCH activities.
- Though all the ASHAs had bank accounts they preferred receiving the incentives in cash. One reason for such preference is that most of the bank accounts are at district headquarters and travelling costs are usually higher than the incentives earned.
- ASHAs are unable to utilize the funds (due to non-cooperation of PRI members) leading to a consequent reduction in fund allocation for the subsequent year.
- There are frequent creation of 'segments' within existing villages and as a result a small population gets fragmented further leading to a situation where there are multiple ASHAs within one VHSNC. Such bifurcation in population and VHSNC fund has led to a difficult work environment for ASHAs.

Bihar

- Most of the ASHAs met, were enthusiastic about their work and spend about three to four hours daily visiting households. In both districts, most of the ASHAs are seen as a resource who has close links with the health system.
- ASHA Training of Module 5, 6 & 7 is fully residential, imparted with the support of state master trainers deputed by 4 State Training Agencies (STA) namely Janani, PHRN, PFI & Caritas India. So far 85 % ASHAs have been trained in Round 1, 62% in round 2 and 4% in round 3 while in 19 out of 38 districts, two rounds of Module 5, 6 & 7 have been completed.
- ASHAs who have cleared up to the 8th grade and wishing to pursue higher education are encouraged to get enrolled for 10th grade through national open schools. In FY 2012-13, 472 ASHAs were enrolled for 10th grade.
- ASHAs have been receiving HBNC incentive of Rs. 250/- but since they have not been provided HBNC kit, they are not able to perform many of the activities during home visits. Non-availability of printed HBNC format and delayed HBNC payments are also areas, which needs to be looked into.
- ASHA Facilitators are expected to extend handholding support to ASHAs. Since ASHA facilitators in the state are still working as ASHA, they find it difficult to manage the work load. Also, there are issues amongst ASHAs of accepting one ASHA as a Facilitator and earning much more than others.
- Discussions with VHSNC members revealed that they are not clear about their roles and responsibilities, amount of funds available and the purpose for which the funds are to be used.
- State has not been able to ensure effective convergence beyond conducting VHNDs, where occasionally members of PRI, Education, and ICDS, PHED are present. It is expected that the situation of convergence at state / district / block will improve once the VHSNC and RKS members are trained, ensuring quality program implementation.

Gujarat

- VHNSC meetings are held regularly once a month and awareness among people regarding such committees was good indicating credibility of the VHSNCs and their role in mobilising the community. Account books were updated and regular fund flow was reported.
- ASHA incentive is paid regularly once a month through E- bank transfers. Their income ranges from Rs.1800 to Rs.2500 per month.
- In Dang district, there is shortage of 102 ASHAs but in Valsad there were 1406 ASHA recruited against 1366 sanctioned owing to small hamlets scattered all over the block.
- Majority of the ASHAs have received module 6 & 7 training up to 2nd round in both the districts. But it was observed that ASHA do not have clear understanding of identifying high risk pregnancy for e.g. they were unable to identify pregnant women as anaemic even though she had an Hb of below 10 mg.
- ASHA support structure not present at district and block level. Though ASHA facilitators are in place, they are not aware of their roles partly due to adhoc selection process and partly due to lack of any capacity building.
- Convergence between ICDS and health department is visible in the community. However, convergence between education department, water and sanitation and rural development was not seen in the field.

Haryana

- Monthly Workshops for DAC/BACs are held for their Orientation and capacity building.
- Drug kits had been provided to all ASHAs with detailed guidelines for use of drug kits. HBNC Kits containing Watch, Thermometer, Weighing Scale, Baby Blanket and a kit bag along with required drugs (like Cotrimoxazole, Syrup Paracetamol, Gentian Violet etc.) are being supplied to ASHAs.
- System of electronic transfer of ASHA performance based incentive payment has been introduced since the last year. Average monthly take home for ASHAs ranges from Rs. 1500- Rs. 2000.
- The State has taken the decision to train all ASHAs in Module 6 and 7 only in the current FY 2013-14.
- ASHA Grievance Redressal Mechanism has been established at NRHM State HQ with a helpline no. while ASHA Grievances Redressal Committees have been constituted only in seven districts.
- Almost 3000 non-performing ASHAs were systematically identified and replaced without the field level implementation of performance indicators.
- During the year untied funds of Rs.3,000/- was released to the VHSNCs. ASHA is a member secretary of the VHSNC and the Sarpanch, ANM and AWW are joint signatories of the VHSNC account.

Himachal Pradesh

- The PRI is functional in Kangra district and there is good involvement of the representatives in the functioning of the VHSNC, RKS and District Health society.
- The VHSNC guidelines have been disseminated and were available at all the SCs visited in Kangra district. The *Up Pradhan* is the president of the VHSNC committee and the female health worker is the member secretary. The VHSNC committee is active in Kangra District. VHSNCs have been formed in all the 283 Panchayats in Chamba, however, the committees are not able to utilize the funds judiciously. The participation of Panchayats and other functionaries is minimal in Chamba.
- After years of legal discourse the state has recently decided to implement the ASHA programme and recruitments are planned from December 2013.
- Convergence amongst the health department, the ICDS and the education department was observed in Kangra district. VHNDs and immunization camps are held at the AWCs while WIFS is being implemented in coordination with the education department.

Jammu and Kashmir

- ASHAs were very active, motivated and knowledgeable and have become the “**Carriers of Change**” in the community.
 - Recognition of ASHAs at the block level through an award has been in place in the state for over 4 years. ASHA rest room i.e. ASHA Ghar was available at District hospital and at CHC Tangadar.
 - Trainings of ASHAs up to 6th module has been completed in Kathua and up to 7th module in Kupwara. ASHAs have started performing Post-natal visits too. The ASHA facilitator supports and monitors ASHA activity.
 - ASHA Drug kits have been provided but regular replenishment is an issue. Incentives are directly transferred to their bank accounts.
 - Though some ASHAs had good knowledge of the HBNC deliverables, the HBNC visits have not yet commenced and HBNC kits have not been provided.
 - The VHSNC funds are generally utilized for sanitation related work. Convergence with ICDS department at AWC is seen but at block level is an issue. Nodal persons for community process needs to be designated across all levels.

Jharkhand

- Involvement of PRIs is gradually increasing and state has conducted a two day orientation of 41032 PRI members in a separate module for PRIs. Quality of service provision for VHND is inadequate, convergence with ICDS is ineffective as “Take home rations” for mothers and children were unavailable and growth monitoring by AWW was not being done.
- State initiatives of capacity building of VHSNC members on roles and responsibilities and fund management is a promising step and has provided a good foundation to VHSNC members who are now prepared to absorb complex skills of village planning and monitoring of public services.
- State has selected 100% Sahiyas against the targeted 40,964. However, the current number is as per the 2001 census and needs to be reworked as per the 2011 Census. Districts are in the process of assessing the coverage gaps due to dropouts through a detailed database and cluster wise mapping and are planning to undertake reallocation of households or selection of new Sahiya as per the need.

- State shows reasonable progress in training of Module 6 and 7. 95% Sahiyas have been trained in Round 1, 85% in Round 2 and 25% in Round 3.
- Presence of a common support structure for Sahiyas and VHSNCs at all four levels is a positive aspect of the programme in Jharkhand. A systematic capacity building of these personnel in protocols of performance monitoring and supportive supervision indicates strong commitment of the state for ensuring their effective functioning and has contributed to good functionality of Sahiyas. Performance monitoring mechanism to assess Sahiya functionality has been initiated.
- Delays in Sahiya payment is a persistent problem for the state and all Sahiyas reported a delay of about six months. Though all Sahiyas confirmed presence of drugs like paracetamol, cotrimoxazole and ORS during the time of the visit, a lack of streamlined mechanisms of drug replenishment and adhoc district level procurement leads to frequent stock outs.
- In FY 2012-13 out of 96 blocks selected for CBM, training for 77 has been completed. Jan sunwais at block level has been completed in 42 blocks while district sunwais have been held only one district so far.
- Figures of consecutive census show a drop in child sex ratio by 23 points. The State is committed towards implementing PCPNDT across the districts and data from AHS also shows a marginal increase of one point for child sex ratio while a substantial improvement of five points is seen for sex ratio at birth in this period of one year.

Karnataka

- ASHAs were found to be vibrant and active and have completed training for Module 6 & 7
- Ten indicator-based performance monitoring system for ASHAs has been implemented in the state.
- Trainings of VHSNC members have been completed and VHSNCs are largely found to be active with regular monthly meetings
- Payments to ASHAs are based on budget line items. This makes it cumbersome since ASHAs occasionally receive payment in parts.
- Most ASHAs have not received ASHA kits. Drug kit replenishment was also found to be poor as many of the ASHAs did not have medicines
- At places untied fund seemed insufficient taking into account that a large part of it was being utilized in buying ASHA sarees (e.g. Buying 18 ASHA sarees from the untied fund of just one VHSNC in Tadas)

Maharashtra

- Round 1 of Module 6 & 7 has been completed and skills of ASHAs were found to be adequate.
- VHSNC, RKS and DHS are registered with optimal fund utilization as per norms. Registers for VHSNCs are maintained, however meetings are reported to be irregular
- Drug kits are regularly replenished.
- Community monitoring is very vibrant in Nandurbar while it is yet to be implemented in Ratnagiri.
- Availability of ASHA ghar/homes was not found in the facilities visited

- Roles of support structures need to be strengthened with better orientation and capacity building.

Meghalaya

- Despite many challenges faced by the states in rolling out training for ASHAs such as lack of fully equipped residential training sites at district and block level and difficult terrains, state has been able to complete training ASHAs in the first three rounds of module 6 and 7. However non residential training has affected the quality of training.
- Ten indicator based performance monitoring has been implemented across the state with regular analysis of ASHA functionality being done against the health outcomes.
- State has introduced additional incentives for ASHAs through 100% matching grants for incentive earned in a year from the state funds.
- State has initiated piloting community based monitoring in 3 blocks each in three districts - East Khasi Hills, Jaintia Hills and West Garo hills covering 9 blocks.
- ASHAs grievances are generally related to irregular payment of disease control programme incentives like NLEP, NVBDCP.
- Poor engagement of VHSNC and PRI members in NRHM activities for addressing low institutional deliveries and high prevalence of communicable diseases observed in both the districts.
- Though the utilization of VHSNC funds is satisfactory, diversification of the activities for which the funds are being utilized is required. Poor involvement of PRIs members in activities of VHSNC and RKS was observed in Ri Bhoi and West Garo Hills.
- Components such as Hb%, urine examination, and physical examination are not being done at VHND sites. There is no line listing of High risk pregnancies and VHND monitoring mechanisms are rudimentary in the state.
- Around 69 ASHA dropped out during 2012-13 and 286 villages, including 88 new villages, are yet to have ASHAs. There are around 198 villages where each ASHA covers more than 1500 population.
- ASHAs have to fill about five formats to claim HBNC incentives which are time consuming and are also not analyzed at any level.

Nagaland

- ASHAs are active in caring of marginalized population as they were aware of migratory population and unreached population in their villages, even though their orientation in “reaching the unreached” is yet to be conducted.
- The process of communitisation of health services is very strong and started much before the inception of NRHM. Thus, committees were formed at various levels, from sub-centre to CHC. These committees play an important role in management of health centres, promoting preventive health, encouraging traditional medicine, checking attendance of staff, disbursing their salaries, granting them casual leave, maintaining the buildings, and monitoring the availability of services.
- Village Health Committees (VHCs) were also formed at village level, which have later been co-opted as the VHSNC under NRHM. However VHC members are yet to be

trained for utilizing funds on the village level activities as majority of the untied funds are utilised for paying the incentives to ASHA and refreshment for VHNDs.

- High dropout rate of 8 to 12% and training gaps were reported. The newly selected ASHAs are not provided training of 1 to 5 modules or induction training of 5 modules and are straightway trained in any ongoing round of Module 6 and 7.
- Training quality was reported to be varied on account of use of English versions of ASHA training module (most of the ASHAs interacted with during the visits were not very comfortable with the language), lack of post training evaluations and faulty equipment kit especially the weighing scale and thermometer.
- ASHA facilitators are placed at block level i.e. one ASHA facilitator provides support and hand holding to 35 to 49 ASHAs of her area. Direct interactions with ASHAs are limited to the monthly meetings and to the ASHAs visit because of difficult terrain.
- Incentives are being paid in cash as well as cheque. It was also reported that ASHAs residing in difficult terrain and hard to reach area face problems in encashment of cheques as they have to travel to nearby town or market to deposit cheque which involves a high travel cost.

Odisha

- Community processes are working very well in the state and many of them serve as promising practices for other states. ASHAs have started undertaking the HBNC visits - 97,338 babies were provided with six home based care visits, 3705 babies and 1063 mothers were identified with danger signs and 1963 babies were referred to the hospital.
- Performance monitoring of ASHA has been implemented and blocks have been graded as 101 Type A Block, 108 Type B Blocks, 64 Type C block and 41 Type D Blocks
- ASHAs receive payment on the 10th of every month through e-transfer to their bank accounts. Online payment through CPSMS has been completed in 4 districts including Jajpur and Koraput.
- State has introduced various non monetary incentives –Swalamban pension scheme, Rs.1 lakh compensation is provided to ASHA's family in case of death while at work from Chief Minister Relief Fund (CMRF); ASHA Gruhas at 143 Delivery points with attached bathroom and toilet facility.
- Remarkably good and efficient coordination between ASHA, AWW and ANMs demonstrated at the GKS meetings. Training of GKS, CDPOs (2-days), Mukhya Sevikas (1-day) and AWWs (as part of sector meetings) on their roles and record keeping. Following the training, the GKS meetings are conducted regularly, on the last Thursday of every month.
- Module 6 and 7 training is almost complete for ASHA in High Focus districts (18) and is under way in non-high focus districts (12), but no proper mechanism to evaluate the quality of trainings has been established.

- ASHA facilitators, SATHIs are selected per sector (for about 25-35 ASHAs, and sometimes even for 50 ASHAs) which affects the quality of mentoring support provided to the ASHAs.

Uttar Pradesh

- In both the districts, ASHA's played a prominent role in motivating pregnant women for utilization of ANC services from government health facilities. Most of the ASHAs were found to be vibrant and active, for promotion of institutional deliveries and immunization, making regular visits to mothers/pregnant women in their villages and counselling them.
- Selection of ASHA Sanganis has been completed in 17 districts while it is underway in remaining districts.
- State has established a system for recognition and cash reward for best performing ASHAs through annual ASHA Sammelans
- State has shown progress in rolling out of training of skills that save lives in 17 CCSP districts while Module 6 & 7 training could not be started in remaining 58 districts on account of delays in procurement of kits and printing of modules.
- Timeliness and structured mechanism for drug replenishment was lacking. Nischay Kits were being purchased by ASHAs themselves to ensure that pregnant women accompany them for delivery.
- Payments of ASHA incentives were reported to be delayed by 2 to 3 months on an average.
- Out of 1,06,704 revenue villages, 51914 VHNSCs have been constituted at GP level. VHSNC meetings are not being conducted regularly and inadequate utilization of funds was observed in most of the places visited.

TOR 6

Information and Knowledge:

Guiding Principles/Strategies of the NHM:

- a. *“Facilitate Knowledge networks and create effective public health institutions”*(Para 2.3.13)
- b. *“Enhance use of information and communication technology to improve health care and health systems performance”*(Para 2.4.2.20)
- c. *“Effective implementation of the complex interventions under NHM necessitates technical support and handholding which requires a multiplicity of skills and competencies. Such resource support needs to be organized through distinct entities/agencies with the ability to convert knowledge gained from the field through practice, research, and training into implementation processes, constant internal learning and renewal, ability to draw on skilled human resources and build institutional memory”*(Para 5.9.3)
- d. *“Given the huge requirement for technical support, other national institutions to meet the technical needs of states and districts in programme planning and implementation need to be involved. This would also strengthen the quality and relevance of work done in these institutions”*(Para 5.9.4)
- e. *“NHM envisages a fully functional health information system facilitating smooth flow of information for effective decision-making. A robust health management information system is essential for decentralized health planning. Lack of indicators and local health needs assessment have been identified as constraints to effective decentralization”*(Para 5.13.1)
- f. *“The health management information systems would be designed to support regular decentralized analysis of data and for decision making at state, district, city and sub-district levels. The information systems will enable local users in management of health service delivery as well as help them in their routine activities”*(Para 5.13.2)
- g. *“Improve Public Health Management by encouraging states to create public health cadre, and strengthening/ creating effective institutions for programme management, providing incentives for improved performance and building high quality research and knowledge management structures”*(Para 2.4.2.19)

Key Findings:

Health Information Systems:

- a. All the states are regularly feeding facility wise data in national HMIS web-portal. But as reported in earlier CRMs, the data from private institutions and medical colleges are minimally uploaded in HMIS by all the states. However in comparison to previous years, the quality and use of information has improved, especially in those states which has local IT systems that enable local analysis and use of information or have focussed on establishing feedback systems.
- b. There are two major issues concerning the improvement of the existing healthcare database. Firstly, designs of primary registers tend to be weak and overly cumbersome.

Data therefore gets lost or its quality compromised in its flow from registers to reports, especially in secondary and tertiary care hospitals where large volumes of cases are being managed. Other parameters of data quality also play a key role in streamlining the process of data accuracy. The issue of data quality also applies to the MCTS, IDSP and malaria reporting.

- c. The second concern is related to the integration of data from multiple sources and adequate utilization of comprehensive health information for programme planning and management. Programme specific data utilization is limited to monitoring the progress against expected level of achievement but evidence-based decision making for taking remedial actions is lacking. Many states (Odisha, Maharashtra, Himachal Pradesh, Haryana, Bihar, and Gujarat) have adopted multiple IT systems for data management and analysis. However, the challenge is to make all the IT applications interoperable to achieve single source data entry and improved analytic capability.

1. Mother and Child Tracking Systems:

States continue to put major efforts into making their MCTS functional and useful. Progress on registration is fair – with some states reporting near 80% registration and others at about 30%. Generation of work plans or due lists is very weak in most states. Delays in generating work-plans from MCTS tend to defeat the purpose of mother and child tracking in most of the states. Some states like Odisha have successfully even achieved this. However, when it comes to its use for closing gaps in service delivery, no state has reached that level of use and this is a matter of concern, for MCTS will have impact on maternal health only if service delivery improves as a consequence. Line listing of severely anaemic women is not stabilised substantially in any state. Proper monitoring and supportive supervision to improve appropriate tracking of identified women is required.

2. External Surveys:

The Annual Health Surveys for the previous year are available for a number of the states under review but the extent of their use is uncertain.

3. SHSRCs and SIHFWs

- a. SHSRCs were functional only in Haryana, Karnataka, Odisha and Maharashtra amongst the states visited. However, where they are established they are contributing significantly- the most positive report being from Odisha.
- b. SIHFWs where established are playing their role in in-service training with varied levels of capacity. The Himachal Pradesh and Odisha reports are the most positive amongst the states visited.
- c. RHFWTs and ANMTCs were not uniformly assessed across states, but where they were seen, there are considerable gaps and constraints.

4. Studies, Evaluations & Knowledge Partnerships:

- a. States have made budgetary provisions for studies and evaluations, but almost no state reports utilization of this, and no major state led studies were reported.

- b. There are no reports of major research work or studies undertaken by the states or of knowledge partnerships. This is despite a number of states having been sanctioned funds for research inputs in their PIPs.

Recommendations:

- A huge effort is going into “facility based reporting on HMIS” and “MCTS reporting”. Both largely pertain to same data elements- but the consolidated figures vary widely. There are problems of data collection, flow and aggregation of information, which underlie this. A serious effort at integrating these systems is essential. It would also help remove the underlying problems that both systems face.
- States need to develop a culture of use of information for short and mid-term planning. This can be achieved by understanding the critical aspect of synthesizing data from multiple sources, and summarizing in view/context of the health situation and trends at local level.
- Most common data quality issues relate to poor primary records, data duplication and other process errors, which are easily identifiable and correctable. States need to systematically solve data quality issues to identify and remove sources of error.
- Health information systems are multiplying rapidly within each state- but they should be able to share data electronically with other databases for example, disease control programmes, MCTS, ICDS programme, civil registration systems etc. The Meta-Data and Data Standards fill an unmet need to provide semantic standardisation across the Health Domain and also provides solution needed for interoperability.
- There must be a clear set of guidelines for SHSRCs, which provides the institutional framework – in terms of governance, mandate, HR policy and financing. A similar framework is also required to make SIHFWs more functional.
- States also need institutional frameworks and capacity building to understand the importance of building knowledge partnerships and reduce dependence on externally funded technical assistance.

State level Findings:

Andhra Pradesh:

- Seventeen out of 23 districts have begun facility level reporting, however, 6 districts are reporting consolidated data only. Most data is entered at the block level.
- Very limited capture of private sector data and incomplete data from district hospitals as well.
- Data from both facility based HMIS and MCTS vary widely and neither are reliable because of the way data collection, reporting and flow is organised.
- Work plan for due services is well generated but use in population based planning is limited.

Bihar:

- The staffing situation for Monitoring and Evaluation staff is fairly good at the state, district, and facility level although some vacancies exist. HMIS supervisors and 33 of the 38 District M&E Officers are in place.
- All facilities have a well-equipped data centre with computer, printer, scanner, camera, telephone and a functional internet facility.
- Bihar has made progressive gains in rolling out the data collection, reporting, entry, analysis and feedback through the District Health Information System (DHIS) Web Portal. Since October 2013, all 38 districts are also reporting facility based data.
- Even though there has been progress, the completeness of data is an issue with only 68 percent of the data being complete.
- Few monitoring visits were undertaken by the DPMU staff to review the accurateness of the HMIS data.
- MCTS has been operationalized across the state, but is able to register only about 59.4 percent of pregnant mothers and 46.3 percent of children. Pregnant women and children accessing either no services or private sector services are missed out.
- There is no SHSRC at the State level. The State Health Society is providing technical support along with several development partners especially supporting the RMNCH+A implementation in high focus districts in Bihar.

Arunachal Pradesh:

- 16 of 17 districts have facility based reporting and 87% of facility reports are captured.
- Use of data is weak and data collection registers are poorly designed.
- MCTS captures only about 36% of pregnant women and 30% of children – and that too limited only to registration with little or no mechanisms or impact for improved service delivery.

Gujarat:

- State has multiple IT based information systems in place with good infrastructure, power supply, equipment and most importantly adequate human resources.
- Regular reporting is established and inventory management has improved, and even generation of work plans for the provider is in place but overall impact on use of information and service delivery still remains uncertain.
- State is cognizant of the necessity of inter-operability and is working on solving it but at present, the systems are not integrated.

Haryana:

- State has multiple IT based information systems in place- the district health information system (DHIS), as well as systems dedicated to maternal and infant death reporting, SNCUs, procurement, referral transport, anaemia tracking, MCTS, human resource, supportive supervision and Nikshay. Has put in place adequate human resources and infrastructure for the same.
- Peripheral workers linked by CUG on mobile.
- MCTS functional with over 90% registered in one district but its value addition to service delivery not certain. In the second district, even registration and updating of records is very poor. MCTS had limited contribution or impact on improved service delivery for mothers as well as for children.
- Gaps identified between manual records and online data, with serious underreporting on to the IT based information system- on both services delivered and outcomes.

Himachal Pradesh:

- Both Facility based direct Web-Portal entry and DHIS are functional and information from latter is used for decision making at local levels.
- Block MIS operators are recruited through outsourcing and placed in every block.
- Mobile SMS is used by ANMs for reporting their monthly data on HMIS.
- Hospital Management Information Systems introduced in district hospitals.
- Reporting on MCTS is one of highest recorded across the state(77% of pregnant women at sub-centre level), but its use for improving quality of care is constrained.
- No SHSRC, SIHFW is functional. RHFWTCS understaffed and poorly functional.

Jammu & Kashmir

- Health information systems is working well and data is used for regular monthly review meetings.
- MCTS data uploading is good, but its use is uncertain.
- No SHSRC in place. No regular faculty in RHFWTC and ANMTCs which face numerous constraints undermining their functionality.

Jharkhand

- Facility based reporting and feedback established but use of information is limited.
- Power cuts and other infrastructural challenges constrain HMIS. Poor reporting of deaths.
- Current level of registration under MCTS is 42 % for pregnant women and 38% for children. Next steps of generation of due lists and use of information for closing service gaps will need to begin.
- State has a SHSRC and an Institute of Public Health in place but in both most staff positions are vacant. The SHSRC has a deputy director holding additional charge.

Karnataka:

- MCTS in place and has received award for mobile SMS reporting by ANMs. However even completion and timeliness of registration and use of information is weak.
- Health information systems are in place and its use in district reviews is much better.
- Functional SHSRC is in place which supports the state in making district action plans and in analysing HMIS data and also providing research inputs.
- SIHFW too has adequate capacity, staff, equipment's, infrastructure and a regular training programme.

Maharashtra:

- Health information systems are up and functional but with limited use of data. Lack of Inter-operability between systems is a problem.
- Progress on MCTS is not documented.
- SHSRC is present and functional, providing research and planning inputs.
- SIHFW also present with adequate capacity and plays its role in the training programmes.

Meghalaya:

- Health information systems well established and CRM team observed good use of data. However, the State faces major problems in terms of internet connectivity and lack of facility level data entry staff and skills.
- MCTS data incomplete and delayed. Due lists are late and their use is limited.

Nagaland

- All facilities reporting on HMIS despite problems of connectivity. However, overall only about 40% deliveries are being captured in HMIS.

Seventh CRM Report

- Registration in MCTS is very low. Service delivery gaps in terms of completing immunization or antenatal care shows very low levels of achievement- and tracking does not seem to help in improving this.
- Work plans for ANMs are not being generated from MCTS.
- Poor utilisation of data for taking any corrective action, e.g. high IUD removal rate seen in one district visited – no effort made to identify the facility / provider or take any corrective action.
- Multiple registers are being maintained, resulting in data loss during transfer between registers.

Odisha

- HMIS data is being used in reviews at all levels with adequate local analysis and display of information. Data validation is good.
- MCTS too has good level of registration and generation of work plans for peripheral providers. However in terms of closing service delivery gaps its contributions are limited.
- The SHSRC has been established and functioning with adequate partnerships and a good understanding of the knowledge management role which it is fulfilling in all respects- as policy support, in planning and in technical support to implementation.
- The SIHFW also serves as an apex in-service training institution with adequate capacity.
- State also has separate resource centres for child health and ASHA.

Uttar Pradesh:

- Making very slow progress on HMIS. Facility based reporting has started up but with poor quality.
- MCTS is at an even more rudimentary stage.
- SHSRC not constituted and SIHFWs have limited capacity.

TOR 7

FINANCIAL MANAGEMENT:

Guiding Principles/Strategies of the NHM:

- i. *“One of the major areas of emphasis in the 12th Plan and in this Framework for implementation is the provision of greater flexibility to the States in planning and the use of resources to finance state plans. Hence instead of fixing all norms centrally, broad principles and illustrative norms will guide planning and implementation”*(Para 8.8)
- ii. *“The NRHM RCH Flexipool would be utilised for Health systems strengthening including Infrastructure, Mobile Medical Units, Patient Transport Systems (for referral and emergency), procurement of equipment and drugs, AYUSH mainstreaming and drugs, support to ASHAs and VHSNC, Maternal and Child Health interventions, Adolescent health interventions, Immunization etc.”*(Para 8.9)
- iii. *“NUHM Flexipool would be utilised to meet the health needs of urban population particularly the poor and vulnerable sections”*(Para 8.10)

Key Findings:

1. HR for Financial Management:

Almost all the states have accounts staff according to their requirements; however, unavailability of accounts officers at the PHC level is a problem in many states. Lack of training amongst the accounts staff on use of Tally software (customized) was reported.

2. Accounting & Audit practices:

At district and block level, manual book keeping is practiced, but there are delays in updating the books. Closing of Cash books is not happening on a daily basis. Delayed submission of concurrent audit reports is an issue in almost all the states. Noncompliance to income tax issues was observed in states like Odisha and Arunachal Pradesh. Electronic transfer of funds is happening only up to block level, and cheques are used for transferring funds, below the blocks bank reconciliation is another common issue reported across all the states.

3. Utilization and Expenditure rates:

Overall, utilization is at the same level as in previous years. But some of the earlier cited reasons – lack of staff, lack of e-transfers of funds, knowledge of accounting processes etc. are much less. The delays and constraints are attributed to additional approvals coming piecemeal and not communicated in time, delays in reporting where financial staff is

inadequate, delays from outside agencies notably PWD, and disbursement of funds to facilities having high unspent balance. However, much more careful study and understanding of this is required. The process of sanction of funds to states and districts is no longer an annual event but extends throughout the year. The flexibility to spend and move across budget line items is much less- and the rates of spend on each line could vary due to a diverse and often unpredictable set of reasons. All of these would also limit the ability to spend.

4. Fund Management:

AMG and untied funds have not been released to blocks though the districts have received funds on time. Since reporting of expenditure is reported to be poor below the block level, this could be one of the main reasons for delay in funds transfer in Meghalaya. The other states have not reported this problem. Diversion of funds from one program to another without approval was observed in all states and should be discouraged. Fund utilization under JSY, untied fund, AMG and RKS is very low across all states while zero utilization under immunization was reported in Odisha.

Recommendations:

- There is a need to further strengthen and create more regular posts in the area of financial management, as consistent with a long term strategy.
- The good progress made in shifting to electronic accounting and electronic transfer of funds should be continued, strengthened and expanded with special support to those states who are unable to achieve this on their own.
- There is a need to ensure regular annual training of about one week to all those at state, district and block level in charge of accounting and financial management functions. This is all the more essential since there is a high turnover in contractual staff. This requires a clear set of training sites and trainers and a training plan.
- There is a need to better understand the causes of delay in expenditure, even in those states where the first order of problems- related to accounting capacity has been clearly overcome.
- There is a need to simplify the process of resource allocation and accounting for resources such that it supports decentralised planning and management without reducing accountability and outcomes- if the efficiency of fund absorption has to increase.

State Findings

Andhra Pradesh:

- NRHM funds are divided at state level, with one pool going to the AP SMIDC for all infrastructure and procurement, another to APVVP for the JSSK and the HDS and the rest to the district health societies. The integrated approach by the district health society is thus lost.
- State and district health societies have irregular or no meetings. They are not registered under Section 12 A, do not file annual reports and are not deducting TDS.

- Group Bank accounts have not been initiated. Gaps in accounting process observed at the periphery indicating poor financial governance at many levels.

Arunachal Pradesh:

- State and district level officers are in place and delegation of powers is adequate. Accounting and auditing processes also appear adequate, though there is scope for improvement on many specific aspects. Utilization of funds is poor- even on major, easy to spend item.
- Group Bank Accounts are not implemented.

Bihar:

- District Accounts Managers are in place in all the districts. At Block level about 8 % positions are vacant, but the post of Director Finance is vacant for over six months.
- Effective implementation of customized version tally ERP 9.0 up to the PHC level was observed.
- Concurrent audit is being implemented and audit is conducted on time. Internal audit wing is well established.
- Bank Reconciliation statement is not being prepared at State level and at PHC level although it is prepared on a monthly basis at the District level.
- State Health Society maintains 18 Bank Accounts for RCH, Mission, RI, IPPI and all NDCP's was conducting separate financial transactions for each programme. This multiplicity of bank accounts renders the financial management of the Mission susceptible to weak internal controls and needs urgent rationalization. The state is maintaining 3 bank accounts for state share which is against the guidelines.
- It is observed that there is frequent of diversion of funds from one pool to other pool which is evident from Audit report of the state.
- Utilization of funds is low in case of both RCH (9.55%) and Mission Flexible Pool (9.18%) against approved PIP up to first quarter of the year 2013-14.

Gujarat:

- Most key positions for finance and accounting are in place.
- Fund utilization has not only been good, it has been consistently higher than the fund received perhaps due to state share and other contributions being also included.
- Accounting and auditing processes seem adequate at most levels, though there are gaps in some facilities.

Haryana:

- Staff is in place. Shortages are seen only at PHC level. All accounting systems are in place and functioning well.
- Low expenditure on RCH components but good utilization in NRHM components of ASHA programme, infrastructure, HR and transport.
- Good analysis provided for factors constraining expenditure.

Himachal Pradesh:

- Slow pace of financial progress around JSY, but on the whole utilization good.
- All RKS seems to be gathering considerable funds, which are lying unutilized.
- Funds transferred electronically upto block level.

Jammu & Kashmir:

- Human resources in place and e-transfer of funds to blocks and facilities is established. Accounting and audit processes in place.
- However, quality of accounting needs improvement. Delays in payment of JSY to beneficiaries noted.

Jharkhand

- State level officers are in place. Concurrent auditors awaited. Audit statement for 2012-13 also not completed.
- Accounting processes weak and need much improvement and hand-holding at all levels.
- E-transfer of funds established but customized version of Tally not in use.

Karnataka

- Staff in position, funds transfer up to block level happening electronically and accounting satisfactory.
- Expenditure and utilization is in line with expectations. Audit processes could be strengthened and made more timely.

Maharashtra:

- Staff in position, e-transfer of funds upto block level happening and accounting satisfactory.
- Problems of utilization of funds especially for JSSK and on some other RCH areas. Causes could not be determined.

Meghalaya:

- All staff in position and funds transfer upto block is done electronically.
- There are many gaps in accounting and flow of funds, which contributes in part to the poor utilization of funds.

Nagaland:

- Adequate financial staff in place, however capacity for finance and accounting is weak at sub-district levels, as seen in inadequate accounting practices and internal controls (e.g. Bank reconciliation statements, aging of advances).
- The district plans do not have budgets and therefore fund allocation does not relate to plans.
- E-transfers to block level implemented. CPSMS being rolled out at a slow pace.. Concurrent audit in place but quality needs to improve.
- Poor monitoring and supervision of sub-district units.

Odisha:

- Human resources, maintenance of account books, shifting to digital systems and implementation of concurrent audit are all well in place.
- Utilization still low and quality of some of the processes like concurrent audit are poor. There are also issues of poor correlation between financial achievement and physical achievement. The ability to match fund-flows to needs and patterns of use needs to be further examined.

Uttar Pradesh:

- There is improvement in staffing for financing functions. But making accounts officers accountable for data entry has undermined their utilization. Training for them is also weak.
- E-transfers up to block level established.
- MCTS operators and block programme managers are outsourced but the agencies are paying the staff much less than agreed upon and even what is agreed upon is much less than approved by GOI
- Poor utilization of funds, especially of the Mission Pool was seen. There are delays in transfer of funds to facilities and fund releases do not match rates of utilization. Large unspent balances with public sector civil construction agencies also contribute to poor utilization of funds.
- Management of user fees very poor and indeed even such high collections are a matter of concern.
- Many problems of accounting were noticed. State may find it useful to train its concurrent auditors and use them to address some of these problems in the district- other than much better training and support to the accounting process.

TOR 8

Health Care Technologies:

Guiding Principles/Strategies of the NHM:

- i. *"In order to achieve the NHM objectives, it is essential that good quality and safe medicines, diagnostics and therapeutic procedures should be accessible, available and affordable to the beneficiaries"*(Para 5.6.1)
- ii. *"The most cost-effective way of providing social protection against the rising costs of health care is by making the major part of health services available through public health facilities on cashless basis. In effect, it means the reduction of not only user fees but all out of pocket expenditures related to health care. Studies show that the major part of expenditure is on drugs and diagnostics. This would be the focus of NHM efforts to reduce OOP expenditures"*(Para 5.6.2)
- iii. *"Access to free drugs is an important initiative under NHM in the 12th Plan. The route to ensuring free drug supply is to strengthen the capacity of the states in procurement, supply chain management and quality assurance, preferably through the establishment of a state level autonomous corporation/body which is in charge not only of transparent and efficient procurement of drugs, but also of quality assurance and logistics, including efficient distribution systems down to the facility level"*(Para 5.6.4)
- iv. *"Making diagnostics free in the hospital is also essential for eliminating OOP expenditure since it is another major cost centre and therefore an NHM priority. Minor equipment, diagnostic reagents and consumables, would have to be made available through funding on caseload and utilization basis. The district untied fund pool can also be used to cover the cost of most diagnostics"*(Para 5.6.5)

Key Findings

1. Free Drug Policy and Drug Availability:

For the first year since NHM began, most states are now articulating a policy of free drugs in public health facilities. This was particularly evident in Bihar, Himachal Pradesh, Maharashtra, Haryana and Gujarat. Himachal Pradesh has rolled out a free drugs scheme for BPL patients, which provides 38 medicines free of cost to all eligible patients across public facilities. In Maharashtra, medicines were available upto the sub centre. Districts with high incidence of snakebites and scorpion bites had sufficient supply of ASV and ASS. On the other

hand, the CRM to Meghalaya observes substantial out of pocket expenditure even on basic drugs. There was shortage of essential drugs in public facilities across the state of Meghalaya, including drugs under the RMNCH+A commodities list viz. IFA, Vitamin A, paediatric co-trimoxazole, zinc, misoprostol etc. In some states, stock-outs of some essential drugs, including ringer lactate, DNS, Dexamethasone shortage was being covered through a system of local purchase to address the patient's needs in many cases from untied fund in Haryana and a similar condition is observed in Himachal Pradesh.

2. Procurement:

Improvement in procurement and logistics systems is slow. The states that have established a medical corporation for procurement of medical equipment and drugs now include Karnataka, Haryana, Bihar and Gujarat. Jammu & Kashmir has begun the process. Maharashtra, Odisha and Himachal Pradesh are committed to establishing such a system but even as of now, there are substantial improvements in procurement and logistics. In Jharkhand and Uttar Pradesh, the state level rate contract with district level order placement system is introduced but its implementation is flawed. CRM teams to Meghalaya, Nagaland and Arunachal Pradesh characterise the state level procurement systems as inadequate and not coordinated with the demands and needs of the districts. Quality assurance should be an integral part of procurement and some states have established their own approaches to this but few are able to meet the TNMSC benchmark in terms of process standards. Karnataka is one state that has put an adequate quality system in place.

3. Inventory Management:

Some form of computerized drug inventory management system is in place for more states than in earlier CRMs. Odisha has developed a web based software application called Odisha Drug Inventory Management System (DIMS), which is doing well. It is also in parallel introducing a Reproductive Health Commodities Logistics Management Information System (RHCLMIS). Maharashtra too has a good system in place. Gujarat has developed Drug Logistic Information Management System and Haryana is developing asset management software. However, more states report improved and new warehouses. Drug inventory management at facilities was unsatisfactory in the states of Himachal Pradesh, Bihar, Jammu and Kashmir, Jharkhand and Nagaland.

4. Human Resources and Infrastructure:

Overall shortage of staff for drugs management was observed but there was effective deployment of the staff. Lack of cold-chain mechanics was noted in a few states. In Bihar, pharmacists were posted in all drug stores. However, the employees need to be trained in computer-based procurement and distribution system and using its analysis as observed in Gujarat.

5. AYUSH Drugs:

The availability, record-keeping and supply of drugs was found satisfactory in case of AYUSH drugs across all the states. However, in many states AYUSH drugs are not included in the Drug inventory management system. In Haryana and Nagaland, the drugs/solutions for

preparing homeopathic drugs were available, but adequate dispensers such as plastic bottle and globules was lacking.

6. Essential Drug List and practice of Standard Treatment Guidelines (STGs):

More states have put in place EDLs and many now display them in facilities. Standard Treatment Guidelines are less in evidence, but even where it is in place, their use appears low.

7. Diagnostic Services:

Diagnostics were found to be available for all patients visiting facilities. However, in most states, patients are found to be paying for diagnostics except beneficiaries covered under JSSK. One exception is Haryana where diagnostics are available free to all RCH patients in most facilities visited. However, other patients were found to be paying for diagnostics, including for ultrasound. Outsourcing diagnostics is another developing trend, but there is insufficient information and mixed perceptions of whether it is working. This has been reported from Bihar and Himachal Pradesh. In Arunachal Pradesh, at the sub-district level none of the facilities provided blood or sputum investigations and interaction with patients revealed that as high as Rs.1000/- was being spent on travelling to District headquarters for basic lab investigations. Jharkhand too has not been able to establish diagnostic services.

8. Equipment:

Availability and maintenance of equipment is a mixed picture across states and is currently an even greater challenge than with drugs. Guideline for better management and maintenance of equipment is a much-required need.

Recommendations:

- States may be encouraged to make a clear articulation of a policy for free drugs and diagnostics, wherein at least the conditions listed in the assured primary health care services are provided free of cost with access through primary care facilities, and most public hospitals up to and including the district hospital provide most drugs and diagnostics free for inpatients and outpatients.
- There is a need to ensure diagnostic services, which often constitutes the major part of the costs at the same time as planning for free drugs.
- The formation of an autonomous corporation for drug logistics is a necessary but not sufficient condition for solving the problems of responsive drug supplies and quality assurance and cost savings. There is a need to disseminate the process standards for procurement, storage and distribution of drugs and their rational use. These could also help evaluate state logistics.
- The procurement and logistics systems should integrate the needs of AYUSH.
- There is a need to examine and prepare guidelines and build capacity for states with regard to procuring, installing and maintaining bio-medical equipment.
- There is also a need to facilitate procurement of equipment (and if possible even for drugs) through central rate contracts- without diminishing the autonomy of states to follow their own tendering process.

State Wise Findings:

Andhra Pradesh:

- The list of EDL was available at the district drug store but this was not displayed at the facilities visited. The computerized monitoring of the drugs in stock, availability and expiry is maintained at the district drug store for re-appropriation of drugs within facilities.
- Certain essential drugs are not available even at the central drug stores and this needs urgent attention.
- Facilities receive 10% of their budget for procuring medicines from outside in case of any shortage. Remaining budget lies with the APMIDC.

Arunachal Pradesh:

- State has a Rs.10 crore drugs budget, and NRHM supplements with Rs.8.4 crores, which is largely to JSSK related drugs including IFA.
- Shortage of drugs in periphery with poor uncoordinated procurement and logistics.
- High out of pocket expenditure on drugs and diagnostics.
- Most diagnostics including basic ones are available only at the district level.

Bihar:

- Supply position of drugs has improved considerably with the State Health Society being authorised to purchase. Rate contracts are issued and districts place orders. Basic quality assurance protocol is also included, with local drug inspectors organising the testing. Conscious effort to encourage rational prescription and introduction of prescription audit is required.
- State Medical Services Corporation also being set up to take over this function on the lines of TNMSC.
- Essential drugs lists notified and being followed, though greater clarity on facility based lists is needed.
- Routine diagnostics done in the facility but all others outsourced to central diagnostics in Patna. Of the outsourced tests, 14 are done free and others are charged to patients. Radiology services are also outsourced.

Gujarat:

- State Medical Services Corporation is established.
- However, role is mainly limited to procurement process. The distribution systems are weak, leading to non-availability of essential drugs in many facilities and oversupply/wastage and expired drugs in others.
- Similar problems are observed with equipment too - with frequent instances of non-installation. That this is despite computerised inventory management system is a matter of concern.

Haryana

- Separate Medical Services Corporation set up.
- Online assets management software for medical equipment developed.
- Free drug supply scheme is launched across the state.
- Marked improvement in storage and inventory management and much better drugs position across the facilities visited. EDL is in place, with measures to limit prescriptions to it.

Himachal Pradesh.

- Free Drugs scheme for BPL patients with list of 38 free medicines in existence.
- OOPE on drugs for BPL is minimised by purchasing drugs for them from *Jan Aushadhi* stores located in district and civil hospitals.
- Access to diagnostics is a problem and outsourcing diagnostics does not seem to have helped. Non-availability of basic diagnostics was seen in the CHC and PHC visited.
- Inadequate mechanisms of equipment procurement, installation and maintenance.
- State is setting up a drugs and equipment procurement mechanism under the state civil supplies corporation. Currently some drugs are procured by corporation, some through *Jan Aushadhi's* and some through local purchase.
- Drug inventory and supply chain management remains unsatisfactory.

Jammu & Kashmir:

- State has established a medical corporation for procurement and logistics- but it is not yet functional. The State is yet to articulate a policy for free drugs.
- At present procurement and distribution of drugs is inadequate in all aspects. Quality assurance systems are also deficient. Shortage of essential drugs at many facilities.
- Equipment availability at "delivery points" is better. There is a health equipment repair facility at both Jammu and in Kashmir divisions for all equipment's in public health facilities.

Jharkhand:

- State corporation for drugs and equipment purchase is yet to be established though there is a commitment to do so. EDL is in place.

- Current system is a state level rate contract for 112 essential drugs- which districts may then procure. However, there are problems – including higher rates as compared to TNMSC, lack of awareness or use of this rate contract by districts and no mechanisms of being able to estimate demand or assure quality.
- Stock inventory management systems are manual and warehouses inadequate and not surprisingly problems of drugs supply and stock out of essential drugs remain.

Karnataka:

- Karnataka Drug Logistic and Warehouse Society established in 2003, and EDL is in place.
- Procurement and quality assurance systems and indenting mechanisms are all in place. Drug availability in facilities is good. Drug warehouses constructed or being constructed.
- Persistent outside prescriptions were seen, with many being irrational.
- Storage at health care facilities weak.
- No effort to strengthen diagnostics.

Maharashtra:

- State has articulated a free drug policy for essential drugs and diagnostics.
- Facility wise EDL and list of assured diagnostics is in place.
- Drug availability seems better- but on a narrow range- and some essential drugs are deficient in many facilities visited.
- No observations recorded on procurement and logistics systems or on equipment.

Meghalaya:

- Major gaps in availability of drugs and diagnostics.
- No clear articulation or implementation of free drugs policy.
- No rate contracts have been issued in last three years.

Nagaland:

- State drug policy is in place and available on state website. EDL and standard treatment guidelines are in place. However, many tenets of the state drug policy are not being implemented. Further, there is poor awareness of the EDL and STGs.
- There is central procurement, but quality assurance systems are weak. Purchases and records are by brand names, and drugs outside the list are being purchased.
- Inventory management at facility level is inadequate.
- Good AYUSH pharmacy and drug testing facilities, but lack of staff compromises its functionality.

Odisha:

- Odisha state has Drug Inventory Management System (DIMS) that is functional and being used quite effectively. However, state is in parallel developing a Reproductive health Commodities Logistics Management System (RHCLMIS) exclusively for RCH commodities, which is currently not in use- perhaps because it is in initial stages.

There are no plans for inter-operability, nor do either monitor equipment, or AYUSH drugs.

- Using DIMS, despite not having a TNMSC like system, the central purchasing authority and stores is able to ensure uninterrupted supply up to the block level. District drug stores can make purchases and distribute to close gaps.
- State has a drug testing and research laboratory, which supported by an IT application, has evolved into a system for drug testing and quality assurance.

Uttar Pradesh

- Drug Logistics system is of state level rate contracts, followed by orders placed by districts and supply made to districts. Following state logistics rules, state level rate contracts were issued and districts placed the orders but the rate-contracted firms have failed to supply leaving the facilities without drugs and a high unspent balance in the district under this head.
- Other aspects, like quality assurance, stock management etc. were also weak.
- EDL is displayed in most facilities.

TOR 9

NATIONAL URBAN HEALTH MISSION:

Guiding Principles/Strategies of the NHM/NUHM

- i. *“The sub-mission of National Urban Health Mission (NUHM) under the NHM strives to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections by facilitating equitable access to quality health care”*(Para 5.11.1)
- ii. *“This situation is further exacerbated by the fact that a large number of urban poor are living in slums that are not part of the official list as slums. This compromises the entitlement of the slum dweller to basic services. Slum populations face greater health hazards due to overcrowding, poor sanitation, lack of access to safe drinking water and environmental pollution. Under NUHM, the most vulnerable including construction site workers, homeless persons, street children, victims of communal violence, invisible habitations such as lime and brick kiln workers would be accorded focused attention and health care through strategies appropriate to the local situation”*(Para 5.11.5)
- iii. *“There is also a section of the population who are not only poor, but also suffers from additional cause of vulnerability and marginalization. This includes the migrant worker, the homeless, the street children, occupational groups like rag pickers, sanitation workers, trans-gender population, commercial sex workers and so on. For these groups to access essential health care services affirmative action is needed. Efforts will be made to ensure that these populations are adequately covered by NHM’s social protection initiatives”*(Para 5.6.8)
- iv. *“The National Urban Health Mission would aim to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies”*(Vision statement of NUHM)

Key Findings:

- a. In every state work has begun on NUHM with identification of slums, gaps in HR and facilities and making of PIPs for submission.
- b. Program management structures for urban health have been initiated in all of the states visited by CRM. While there is some uniformity, there is diversity in some states and in some mega cities in terms of structures.

- c. Visits to slum areas and Focus Groups discussions were conducted in the CRM districts to understand the needs vis-à-vis existing coverage and associated issues. The main findings are a lack of services, even of core RCH services in many areas, which re-emphasises the urgent needs for NUHM
- d. FGDs done through CRM visits present a picture of diverse needs. For example, in Jharkhand FGDs highlighted health related ailments of Kala Azar, Malaria, Filariasis, RTIs, water borne ailments such as GE, Jaundice etc. In most states, there was widespread NCD and mental health issues. Special strategies are needed to address increasing prevalence of substance abuse and dependence in the slum areas, alcohol abuse, and domestic violence victims including psychological counselling to treat psychological problems.
- e. Many cities visited had functional urban facilities in PPP mode and community health workers. For example, Urban slum Health Centres (USHC) located in Key Focus Area (KFA) for deprived slum population (migrant labourers, street children, etc.) are being implemented by NGOs under PPP in Odisha. There is a need to maintain continuity of these programmes as well as upgrade them.
- f. Involvement of urban local bodies is varied, with some states like Maharashtra having made a good effort and others yet to start up. Strengthening of convergence between ULB, State Health Department and related other departments such as Social and women welfare etc. are the need of the hour.
- g. RCH and other primary care service components at UFWCs and UPHCs are to be strengthened even in maternal health aspect, such as performing normal deliveries, in order to reduce patient loads on DH and tertiary facilities. Effective referral linkages are needed between the existing primary health structures and tertiary health care structures, other NGO network and PPP facilities, wherever they are in place.

Recommendations:

- Adequate capacity building to make city plans for NUHM.
- Ensure existing urban health care infrastructure and systems are seamlessly integrated with those that are being introduced with NUHM funding.
- Over all, existing Urban Health infrastructure particularly primary health care related, needs to be mainstreamed into NUHM and strengthened in terms of comprehensive, need-based coverage of services, delivery, staff/HR, drugs and equipment and at the same time enhancement of quality dimensions of health care needed.

State Findings

Andhra Pradesh:

- One urban PHC in Wanaparthy town of Mahboobnagar district was visited which largely provides RCH services to a population of about 20,000 with a staff of one medical officer, one community organizer, 2 ANMs and 3 support staff.
- State NUHM PIP aims to reach 116 ULBs, with focus on 33. There would be separate PMUs for the three major cities. In all, there would be 471 UPHCs, 2394 ANMs, 4929 ASHAs and 19733 MAS deployed in the first phase.

Arunachal Pradesh

- NUHM PIP for state capital prepared and submitted, mapping of slums stated to be completed by urban development department. Two staff have been earmarked for NUHM to begin work.

Gujarat:

- Gujarat urban Health Project (GUHP) was launched in 2011 in 25 districts (except Dang District) including Valsad (CRM district) to provide health services to vulnerable. GIS mapping of primary health care facilities and urban slums in 71 cities has been completed.
- City and state level PIPs are prepared and submitted to GOI.
- Urban PHCs functioning in the urban slum are managed by the state Government in the Municipality area and those functioning in the corporation area are managed by ULBs, under PPP (in the metro) and under RCH-II/ NRHM.
- Outreach services like Urban Health & Nutrition days are conducted in urban slum areas at the district and corporation levels.
- Out of 4924 community based health worker/link worker 3900 have been placed in the slum areas in the districts as well as corporations

Haryana:

- NUHM PIP for 29 urban areas of Haryana has been submitted.
- There are a fair amount of facilities already in place but the proposal is to increase from the existing 59 to over 150.
- Current level of outreach of services in urban areas very limited.

Himachal Pradesh:

- Implementation of NUHM has begun with urban slum mapping in Shimla and a PIP submitted for the same. State plans to focus on industrial belts of Sirmour, Una and Solan as well.
- Group discussions in a slum in districts visited showed that NGO based community health workers were providing basic immunization and some symptomatic health care for acute minor illnesses. Population were largely made of migrants from Rajasthan and Maharashtra.
- No specific programmes for vulnerable populations were evident.

Jammu & Kashmir:

- Implementation of NUHM has begun with mapping of slums in capital cities of Srinagar and Jammu. Seven more towns are to be covered in phase I.
- Existing facilities and programmes mapped, gaps identified and accordingly a state PIP has been drawn up.
- Coordination with urban local bodies and other departments needed.

Jharkhand:

- State has prepared and submitted PIP. However, urban local bodies in cities visited were not consulted. Discussions with elected or other officials of these bodies shows limited awareness on the programme.
- Focus group discussions point out to lack of key services, which they need most, lack of drugs with outside prescriptions being the norm and no referral system.
- Living conditions are very poor; vector breeding unchecked and urban malaria is a problem.
- Even core RCH services not reaching properly in the slums showing how urgently an NUHM intervention is required.

Karnataka:

- NUHM process has started in the state with necessary inclusions in governance and first set of cities to be taken up identified. District towns visited by CRM are not part of this first phase.
- There is one urban PHC in PPP mode in Gulbarga city under urban RCH and others under NRHM flexi-pool. They largely provide RCH services. However, there is a large caseload of RTIs and of mental health and other NCD patients. Drug supply is good.
- Referral linkages weak and no programmes to address growing NCD issues.

Maharashtra:

- NUHM process started and state has submitted its PIP after extensive consultations with urban local bodies. Process has identified gaps and made proposals to close these gaps which are largely related to skilled human resources.

Meghalaya:

- State has three towns to be covered under NUHM- Shillong, Tura and Jowai. Slums have been mapped, gaps identified and the PIP has been submitted.

Nagaland:

- NUHM process starting up, with identification of slums needing services. Work has begun largely in Dimapur town, which has large migrant population and is a potential epidemic hotspot.
- In one such area, Burma camp, dwellers have identified and donated land for an UPHC. These slums have considerable community organizations and NGO presence, whose strengths can be used. There is a functional PPP clinic run by a faith-based organisation.

Odisha:

- Process of implementing NUHM has begun with changes in governance and management structures to take on this task.
- There are a large number of schemes and programmes, many of which are in PPP mode to address basic public services like water, sanitation and housing.
- Urban PHCs outsourced to NGOs provide health care in most cities and towns.
- Ward level coordination committees have been planned for convergence.

Uttar Pradesh:

- Four Urban Health posts have been started in Mathura city which are being supported by a development partner - UHI.
- Preparatory activity regarding NUHM has been initiated and the State Plan has been submitted.
- SPMU under the overall guidance of the MD, NHM with the urban health cell is in place at the SPMU.

TOR 10:

GOVERNANCE & MANAGEMENT:

Guiding Principles/Strategies of the NHM:

- i. *“Strengthen state level implementation capacity to progress towards achievement of universal health care through flexible and responsive resource allocation, the creation of efficient institutional mechanisms, rules, regulations and processes to enable effective decentralized health planning and management”*(Para 2.3.9)
- ii. *“Encourage and enable the involvement of Panchayati Raj Institutions (PRIs) /Urban Local Bodies (ULBs) representatives in the governance and oversight of health services, and undertake proactive efforts for convergence and concerted action on social determinants of health such as food and nutrition, safe drinking water, sanitation and hygiene, housing, environment and waste management, education, child marriage, gender and social inequity”*(Para 2.3.14)
- iii. *“Improve Public Health Management by encouraging states to create public health cadre, and strengthening/ creating effective institutions for programme management, providing incentives for improved performance and building high quality research and knowledge management structures”*(Para 2.4.2.19)
- iv. *“Establish Accountability Frameworks at all levels for improved oversight of programme implementation and achievement of goals. Mechanisms for accountability shall range from participatory community processes like Jan Sunwais/Samwads, Social Audit through Gram Sabhas to professional independent concurrent evaluation”*(Para 2.4.2.24)

Key Findings:

1. Governance:

- a. Across all states, the state health societies and district health societies are functional and much better coordinated with pre-existing structures of the department and the Directorate. There are some states however where coordination is still a problem.
- b. The roles of the Directorate are however weak.
- c. The level of governance exercised by the Governing Board is uncertain. Most decisions are at the level of the executive.
- d. The role of Panchayat Raj institutions remains limited, with active participation at the village level, but very little above this.
- e. With respect to decentralization, district plans and allocation according to district plans is less evident than before and there is limited flexibility for districts and facilities to make decisions on resource allocation.

2. Programme Management

- a. Most states have an adequate State Programme Management Unit in place- but the capacity of District Programme Management Units is more varied.
- b. The quality and functioning of Block Programme Management is even weaker and many states do not have adequate staff in place.
- c. Public health cadre has not started up in any state. The maximum advance is in Maharashtra where a committee has examined it and in Karnataka where there is an active encouragement for public health training.
- d. The practice of arranging for annual training of Programme Management Staff working at various levels, or at least induction training, a feature of the early years is no longer seen. PMU staff report that they have hardly had any opportunities for enhancing their management and leadership capacities.
- e. Some states, such as Odisha, have initiated performance review measures for management staff.
- f. It was a common finding that for officers working at peripheral level access to up-to-date guidelines is a challenge. Most often they do not receive them or the ones followed by them are not the latest guidelines, leading to confusion and non-implementation of programmes.
- g. Efforts for integrated action and convergence are visible across States but success appears elusive. A few attempts made by proactive officers lasts only for a short time.
- h. Difference in pay package between regular and contractual staff is a widespread feature and causes de-motivation and consequent attrition.

3. Supervision & Monitoring

- a. All States have initiated mechanisms of Supportive Supervision but with different degrees of effectiveness. Some states have started State Review Missions (e.g. Jharkhand), modelled similar to the CRMs. This is a good initiative and appropriate focus on 'action taken on recommendations' of these Missions would help.
- b. E-governance systems are yet to take off. Maharashtra has shown a good example of e-filing systems at the NRHM office, which allows files to be tracked and disposed off in a much shorter time.

4. Accountability Mechanisms

- a. Horizontal Accountability mechanisms within the State – like community monitoring or Jan Sunwais etc. are few.

- b. A few states have reported setting up of District Vigilance and Monitoring Committees, but their effectiveness is uncertain.
- c. Social audits are yet to be reported. The number of states reporting community monitoring activity is limited to Maharashtra and Bihar.

5. Regulations

- a. Steps are taken to implement PCPNDT Act by the States and implementation of Clinical Establishments Act is just picking up. Jharkhand is a good model on this, where appropriate authorities have been notified and are functional (for registration of Clinical Establishments etc.)

Recommendations

- There is a need to disseminate the NHM Framework widely and invest in sensitising and orienting the entire leadership to this document as was done for the NRHM document in the year 2006-07. This would help the governance and accountability framework of the mission, (section 5.14.), its directions for improving public health management (section 5.9), its strategies monitoring and evaluation (chapter 7) all of which are essential to the success of the Mission.
- With the adoption of the new NHM framework for implementation, there is a need to renew the commitment to decentralization, integration and convergence and the single most important tool for this is the district health plan as elaborated in the NHM Framework for implementation (section 5.1)
- There is a requirement to strengthen the PMU staff, to orient them on the specific roles and support in relation to the existing governance structures, so that better output is possible at institutional/block/district and state level.
- State level sharing forums are a useful mechanism for sharing experiences and providing feedback.
- Encourage supportive supervision teams / programme officers in-charge to hold 'night-stays' or working with teams at the peripheral level facilities to understand the actual problems faced by the health staff posted there / community accessing services from such institutions.
- Encourage community monitoring of facilities and the participation of community representatives in the functioning of public health institutions.
- It is suggested that a mechanism to ensure access to guidelines at the periphery and ensuring that an 'indexing mechanism' is followed at the institutions, so that there is no confusion on 'which guidelines' to be followed.
- Expedite and support states for consultations on Clinical Establishments Act to actively consider a possible adaption/adoption.

State Findings:

Andhra Pradesh:

- The sub-district management structure, consisting of the post of senior public health officer and the community nutrition and health cluster is a good effort put in place two years back; to provide a coordinated block level leadership is under-utilized and languishing. Need to re-visit this and understand the reasons for its constraints.
- Weak programme management units at state and district hamper the programme.
- Coordination with departments of medical education, APVVP –that looks after secondary care and the primary care system is poor.

Arunachal Pradesh:

- Poor coordination of NRHM and state directorates persists. Regular supervision and monitoring weak.
- District health societies are functioning adequately in one of two districts. District planning is being done in both districts. RKS functioning weak.

Bihar:

- State and district health societies are in place- but governing bodies of latter do not meet.
- RKS is functional, but with irregular meetings and a weak role in actual leadership.
- A robust state programme management unit. Good tenure and continuity are seen at the Mission Director level. District programme management units require more training.
- Public health cadres are not in place. Supervisory visits have started up- but are not adequate in quality or frequency to make the difference.
- Social audit is part of the community monitoring programme. Ten Jan Sunwais have been conducted so far.
- District Vigilance and Monitoring committees formed and have become functional.
- Clinical Establishments Act adopted by state.

Gujarat:

- The NRHM institutions- SHS, DHS, RKS- are all in place and adequately functional.
- Supervision at all levels remains very weak.
- Lack of coordination between regional deputy director posts who control CHCs and the CDHO who controls the PHCs hampers the programme.

Haryana:

- The NRHM institutions are all in pace and adequately functional and even the DPMUs are well staffed, though they are not well trained.
- There is an improvement in supervision of facilities and the tools of supervision are actively being used.
- There are no social audits, community accountability processes or Grievance Redressal mechanisms in place.

Himachal Pradesh

- State Programme Management Unit has a strong structure, but at district and block levels the PMUs are weak. Exclusive block medical officer for public health is a good idea, but it is weak in implementation.
- State and district health societies are functional. Rogi Kalyan Samitis still have the earlier orientation where they make money through user fees, and now through RSBY also, but do not spend it on amenities or improved services
- Efforts at supportive supervision initiated.
- Measures such as social audit and Grievance Redressal not in place.

Jammu & Kashmir

- Programme Management Units functional and integrated with directorates. PMU staff not adequately trained.
- District Vigilance and Monitoring Committees functional.
- Monthly reviews institutionalised. Regular monitoring visits are in place. Retired CHMOs contribute to monitoring in their districts.
- Implementation of Clinical Establishment Act initiated.

Jharkhand:

- State Programme Management Unit functional and coordinates well with directorate.
- Many other units such as IPH, state health resource centre, ASHA and VHSNC programme management units etc. have remained understaffed and poorly functional.
- District Programme Management units functional. Block level units have high vacancies. No regular programme of training.
- State has adopted Clinical Establishments Act, notified state council and begun process for establishing district registration authority.

Karnataka:

- Programme Management Units well integrated with directorate, fully staffed and functional.
- Has set up a committee for creation of public health cadre and is also encouraging doctors and programme officers to get public health management training.
- State and district health societies functional.

Seventh CRM Report

- District Vigilance and Monitoring Committee and ASHA Grievance committees are reported as functional.
- Monitoring visits are planned but their quality is not certain.

Maharashtra:

- State and District health societies are in place.
- Rogi Kalyan samitis are functioning well and utilising resources at their disposal.
- Planned Supervision and Monitoring visits taking place adequately.
- Community based monitoring is well established and has contributed to increased access, quality and accountability.
- More training inputs to management staff is a felt need.

Meghalaya:

- State and district health societies' and programme management units are in place and functioning well.
- Regular review meetings held at district and block level but monitoring visits could be strengthened.
- No formal accountability mechanisms are in place; either vigilance committees, or social audits nor community monitoring.
- Implementation of Clinical Establishments Act is on-going.

Nagaland

- Good integration between State health society, state programme managers and Directorates- with officers being interchangeable and consultants working directly under officers on all key areas.
- Functional district and block level programme management units.
- HR policies for contractual staff, including for management staff deficient and not adequate for motivation, performance or even retention. Better skills through training, better compensation packages and a better HR management is required.
- Some RKS are well functional, but others are not.
- Review meetings at various levels are not streamlined, with lack of clear articulation of decisions and responsibilities, and mechanisms for follow up.
- Supportive supervision is very weak.

Odisha

- Both state and district health societies and programme management units well in place and there is good integration with Directorates.
- Modest devolution of powers to district level is seen.
- Performance appraisal and regular salary increment introduced.
- Supportive Supervision is well organised.
- Other institutions- SIHFW and SHSRCs and Community Processes Management Unit are also well functional.
- Block Programme Management units however need to be strengthened.

Uttar Pradesh No observations recorded

Positives and Challenges

ANDHRA PRADESH**DISTRICTS/INSTITUTIONS VISITED**

District Mahboobnagar	District Chittoor
DH, Mahbubnagar	Government Maternity Hospital, SVRR, Tirupathi
Area Hospital , Nagarkurnool	DH, Chittoor
CHC Achampet Kalwakurthi	Area Hospital , Srikalahasthi
PHC, Bijnepalli Balanagar Uppanuntala Kalwakurthy Bijinepalli Kothuru	CHC Puttur
Community Health and Nutrition Cluster , Boyapalli	PHC Tarigonda, Gurramkonda, Chowdepalli, Mulakalacheruvu Peruru
UHC Ramayabowla, DHQ (Matches NGO), Borabanda , Hyderabad	Community Health and Nutrition Cluster, Vayalpadu, Punganur, Puttur
Sub-Centre Amistapur, Rudraram Veltoor Rangapur Penjerla (VHND also) Rangareddyguda (Jedcherla/Badepalli CHNC)	Sub-Centre Peddakannali, Marripadu, Sangasamudram, Gurramkonda, Perur, Burrakailakota, Pudipatla, A-Kothakota, Patrapalle Rompicherla Piler
Central Drug Store, State, Mahbubnagar	Central Drug Store , Tirupathi
AW Centre , Veltoor	AW Centre , Piler
VHND , Penjerla	VHND , Rompicherla AW Centre

REVIEW TEAM

- Dr. Teja Ram,DC(FP-II), MoHFW
- Dr S R Chinta ,Asst. Adviser-AYUSH, MoHFW
- Dr. Sheetal Rahi ,Medical Officer (AH), MoHFW
- Dr Suman Lata Wattal DD, NVBDCP , MoHFW
- Sh. Puneet Jain, FMG, MoHFW
- Dr. Salima Bhatia Consultant-Policy and Planning, NRHM-I
- Dr. Venkatesh Srinivasan, Assistant Representative, UNFPA
- Ms. Shobhana Singh, Consultant, Family Planning , MoHFW
- Ms Anamika Saxena Training Division , MoHFW
- Ms. Aparna Addala Sr Program Manager , SAATHII
- Dr. Chakrapani Chatla, Consultant, RNTCP , WHO
- Dr. Shazia Anjum, Consultant, RNTCP, WHO
- Mr. Ritesh Laddha, Prayas
- Sh. Bhaswat Das, RRC-NE

POSITIVES

- The state launched screening programmes for individuals over 30 years and pregnant women for Diabetes and Hypertension in eight districts through outreach in the community, at sub centres and CHCs. Of the 84 lakh individuals screened, the case detection rate was 7.12% for Diabetes and 7.32% for Hypertension.
- Diagnostic services for the MDR TB have increased substantially in recent periods. Andhra Pradesh is one of the leading states in implementing PMDT successfully and is one of the training centres for National Level training on PMDT.
- There is a robust central drug procurement system and infrastructure development in place. Andhra Pradesh State Medical Infrastructure Corporation Ltd. (APSMIDC) has been established to ensure staff accommodation in medical institutions in rural and semi-urban areas.
- The state has initiated “Bangaru Talli”, a scheme to delaying age at marriage and enabling school retention and completion of undergraduate degree. Financial incentives ranging from Rs.1000 to Rs.3000 every year are provided through the entire educational period - ensuring completion of school admission, middle school, secondary school, higher secondary and up to graduation.
- Districts have a micro-plan for reaching the marginalized sections with health care services through outreach services, MMU, VHSNC and ASHA.

CHALLENGES

- Based on state HMIS data, nearly 27% of deliveries are still unreported. Of the 68% of institutional deliveries, the proportion of public sector deliveries (46%) is lower than that in private sector (54%). About 5% of deliveries are home based.
- Quality of care is still an issue with poor biomedical waste disposal owing to non-renewal of contract with the private agency. Inadequate display of protocols of infection control and BMW management was observed in the visited facilities.
- The state is not utilizing the potential of the ASHA and Village Health, Sanitation and Nutrition Committees. There are no support structures for the community processes programme and consequently the ten-indicator performance monitoring system is yet to be established. There are no facilities for the ASHA in public sector institutions such as rest houses.
- Certain essential drugs are not available even at the central drug stores and this poses a serious challenge. The essential medicines list was not displayed uniformly and stocking at drugs stores and pharmacies needs to be improved.
- For the year 2012-13, overall budget utilization is less than 20%. Specifically, about 40% was used from the RCH flexipool, and 30% under the Mission Flexi pool.
- The State has not yet established state and district programme management units, and substantial delays in contracting such staff are reported. As a consequence, there are few field visits and weak supportive supervision

ARUNACHAL PRADESH

DISTRICTS/INSTITUTIONS VISITED

District West Kameng	District Upper Subansiri
DH Bomdilla	DH Daporijo
CHC Dirang, Rupa	CHC Maro, Talinga, Muri Mugli
PHC Bhalukpong, Singchung	PHC Boririzo, Kodak
SC Tippi, Morsing, Silari	SC Sippi, Ligu, Gepen

REVIEW TEAM

- Ms. Preeti Pant, Director(NRHM-III), MoH&FW
- Sh. Shiv Singh Meena, Director, Planning Commission
- Dr. Kalpana Baruah, Joint Director, NVBDCP
- Sh. Kedar Nath Verma, DD (NRHM), MoH&FW
- Mr. Daya Shankar Singh, Social Mobilization Specialist (FHI360)
- Dr. Antony K R, President, Public Health Resource Network
- Dr. Rajeev Gera, Senior, Advisor,PHFI
- Dr. Ashish Chakraborty, Consultant NRU
- Sh. Sanjeev Rathore, FMG, MoH&FW
- Dr. Deka Dhrujyoti, Consultant, WHO-RNTCP
- Dr. Ashalata Pati, Consultant, MoH&FW
- Dr Madhusudan Yadav ,Consultant, NHSRC
- Ms. Sonal Dhingra, Young Professional, Planning Commission
- Dr. Asmita Jyoti Singh, Senior Consultant, NRHM MoH&FW

POSITIVES

- Given the geographic terrain and high access barriers to health facilities, the state has enabled sub-centre ANMs to provide skilled birth attendance for home deliveries.
- Effective Co-location of AYUSH facilities has led to higher caseloads in district hospitals.
- ASHAs have been trained in Module 6 and 7 and have started making home visits to provide newborn and post natal care, but the quality of care needs improvement.
- At all visited health facilities as well as during patient interactions it was observed that attitude of providers was patient friendly.

CHALLENGES

- The state has not yet been able to ensure Monitoring/Supportive supervisory mechanisms at any level.
- 108 services have not yet been initiated in the State, despite the inability of the existing mechanism of referral transport to provide assured service.
- There is discordance between up-grading health facilities and caseloads and spectrum of services provided.
- The state has a long way to go in terms of meeting its Human Resource needs. There is no increase in number of sanctioned posts, no special drives are being carried out to recruit specialists, nor have incentives been institutionalized for people working in difficult areas.
- High out of pocket expenses on account of drugs, diagnostics and transport are being incurred in Upper Subansiri district.
- Supportive services (cleaning, housekeeping, diet) need improvement. In Upper Subansiri, none of the health facilities provided diet to in patients.
- Meetings of DHS, QA committee, and RKS do not take place regularly and records of decisions taken are not maintained in most places.

BIHAR

DISTRICTS/INSTITUTIONS VISITED

District Purnea	District Vaishali
Sadar Hospital	Sadar Hospital
ANMTC Purnea	ANMTC Vaishali, Private ANMTC
Sub-Divisional Hospital Dhamdaha, Banmanki	Sub-Divisional Hospital Mahua
BPHC Bhawanipur and K. Nagar	BPHC Bidupur, Goraul, Rajapakar, Vaishali, Patepur, Bhagwanpur
APHC Sarsi Akbarpur Rangpura Sondeep Damaili	APHC Chasikandar, Pakoli
Sub-Centres Akbarpur, Sondeep Supauli, Gokhalpur Mirchai Badi	Sub-Centres Lalganj, Zafarpatti, Kutubpur, Bahuara
VHSND Dhamgara, Badhari, Jabe, Badhi Tola, Deemapur, Damdaga Tola, Mushahar Tola, Pipra Vishanpu	VHSND Madhurapur, Chachar, Pakri Khusua Toal
MMU Matia Musehri and Purnea East	MMU Vaishali
SIHFW Patna	Ultrasound clinics Hazipur

REVIEW TEAM

- Dr. Sushma Dureja, Deputy Commissioner, Adolescent Health, MoHFW
- Dr. R. K. Das Gupta, Joint Director, NVBDCP, MoHFW
- Ms. Sheena Chhabra, Chief, HSD, USAID
- Mr. Alok Vajpeyi, Head, Core Grants and Knowledge Management, PFI
- Mr. Biraj Kanti Shome, Regional Coordinator, Community Mobilization, RRC-NE
- Dr. Sanjeev Jha, Consultant, RNTCP, WHO
- Mr. Vipin Garg, Consultant, JSY, MoHFW
- Dr. Sarita Sinha, Consultant, Planning & Policy NHM, MoHFW
- Dr. R.S. Gupta, DDG, TB, MoHFW
- Dr. V. K. Shahi, Assistant Director, AYUSH, MoHFW
- Dr. S. N. Bagchi, Senior Programme Manager, Health System Support Unit, PHFI
- Ms. Mona Gupta, Associate Director, TMSA
- Mr. K. Kaushal, Consultant, Finance, MoHFW
- Dr. Anisur Rahman, Consultant, PNDT, MoHFW
- Ms. Zahra Afroz, Young Professional, Planning Commission
- Mr. Vinod Kumar, Senior Programme Officer, UP, BMGF

POSITIVES

- The state has developed an HRIS web portal to capture personnel/HR information. The human resource capacity has been strengthened considerably, with the state adding 1409 doctors (from state budget), 1384 AYUSH MOs, 1512 staff nurses, and 8529 ANMs on contract, in addition to the regular staff. Rational posting of existing specialists and EmOC/LSAS doctors has improved.
- 84,860 ASHAs, supported by supervisory posts at every level: 533 community mobilizers at block, 38 at district and 9 at divisional levels are in place, although the state has not yet recruited candidates where there is attrition. The state also has 4405 Mamas.
- Free drugs are available in all public health facilities
- Ranking of districts and divisions based on on-line dashboard system for monitoring progress is underway enabling more focused supervision and support.
- State has piloted innovations to improve interpersonal communication by ASHA (Mobile Kunji) and another to strengthen payment mechanisms (Project HOPE).
- The state has established program management units at all levels and has more than 1400 posts of program managers at all levels.
- The Bihar Medical Services & Infrastructure Corporation to procure drugs and equipment and build quality health infrastructure is now functional.

CHALLENGES

- Huge infrastructure gaps remain. As per population norms Bihar still requires 795 CHCs, 2130 PHCs and 11064 Sub-centres. These numbers are higher when the principle of 'time to care' is considered.
- About 15%, i.e. only 204 out of 1330 APHCs (which cater to a population of 30,000 to 50,000) serve as a Level 1 facility. Other APHCs provide only OPD services, with only facilities or block level or higher providing inpatient care.
- Block PHCs with 6-9 beds cater to a population of approximately 2 lakhs, leading to overcrowding and DHs with less number of beds makes it impossible to provide quality services. 48 hours stay is well nigh impossible, and mothers and newborns are kept in the open.
- With only 127 gynaecologists, 58 anaesthetists, and 119 paediatricians in the government system, availability of specialists remains a problem. State is yet to design an incentive package to attract specialists.
- Rational deployment is also an issue: Data from the HRIS shows that 5% (9 gynaecologists, 2 anaesthetists, 4 paediatricians) are still posted in APHCs, 30% are posted in the BPHCs. Similarly 20% of EmOC and LSAS trained MOs(10 EmOC and 12 LSAS trained MO)s are posted in non-FRUs, indicating that their services are not utilized by the system, despite significant investment.
- Only 44% of LSAS and 22% of EmOC trained MOs are performing, indicating that the state has yet to strengthen its monitoring and supervisory mechanisms.
- Despite the increase in Dial 102 (567), Basic Life Saving (BLS) ambulances, "dial 108" (50), five Advanced Life Support (ALS), and 45 BLS ambulances, the referral transport system currently cater only to 26 % of pregnant women for pick-up and only 24 % for drop back. The absence of a centralized single number (state has three numbers: 102,108 and 1099 each catering to specific needs) creates confusion..

Seventh CRM Report

- Frontline supervision is almost non-existent with only 432 LHVs left to monitor 17726 ANMs, with most LHVs being on the verge of retirement. There is no alternate supervisory cadre in place. Interaction during field visit shows that supervision by officials and MOs in regular cadre is rare and ad-hoc.
- Although the state has added almost 2000 program managers/supervisory staff, and mandated regular field visits and use of checklists that are uploaded on the website, follow up action is non-existent, partly on account of limited authority of contractual staff over service providers, and little support from state management structures.
- There is little in-service training, with the SIHFW having only 4 regular staff. There are no district training centres, leading to slow pace of training programmes.

GUJARAT

DISTRICTS/INSTITUTIONS VISITED

District Valsad	District Dang
GMERS Medical College	DH Dang
Shrimat Rajchandra Charitable Hospital	CHC Waghai
SDH Dharampur	PHC Shamgahan, Gadhavi, Pimpri, Pipaldahad, Shamghar, Kalibel
CHC Bhilad, Kaprada	SC Barkhandia, Rambhas, Pipaldahad, Shamghar, Nadakchand, Sodmal, Baripada
PHC Sanjan, Sutarpada, Kakadua	
SC Sanjan, Kaprada, Sutarpada	

REVIEW TEAM

- Dr.Dinesh Baswal, DC (MH-II-III), MoHFW
- Ms.Kavita Singh, Director (NRHM-Fiannce), MoHFW
- Dr.Suresh, Research Officer, AYUSH
- Dr.Saurabh Goel, Assistant Diretor, IDSP
- Dr.Ankur Yadav, NIHFW
- Dr.Rajesh Narwal, Advisor, Public Health Planning, NHSRC
- Dr. Shailesh Kumar Sharma, Fellow, NHSRC
- Dr.Shiv Kumar, UNDP
- Dr.Sarang P Pedgaonkar, IIPS
- Dr. Jatin Dhingra, Urban Health
- Dr.Anil Kashyap, NRHM – I
- Ms.Safia Haque, Consultant, JSY
- Dr.DSA Karthikeyan, RNTCP
- Mr.Subhash Chand Khatri, RCH
- Sh.M.M.Manna, FMG
- Dr. Manju Singh, NRU

POSITIVES:

- The state has made a start towards the National Urban Health Mission in a phased manner, and GIS mapping of Primary Health care facilities and urban slums in 71 cities is now complete.
- Outreach services like Urban Health & Nutrition Day are conducted in urban slum area at the district level & corporation level; also, 3900 out of 4924 Community Health worker / Link worker have been placed in urban slums by the state.
- Satisfactory level of awareness on JSY benefits among the beneficiaries and ASHAs.
- Performance of MMUs in Valsad is relatively good with an average 110 Patients per day
- VHNDs numbers appear to be in synergy with numbers planned.
- Mobile *Mamta Diwas* is an innovation to fill local gaps.
- 108 *Khilkhilahatand Rakt dan Kendra*, Valsad running under PPP model
- Screening of sickle cell anemia is taking place in tribal districts.

CHALLENGES:

- Quality of care in health facilities is a challenge with poor Biomedical Waste Management practices in few facilities, non adherence to Standard Treatment Protocols, no display of partograph, or AMTSL in Labour wards, critical patients treated at lower level of facilities, deficient Infection control practices, SNCU protocols not being followed, and poorly functional ILRs and temperature monitors.
- Home deliveries are still high e.g. nearly 78% in PHC/SC Pipalhada
- In most places, line listing for severely anaemic mothers is not being done.
- In the case of referral transport, the nature of vehicle provided does not match the terrain, for Dang district, three of the five ambulances were not able to reach the interior due to the large size of vehicle, leading to home deliveries.
- Drop back facility is low as compared to state average (2.74 per ambulance/ per day) in both districts (Dang - 0.94 & Valsad - 1.88 per ambulance/ per day). Hiring private vehicles by beneficiaries was reported leading to OOP expenses. Beneficiaries reported two to six month delay in JSY payments.
- No institutional mechanism for grievance redressal were established under JSSK
- Maternal deaths are being under reported in Valsad, and only facility-based reviews are conducted.
- Immunization coverage is compromised due to migration, and the state is yet to develop satisfactory mechanisms to address coverage at source and destination.
- Data quality of HMIS is sub - optimal with little attention to data analysis. Use of HMIS data in planning and management of health programmes is negligible. Several formats for MIS systems leads to duplication and confusion.

• HARYANA

DISTRICTS/INSTITUTIONS VISITED

District Palwal	District Ambala
DH Palwal	DH, Ambala
CHC Hodal, Hathin	SDH Naraingarh
PHC Mandkola, Hassanpur, Alawalpur	CHC Shehjadpur, Mullana, Chaudmastpur
Sub-Centre Pondri, Gehlab, Prithla, Deeghot, Janoli,	PHC Nahoni, Samlehdi,
District Training Centre, Palwal	Sub-Centre Khodakhurd, Berpura, Lalpur, Dhanana
MMU, Palwal	Villages Tangedia and Lottan
District Vaccine store	

REVIEW TEAM

- Dr. Tarsem Chand, Director (CEA), MoHFW
- Mr. Raj Kumar, Director, (AYUSH), MoHFW
- Mr. Joytrimoy Nandi, Research Officer (NVBDCP), MoHFW
- Dr. Preeti Kumar, Project Director/Associate Professor, PHFI
- Dr. Suchitra Lisam, Sr. Consultant, NHSRC
- Dr. Gulfam Hashmi, Consultant (Regional Co-ordinator NRU), MoHFW
- Dr. Priyanka Agrawal, Consultant (RNTCP), WHO – HQ for Punjab/Chandigarh
- Mr. Rajiv Shaurastri, Project Director, PFI
- Mr. Vipin Joseph, Consultant (RCH- Monitoring), MoHFW
- Mr. Sahil Chopra, Consultant –NRHM, MoHFW
- Mr. Vikas Sheemar, Consultant (NRHM-MIS), MoHFW
- Mr. Satyajit Sahoo, Consultant (FMG), MoHFW

POSITIVES

- The state has made focused efforts to improve quality by establishment of septic and aseptic labour rooms, pre-natal and post natal wards, MTP/procedure rooms and availability of drugs and functional equipment's, display of guidelines/protocols, use of partograph in delivery points
- Similarly, quality improvements in immunization programmes and outreach sessions are well organized with availability of due-lists, efficient cold chain, availability of trained HR, good record keeping. Measles Surveillance has been initiated in all 21 districts with technical support from NPSP-WHO.
- Quality Assurance systems in Immunization are constituted and closer monitoring and evaluation of immunization programme through RAPID & IFVs, implementation of Effective Vaccine Management is being undertaken.
- Anemia Tracking Module (MIS) is in place to track anaemia among pregnant women. High Risk Pregnancy stamps and marking with red pen in the ANC register to highlight severely anaemic patients is done along with community case detection. Management is followed up from outreach to facility level with the support of ASHA and ANM. Injectable Iron has also been included in the EDL up to CHC level
- The state has used the services of development partner USAID through MCHIP to undertake strengthening of several processes to improve HR and quality of services. MCHIP is undertaking an assessment of 45 nursing and midwifery training centres in both public and private sectors to identify gaps with respect to infrastructure, human resources, logistics and equipment's/knowledge and skills of final year students, improving supportive supervision mechanism, and Facility Readiness assessment in all delivery points of 17 districts.
- Supportive Supervision system is in place, and is being undertaken in close collaboration with PGIMS Rohtak, Haryana. Quarterly visits since 2012, by external monitors from the local medical college, NRHM HQ and state training institutes enables identification of gaps and follow up action. This has resulted in marked improvements in IEC, drugs & equipment availability. Confidence, knowledge practices and Skills showed improvement.
- Web-based Maternal Death, Infant Death and Still Birth Reporting System (MIDRS) have been established.
- Accreditation process of SNCU by NNF has been initiated and self-assessment scores being used.
- RBSK was launched in July 2013 and activities initiated in three districts through the establishment of District Early Intervention Center (DEIC).
- Through the Centralized Procurement of Drugs policy, warehouse at strategic locations has been set up. Provision of infrastructure support, Online Software "Drug Procurement Management Unit (DPMU)" was developed by NIC Haryana and Drug Testing Labs for quality check were empanelled.
- NUHM initiated with establishment of Urban Health Cell within SPMU, 2 urban FRUs functional at Faridabad, 56 urban ambulances proposed

CHALLENGES

- Decentralized planning below the district is not taking place, since Programme Management Units/structures have not been established at block levels.
- The SNCU is not optimally utilized due to lack of adequate staffs (pediatrician or trained M.Os and staff nurses) to provide services round the clock. At CHCs visited in Palwal, there were no in-patients admitted in NBSU due to lack of manpower.
- No facility is able to retain the women following delivery for the required 48 hours under JSSK due to lack of facilities for keeping in-patients. It is an accepted practice to discharge patients' early following delivery, particularly normal deliveries due to unavailability of support facilities for admitting in-patients, even at CHC/PHCs level.
- Surveillance case detection and treatment of vector control measures are relatively weak in Palwal. In PHC Hathin – outbreak of Malaria detected late due to poor active surveillance.
- Support mechanism for ASHAs is weak and very few ASHA facilitators are in place. The roles and responsibilities of intermediate level functionaries such as LHV, ANM coordinators and ASHA facilitators need to be better defined and their services utilized optimally. ASHA helpline is not working effectively and many ASHA were not aware of its existence. ASHAs are not aware of the replenishment procedure and complete set of drug kits is not provided.
- There is no social audit or other accountability mechanism for health, including community monitoring in place in the district. There is no community participation, involvement or ownership seen at any level in the districts visited. District Vigilance and Monitoring Committee was established in 2012 but no meeting records were seen in the districts.
- Fiscal management in the state shows many loopholes: Diversification of fund happens because of maintaining group accounts, and in which the fund does not get transferred to different programme heads. Shortages of accountant results in non-maintenance of books of account in PHC. The number of pending UCs for RCH-II and Mission Flexi Pool has also increased in the last two years.

HIMACHAL PRADESH**DISTRICTS/INSTITUTIONS VISITED**

District Kangra	District Chamba
Zonal Hospital, Dharamsala	Regional Hospital, Chamba
Tanda Medical College	-
Civil Hospital Palampur, Nurpur, Kangra	Civil Hospital Chowari
CHC Nagrota Bagwan, Shahpur	CHC Bharmor, Sahoo
PHC Chamunda, Tiara, Kheria	PHC Rajnagar, Bathri, Banikhet
SC Seerthana, Jadrangal, Sidhbari, Kohli, Baranda	SC Kalsui, Rajnagar, Kiani, Lahal, Sarol
Regional Training Centre, Kangra	
Urban Slum, Dharamsala Villages	Anganwadi Rajnagar & Bharmor Govt. High School, Rajnagar Primary School, Bharmour

REVIEW TEAM

- Shri Ramesh Chand Danday, Director (NRHM), MoHFW
- Shri. B.K.Pandey, Advisor, Planning Commission
- Dr (Smt) Nupur Roy, Additional Director, NVBDCP, MoHFW
- Shri A D Bawari, Under Secretary, (NRHM), MoHFW
- Dr. H S Kathait, Research Officer (AYUSH), MoHFW
- Mr. Sunil Nandraj, Advisor, PHFI
- Dr. Amit Shah, Advisor, (RH/FP), USAID
- Mr. Pushpraj Dalal, USAID project – IHB
- Dr. Abhijit Prabhughate, Director (Knowledge Management & Research), PFI
- Mr. Jayanta Kumar Mandal, Consultant, FMG
- Dr Kaushal K, WHO Consultant, RNTCP
- Mr. Satish Kumar, Consultant, IEC
- Ms. Sumitha Chalil, Consultant, NRHM II
- Ms. Shilpa John, Consultant, NHSRC

POSITIVES

- There is good infrastructure across the State with the IPHS designs adapted to suit State requirements. The average population served by each level of facility is slightly higher than the national norms in case of SCs and CHCs whereas it is lesser for the PHCs and DHs.
- Career progression options for health workers were made available by the State for e.g. the health workers who wanted to opt for becoming health educators and thereon went on to become Mass Education and Information Officers (MEIO).
- The State offers an incentive-based deployment in place for retention of skilled human resources in the hard to reach areas, which has led to an improvement in the availability of doctors in these areas.
- Under the *Muskan* initiative, all BPL and all elderly people above the age of 65 years are provided with free dentures in the state.
- The State has provided mobile phones to the male and female health workers in order to enable HMIS based reporting directly from the Sub Centre level.
- Multi-specialty surgical camps are organized in various parts of the State. The camps focus on general surgeries (elective and emergency), obstetric and gynaecological surgeries (elective, emergency and MTP), family planning (sterilization) operations and eye surgeries.
- Highly motivated and dedicated staff members were encountered in the Kangra district across all levels of facilities from the Sub centre upwards.
- Engagement of the NGOs and Civil Society participation in public health initiatives was noted to be very high at some of the facilities visited in Kangra district.

CHALLENGES

- There continues to be an acute shortage of ANMs/MPWs and paramedics.
- As a result of the total home deliveries in the state, the non-SBA home delivery figures are very high (19% as compared to 2% SBA home deliveries)
- Drug procurement system continues to be a challenge and considerable lead time (of up to six months in the procurement and supply) was noted in the field.
- There are increasing incidences of leishmaniasis and scrub typhus and no coherent plan was noted in order to address these threats.
- Persisting OOP primarily in terms of the drug purchase, was cited by beneficiaries.
- Quality of care in institutional deliveries, provision of EmOC, and safe abortions is a challenge: The SOP protocols were not visibly displayed and poor management of complications was observed.

JAMMU AND KASHMIR

DISTRICTS/INSTITUTIONS VISITED

District Kathua	District Kupwara
Government District Hospital	Handwara District Hospital
FRU/CHC Hirangar, Billawar, Bani	Kupwara (SDH/CHC) CHC Tangdar, Kralgund
24 x 7 PHC Lakhanpur, Dinga Amb PHC Bhoond	PHC Chogal, Villgam, Tregham NTPHC Durgmulla
SC Bannucchak, Gujroo-Nagrota, Durang	SC Malakpora, Kachloo, Thayam, Traboni, Pothsai
Villages Durang, Bani, Gatti, Kanthal, Chandal, Bannucchak, Gujroo-Nagrota	

REVIEW TEAM

- Dr. M.K. Aggarwal, Deputy Commissioner (UIP), MoHFW
- Dr M A Qasmi, Deputy Adviser-AYUSH
- Dr Rajesh Kumar, NIHFW
- Sh K K Makwana, Planning Commission
- Sh R K Thapar US(NRHM-Fin), MoHFW
- Mr Ashok Soni, State Project Director, PFI
- Ms Sowjanya Mediseti, SAATHI
- Dr Sonali Rawal NRHM-I
- Dr Surekha Garimella, PHFI
- Sh. Rahul Govila, FMG
- Dr Sanjay Arora, WHO-RNTCP
- Dr Amit Katewa, NVBDCP
- Sh. Rakesh Shokeen, MoHFW
- Dr Navneet Ranjan, NHSRC

POSITIVES:

- Overall, the state has adequate infrastructure, in numbers and distribution, with a wide range of services provided at DH, SDH, CHC and 24x7 PHCs including normal and caesarean deliveries, surgeries, inpatient and outpatient care.
- JSSK is being implemented effectively that curtailed out-of-pocket expenses of pregnant mother and sick neonates, except for transportation.
- Display of IEC material and signages, citizen charters, technical protocols were found adequate.
- ARSH Clinic and SNCUs are fully functional at District Hospitals.
- Immunization services are available at all levels and birth doses of Hep B and zero dose of OPV is given for institutional delivery.
- Exemplary work is being done under NPCDCS programme in Kupwara which is equipped with 4 bedded CCU, Geriatric ward, Day care chemotherapy centre and a physiotherapy unit as well as OPD services with good case load.
- Facility based HMIS reporting is being done at facility level across the State, and the data is being used for district level review meeting and monthly district level meeting.
- All the funds are being transferred from the State to the Districts and downward peripheries i.e. CHC, PHC and Sub Centres via e-transfer. Delegation of financial powers was seen at almost all visiting facility centres and DHS.
- The State has instituted a monitoring system by appointing retired CMOs as monitors who conduct regular monitoring visits at facilities in their districts.

CHALLENGES:

- Patient transport services needs to be strengthened, and given the pockets of inaccessible areas with no motorable roads, there is need to identify alternative modes of transport like the *Palki*.
- Blood banks were found only at the DH level but blood storage units at the CHCs/FRUs levels were non-functional.
- Outreach activities for immunization were deficient and children were being mobilized only to sub-centres and VHNDs for drop-outs.
- No NRCs were available in either district despite the burden of malnutrition as evidenced by the growth charts at AWCs.
- Although ASHAs have been trained in round 1 of HBNC and were knowledgeable, their opportunity to use their skills is limited, as they have not yet been provided with HBNC kits and therefore HBNC services are not operationalised.
- National Iron + Initiative/WIFS are not yet implemented in the State. IFA tablets are not available in most of the facilities visited.
- Case detection for paediatric TB needs to be improved as paediatric TB constitutes only 3% of new cases detected. TB Notification from Private Health Institutions is a lacuna.
- The state needs an HR policy to assess the gap in regular positions and to avoid substitutions under NRHM.
- The State needs to implement free essential drug policy for all at public health facilities, and strengthen its Medical Corporation for procurement and logistics.

JHARKHAND**DISTRICTS/INSTITUTIONS VISITED**

District Bokaro	District Sahibganj
Bokaro General Hospital	Sadar Hospital, Sahibganj
SDH Chas	SDH Rajmahal
CHC Nawadih, Peterwar, Chas	CHC Taljhari
APHC Chalkari	PHC Udhawa, Mirzachoki,
HSC Chapri, Harladih, Partar, Bijulia	HSC Koyla Bazar, Khorikhotana, Tertaria, Madansahi, Maharajpur, Sakrigali and Sahiya meeting
UHC Yadohadih More	VHND HSC Karalh (Khorikhotana)
AWC Pindrar	MCH, MTC, Mamata wahan
MMU Umari	

REVIEW TEAM

- Shri Dilip Kumar Director (NRHM)
- Dr Jalees Subhani, Deputy Advisor, AYUSH
- Sh. Sanjay Kumar, Deputy Director, MCTS
- Shri Vikas Arya, Dir (EPW), MoHFW
- Dr Suvesh Consultant Adolescent Health; MOHFW
- Dr J Bhattacharya, NVBDCP
- Ms Shraddha Masih, Consultant NRHM; MOHFW
- Dr Mithila, Consultant, Family Planning MOHFW
- Mr Samarjit Chakraborty, Project Director, PFI
- Dr Sachin Gupta, USAID
- Ms. Monica Chaturvedi, Senior Advisor PHFI
- Shri Prabhask Jha, Consultant NRHM- Finance
- Dr. Shalini Singh, Consultant, NHSRC

POSITIVES

- State has added substantial new infrastructure, and all CHCs and more than 90% of PHCs function through government buildings. The challenges of geographic dispersion and left wing extremism limit access to higher facilities, but the state has strengthened peripheral facilities and provided for staff quarters in sub-centres designated as delivery points.
- There is a consistent increase in figures for OPD and IPD in the last three years. OPD service utilization increased by 35% from 2009 to 2013 and for the same period a 46% increase in utilization for institutional delivery is noted, attributable to JSSK.
- “Mamta Vaahans”, a PPP initiative for transport, has contributed to an increase in institutional delivery. The state has established a referral network in all districts, with round the clock call centres at the district level. Vehicles have been arranged through local providers at the panchayat level.
- A State-specific mixed media communication strategy for Maternal and Child Health using a life-cycle approach developed by a cell for Social and Behaviour Change Communication, with expertise in Mass and Alternate media, Creative art design, Consultant media/IEC, training and capacity building.
- A substantial increase in the number of delivery points from 686 in FY-2011-12 to 909 in current FY is noted. Most of this has been at the CHC, PHC and HSC level. In the same time period the number of FRUs has gone up from 17 to 48.
- In 11 districts with high IMR, a newborn week to improve detection of high risk newborns through Sahiyas was instituted. . 10,716 newborns were visited, 578 were identified as high risk, 283 were referred and 66 infant deaths were reported.
- Malnutrition treatment Centres have been established across all the districts, and are located in high prevalence areas. All Sahiyas have been trained in identifying malnourished children and this has increased referrals to MTC by ten times since FY 2010-11.
- Ongoing mentoring and handholding by a committed Village Health Sahiya Resource centre has ensured continuous strengthening of community process. A strong Sahiya programme, well established VHSNCs, training of PRIs and members of VSHNC in community based monitoring are positive initiatives. Streamlined mechanisms have been created for -training of Sahiyas and supportive supervision is systematically undertaken using protocols of performance monitoring.
- The recruitment of regular doctors which was in abeyance since statehood was reinitiated in 2012. The state has established the HRMIS for workforce management.
- A new initiative in the form of State Review Mission every quarter to strengthen programme monitoring and ensuring supervision by programme experts.

CHALLENGES

- There is irrational deployment of medical officers in the districts and LSAS and EmONC trained MOs are not being used in strengthening FRUs.
- Availability of drugs and equipment as per 5X5 RMNCH+ A matrix is missing across the facilities. Unavailability of either equipment or reagents for routine diagnostics such as urine albumin and Hb% leads to incomplete ANC for pregnant women right from DH to HSCs. Lack of Maternal and Child Protection Cards hampers tracking of ANC status and immunization services for mother and child.

- Staff sensitization on standard protocols for Facility based new born care needs to be strengthened; need to ensure creation and optimal utilisation of SNCUs and NBSUs through adequate posting of staff trained in NSSK and F-IMNCI.
- Out of pocket expenditure still reported on drugs and some diagnostics in spite of rolling of JSSK; awareness on JSSK entitlements and free provision of drop back is low. Backlogs of JSY payments still reported in certain blocks.
- Systems for maternal and infant death review need to be improved through greater action on facility and community based reporting with verbal autopsy for all cases so that the time, place and cause of death can be identified and corrective actions can be planned.
- Consolidation of achievement in malaria made so far, ABER has decreased to sub optimal from 7.1 % to 6.9% this year and needs to be maintained at >10%. Sahiyas to be involved in case detection & treatment of Malaria to further reduce the API and balance quantity of LLIN should be procured at the earliest. Entomological surveillance activities to be started in full earnest.
- Recruitment in district level is in abeyance for the past several years and adhoc arrangements are in vogue; (53%) posts of MOs have been filled so far against the target of 2983. In addition, the State does not have a specialist cadre, which makes it difficult for the planners to identify Medical Officers with post-graduation and post them in the identified FRUs. Finding specialists willing to join the FRUs remains a major hurdle.
- Delayed payments for Sahiyas for as much as six to nine months and drug kit unavailability are two persistent challenges for the programme since the last several years and need immediate action.
- E-transfer of funds up-to Block Level, but no computerized system for the maintaining the records. Tally recently been installed in CHC&PHC but is not operational. District, Block and PHC accountant not trained in Tally ERP-9. Need for more training and support from the state level to make the system operational. Although the finance and accounts staff are trained in financial procedures regarding NRHM, they lack clarity with regard to the guidelines and procedures of NRHM.
- Central rate contracting for only 112 drugs has been done. Action taken by State Headquarters not conveyed at the district level and district level procurement of the same drugs being done Essential drug list not known at the district level and medicines tendered at the State and District level not known to field staff (MOICs or DS).
- Vacancies in the district and block programme management unit affects programme management, and Medical officers are being given additional charge. Programme managers find it difficult to discharge their duties due to limited capacities as except for adhoc orientation on certain schemes, no induction training or orientation has been conducted so far.

KARNATAKA**Districts/Institutions Visited**

District Gulbarga	District Haveri
DH Gulbarga	DH Haveri
Taluk Hospital Jewargi, Sedam	Taluk Hospital Shiggoan, Byadagi
CHC Mudhol, Malkhed, Gundagurti	CHC Rattihalli
PHC Mandewal, Jeratgi, Aurad, Mahagaon, Ambalga, Madbool, Kadganchi UHC: New Rahmat nagar, Ghazipura Urban PHC, Gullar Gali (Slum)	PHC Tadas, Attigeri, Kaginele
SC Khanadal, Kattisangavi, Mandeval, Aurad, Sindigi, Madaki, Dhottargaon, Ranjol, and Goturu	SC Neeralagi, Kuruba gonda, Attigeri
Villages Khanadal, Kattisangavi, Mahagaon, Madaki, Neeloor, Chandapur, Sindgi, Kanasur, Dhottargaon, Bennur K, Goturu	Villages Neeralagi, Tadas, Kuruba gonda, Attigeri
ANM Training Centre-Gulbarga; District Training Centre and R.F.W.T.C.-Gulbarga; Regional Drug Warehouse-Gulbarga; Schools: Sindgi, Kadganchi; Anganwadi centre : Kanasur	Ayush Hospital: Shiggoan; ANM/GNM training center Haveri; District Vaccine stores; Schools - Attigeri and Tadas; Mobile medical unit: Sheelavanta Somapura, Shiggoan Block; Anganwadi center: Devagiri; SIHFW, Karnataka drug logistics and warehouse.

REVIEW TEAM

- Dr. Manisha Malhotra, DC-MH, MoHFW
- Dr. P.K.Srivastava, JD, NVBDCP
- Mr. Zacharia George, Dy. Advisor, Planning Commission
- Dr. Raghu, Deputy Advisor, AYUSH
- Dr. S. S. Das, MoHFW
- Mr. M. K. Chowdhury, US, MoHFW
- Dr. Raveesh R Mugali, UNICEF
- Sh. Sanjeev Gupta, FMG
- Dr. Balaji Naik. R, WHO-RNTCP
- Dr. Raghunath Prasad Saini, RCH
- Ms. Chhaya Pachauli, Prayas CSO
- Dr. Shashikala, NHSRC
- Dr. Nikhil Utture, Consultant, NRHM, MoHFW, GOI
- Mr. Yogesh Kumar Singh, Planning Commission

POSITIVES

- The Karnataka State Civil Services Act, 2011 (Regulation of Transfer of Medical Officers & Other Staff) has enabled streamlining of transfers and postings.
- Overall infrastructure is adequate, with average population per PHC being 25998 and Sub centre being 6887, with 989 beds/population. Infrastructure development is satisfactory with exception of Staff Quarters.
- Rationale deployment initiative aided by a web based HR portal for regular staffs, and a compulsory six year medical service clause.
- Innovation to fill vacancies of District Nursing Officer/District Nursing Supervisor Post done by training LHV as Community Public health Nurses.
- Proportion of nurses with high level of skills across facilities is commendable
- Prasuthi Araike' Programme is popular among the beneficiaries and institutional deliveries show a steady increasing trend.
- SNCU s are in place and services are utilized well with referrals of Sick newborn.
- Effective ASHA monitoring mechanism with 10 indicator-based performance monitoring system implemented. Online system of ASHA payments is commendable.
- Karnataka Drug Logistic and Warehouse Society a dedicated agency for procurement and supply of drugs and establishment of warehouses, with a three-tiered system of drug quality check functioning effectively.
- The District PMU includes technical and management personnel. Program management staffs are in place with capacity building done.

CHALLENGES

- Financial management needs improvement- books of Accounts of the District and Block level need to be properly maintained as per the double entry system. A huge number of Advances are still pending at district level and also at State level. Regular Financial Monitoring - at all levels needed.
- Program management-Monitoring/Supportive Supervision through field visits and monitoring of follow up action needs to be strengthened.
- Drug storage systems at health facilities were weak with lack of space, shelves, poor ventilation at the storehouses, no systematic arrangement of drug storage and incomplete record keeping.
- Not all facilities had a display of list of drugs outside drug dispensing counter.
- Provision of Safe abortion services is a weak area. Medical abortion drugs were not available, and outdated technology (E.g. D& C) was still being used.
- Effective referral transport and linkages need to be ensured and multiple referrals between health facilities to be addressed.
- Quality of Maternal Death Review needs to be improved.
- ANC registers do not reflect four ANCs in most facilities. Many columns are left blank and recording of high-risk indicators of pregnancy such as BP, urine test results and others are not documented.
- Awareness about JSSK entitlements was low among JSSK necessitating active IEC campaign on services and entitlements.
- Grievance redressal Systems, Diet and drop back facility for in-patients especially delivered mothers needs to be assured particularly in Gulbarga district.
- Several vacancies noted among Regular sanctioned posts of GDMOs and Nurses

- High default rate, paediatric case notification and shortage of paediatric TB drugs seen in RNTCP

MAHARASHTRA

DISTRICTS/INSTITUTIONS VISITED

District Ratnagiri	District Nandurbar
DH Ratnagiri	DH Nandurbar
SDH Kamthe	SDH Taloda
RH Sangameshwar, Rajapur	RH Dhadgaon
PHC Shirgaon, Pawas, Sakarpa, Uni	PHC Somaval, Bilgam, Chinchpada
SC Nivegaon, Kusumb, Kalsavli, Nivebudruk	SC Saurat, Aamlad, Pati, Kakarda
VHND Karagir, Shantinagar	MMU Dhadgaon, Taloda
MMU	Boat dispensary-Dhadgaon

REVIEW TEAM

- Dr. Sila Deb, DC, MoHFW
- Dr. D Bachani, DC(NCD), MoHFW
- Ms. Jhimly Baruah, USAID Project
- Dr. Suryavanshi, RNTCP
- Dr. Nirmala Mishra PHFI
- Dr. Sanjay Kapur, USAID
- Dr. Anil Kandukuri, NHSRC
- Dr. P. R. Sodani, IIHMR
- Sh. Anil Garg, FMG
- Dr. B. R. Thappar, NVBDCP
- Ms Mrunal Pandit,FP
- Dr. Faisal Shaikh, NRHM-I
- Dr. G. C. Gaur, Technical Officer, Ayush
- Dr. Joyeta Ghoshal, TMSA
- Dr. Anil Agarwal, UNICEF

POSITIVES:

- The state has used multiple mechanisms such as Mobile Medical units (MMUs), floating dispensaries, and sub centres constructed of fibre glass, in underserved tribal/forest area to reach the underserved population.
- Strong referral network through 102 vehicles is in place, with the vehicles adhering to the GOI / NAS in design are GPS fitted, and the call centres are available in DH, enabling regular Pick and drop back services for JSSK.
- Good collocation of AYUSH services in all facilities with availability of AYUSH drugs has resulted in increase in utilization of AYUSH OPD.
- Nearly 87 % of TB patients are examined for HIV testing, with 98% of the co-infected are provided CPT and 86% are provided ART.
- Computerized drug inventory management system in place
- The State has initiated Palliative Care centre with support from Tata Memorial Hospital, Mumbai for treatment of the terminally ill.
- IEC Display at the facilities is good, with promotional materials on Sickle Cell, Tobacco control, ARSH and PC and PNDDT.
- ASHA trained in two rounds of Module 6 and 7, and display good knowledge and skills. VHSNC, RKS and DHS are registered and optimally utilising funds as per norms. Registers are well maintained.
- Innovations under IT: Health advice call centre (HACC)-104 service, Mobile delivery kit, ASHA monitoring software, Telemedicine and CME through teleconferencing are in place and functioning well.
- State has introduced new initiatives of e-filing and e-transfer, which has improved the system for speedy transfer of funds and overall efficiency

CHALLENGES:

- Newborn care corners need to be operationalized in all delivery points and equipment from non-functional sites relocated to delivery points.
- Grievance redressal mechanism (for JSSK) was not in place in several facilities.
- Supply side constraints: lack of ECPs and irregular availability of Nischay kits.
- Need for Pro-active role of ASHAs in HBNC - postnatal counselling in early recognition of danger signs, promotion of breast feeding and discouraging commercial formula feeds
- Need for strengthening the counselling of Post natal mothers in the Postnatal Wards for adoption of family planning method by cafeteria choice – condom/ PPIUCD / sterilization
- ASHA Block Facilitator roles needs to be redefined and support mechanism need to be strengthened.
- State need to analyse the approved budget/ activity and get approval for re-appropriation of certain activities requiring more funds.
- Inadequate performance monitoring of the staff and facilities, even though HMIS and staff performance monitoring software is in place.

- Poor retention and motivation of the contractual staff recruited under NRHM
- Need to establish an integrated grievance redressal system having a Common Toll Free number for managers, providers and beneficiaries to ensure better accountability and transparency in the districts.

MEGHALYA

DISTRICTS/INSTITUTIONS VISITED

District Ri Bhoi	District West Garo Hills
DH Nangpoh	MCH Hospital Tura Civil Hospital Tura
CHC Umsning, Bhoirymbong,	CHC Selsella, Ampati, Dalu, Alagre
PHC Umtraï, Umden, Byrnihat,	PHC Asanang, Babadam (PPP), Garobadha, Kherapara
SC Mawlasnai, Sonidan, Umroi, Mermain, Iapngar, Pynthor,	SC Aandharkona, Damalgre, Rimrangpara
Villages Yo Umroi, Bhoirymbong, Pynthor, Sonidan, Mawtneng, Thadnongyiaw	Village Bhalupura

REVIEW TEAM

- Dr. Sher Singh Kashotia, Asst. Dir, NVBDCP, MoHFW
- Dr. Adarsh Kumar, Asst. Dir, AYUSH, MoHFW
- Dr. Vipin, RO, AYUSH, MoHFW
- Mr. P L Verma, DS, M/o Tribal Affairs
- Dr. L. Ramakrishnan, SAATHII
- Dr. Sudha Balakrishnan, UNICEF
- Dr. Alok K Mathur, Associate Prof, IHMR Jaipur
- Dr. Gautam B, WHO Consultant, RNTCP
- Dr. Ruchika Arora, Consultant, MoHFW
- Dr. Shahab Ali Siddiqui, Consultant, NRHM-I, MoHFW
- Ms. Pallabhi B Gohain, Consultant VBD, MoHFW
- Dr. Pooja Passi, TMSA
- Mr. Venkatesh Roddawar, NHSRC
- Mr. Nikhil Herur, Consultant, MH Div., MoHFW
- Mr. Dharmendra Kumar, FMR Consultant, MoHFW

POSITIVES:

- Meghalaya Maternal Benefit Scheme (MMBS) has given an additional thrust to JSY in the state, which provides additional Rs.4000 up to 2 children.
- Outreach of routine immunization is good through VHNDs and fixed health days. Most ANMs at sub centres are knowledgeable aware and delivering services as per guidelines.
- Ri Bhoi district has dedicated AFHS centre at district hospital and CHC, which are well staffed and equipped with IEC tools and appropriate records being maintained. Around 40 functional adolescent clinics established in all CHCs and DHs and a model ARSH clinic established in Ganesh Das hospital in Shillong.
- Downward trend observed in the incidence of malaria cases, Plasmodium falciparum (Pf), Plasmodium vivax (Pv) and deaths related to malaria shows downward trend, from 197 deaths in 2009 to 52 deaths in 2012 which is 73% change in death rate.
- Facility data examined in registers at CHCs and PHCs were found to tally fully with the HMIS data – validation and verification at block and district levels appears to be strong.
- Almost all health facilities are co-located with AYUSH clinics with consultation and dispensing rooms at CHCs and DHs level.
- State has initiated piloting community based monitoring in 3 blocks each in three districts - East Khasi Hills, Jaintia Hills and West Garo Hills covering 9 blocks.

CHALLENGES:

- The state of health infrastructure shows poor level of coverage and in terms of required facilities, there is a deficit of 57%, 58% and 70% of CHCs, PHCs and health sub-centres in the state, which is one of the essential factor for improving public health outcomes in the state.
- Low utilization of MMU services observed and not well equipped to provide diagnostic services and no GPS system installed. No system in place for monitoring the performance of MMU despite the availability of DPMU and BPMU structures available in the district.
- No line listing of high-risk pregnant women, eligible couple or follow up was being conducted.
- NBCC were up and functional but in 50 % facilities ANM/SN was unable to operate the baby warmer. NBSU and SNCU in MCH Hospital were hampered by staff shortages.
- Both districts have more than 70% home deliveries (with less than 5% assisted by SBA) and around 30% institutional deliveries. However, only 2% of reported maternal deaths are reviewed.
- There is no rational deployment of HR especially when state has more than the required number of staff. Differences between DHS and NRHM on HR issues viz. recruitment, training and deployment observed. Lack of adequate training infrastructure both in terms of HR (Master trainers) and facilities observed in the state. The State only has 2 GNM schools and 1 ANMTC.
- State has many challenges in rolling out training for ASHAs due to lack of fully equipped residential training sites at district and block level. ASHAs grievance are generally related to irregular payment of disease control programme incentives like NLEP, NVBDCP.
- With respect to MCTS, high numbers of home deliveries leads to some mothers and children not being included in MCTS. Delays in MCTS report and work plan generation, leads to limited use of data by frontline health workers for planning and gap identification.

Seventh CRM Report

- Cashbooks are not closed on a daily basis. It is observed that in Nangpoh DH, daily cashbook balance were not maintained appropriately. Most facilities do not prepare Bank Reconciliation Statement (BRS) on monthly basis.
- EDLs were displayed, but some essential drugs IFA, Zinc, Vit -A, Vit-K, Misoprostol and supplies like gloves were not available in either district, and at state levels.
- Free Drug policy not implemented and out of pocket expenditure found to the amount of Rs.100 was observed for many patients. Simple drugs like Diclofenac, Inj. Realgen, Syrup Quinine were being bought from outside.
- State proposed NUHM in three major towns – Shillong, Tura, and Jaintio Jo wai. Three towns cover 68 slums out of which 29 are notified slums. However, Urban RCH Service delivery indicators like ANC and PNC show poor performance (31% ANC, 19% PNC)

NAGALAND**DISTRICTS/INSTITUTIONS VISITED**

District Dimapur	District Peren
District Hospital Dimapur Nursing School District Laboratory	District Hospital Peren
CHC Medziphema, Dhansiripar	CHC Jalukie
PHC Molvom, Sirginijam, Neuiland, Chokodima	PHC Tenning ,Azailong, Ahtihbung
SC Tsiepama, Diezephe, Bade, L. Vihoto, Manglimukh, Doyapur Town health sub center - urban health post	SC Samzuram ,Mhainamtsi, Punglwa,Bongkolong
VHND Aoyimiti, Aoyimchen	VHND Jalukie B, Nchangram
Maova – village community center Nursing school Dimapur District TB Hospital AYUSH Pharmacy and Drug testing centre	IRC centre, Jalukie
Burma camp slums New Market red light areas	Marketplace near Punglwa

REVIEW TEAM

- Dr. Pradeep Haldar, Dy. Commissioner, Immunisation, (MoHFW)
- Mrs. P Padmavati, Assistant Director, NRHM, (MoHFW)
- Dr. K C Meena, Dy. Assistant Director, NVBDCP (MoHFW)
- Dr. Suresh Dalpath, Dy. Director-Child Health (Govt. of Haryana)
- Ms. Upasna Varu, HIV Specialist (Unicef, Guwahati)
- Mr. V R Raman, Principal Fellow, Health Governance (PHFI)
- Dr. Manoj Singh, Consultant, Community Participation (NHSRC)
- Dr. Rajeev Agarwal, Sr. Consultant, Maternal Health (MoHFW)
- Dr. Ravish Behal, TMSA
- Dr. Nitasha M Kaur, Consultant, NRHM (MoHFW)
- Mr. Arun Unnikrishnan, DNIP Care
- Mr. Rajeev Prasad, Finance Assistant, FMG (MoHFW)
- Mr. Rajeev Kr. Bhalla, NRHM (MoHFW)

POSITIVES

- The pace of construction for infrastructure in the state is good, with all the work being undertaken in the last two years almost complete.
- Standard Operating Protocols (SOPs) on MNCH, infection control, asepsis and waste disposal in Labour rooms and Operation Theatres were in place
- There is significant progress in setting up facility based newborn care services. Newborn care corners were available at all visited sub-centre/ PHCs / CHC delivery points
- VHND emerges as a good platform to deliver comprehensive health services- ANC check-up, immunization, and general OPD, with active involvement of VHSNCs members comprising of village head, church member and village youth.
- The process of communitisation of health services is strong in Nagaland. ASHAs were found to be overall adequate in numbers, training of module 6 and 7 is going on in the State, ASHA performance monitoring is being done regularly. IEC material in all the facilities was displayed in local language,
- RD Kits for malaria and ACT available at all facilities from GoI (NVBDCP) supply.
- NGOs coordinating Targeted Interventions with good coverage of vulnerable communities, and not just limited to the areas they receive financial support for.
- Good integration with NACP initiated through pooling of Lab. Techs (NRHM/ DHS/ NSACS), ICTC Counsellors providing ARSH services; RKS fund used for local purchase of OI drugs.
- In Dimapur district, urban slum populations are well organised (have unions) and are supporting health system in some areas, by way of providing land for health facility, identification and mobilisation of target population. Community leaders were enthusiastic about the launch of NUHM and ready to continue their support.

CHALLENGES

- The major gap in the Infrastructure is a relative shortage of Staff quarters.
- Due to low population coverage by facilities, utilization of services is sub-optimal in the health facilities.
- Poor awareness and practices related to segregation of biomedical waste at point of generation, and its disposal.
- State has 76 level ambulances linked to 102 call centre. Ambulances are GPS fitted, installed vehicle-tracking system and are stationed at district and block level facilities. However, the toll free number is not functional and GPS software is not working due to lack of maintenance. Further, poor network coverage is resulting in non-connectivity of calls to ambulance drivers and utilisation of referral transport services is poor.
- DH and CHC do not have adequate complement of specialists, which is a challenge
- Under JSY, Cash payments were being made to beneficiaries and ASHAs, and rather than ensure cashless services under JSSK, cash was given to the women for provision of diet and Referral Transport
- Some of the essential drugs not available such as IFA syrup, Zinc Tablets, Inj. Mag. Sulph, Vitamin A.
- Maternal deaths were found unreported.

Seventh CRM Report

- Out of pocket expenses still being incurred on drugs, blood (for screening tests), and diagnostics. Some officials and district personnel were still unaware of JSSK entitlements, despite the display of JSSK entitlements in all health facilities. There was poor awareness of free entitlements among staff at all levels, and ASHAs.
- RTI/STI and MTP services are not being provided at any level except DH. IUCD insertion service quality is a concern – high (30-40%) removal rates seen in Peren District.
- Record keeping was found inadequate. There was underreporting of vaccinated children in MCTS and HMIS registers.
- Poor knowledge and skills of danger signs among ASHA for HBNC visits indicating training gaps; evaluation and practicing of skills during training is not being done
- VHSNC untied funds predominantly used for conducting VHND, including for TA/ DA and honorarium for ANM and ASHA
- Lack of coordination between different departments like ICDS, Health, Nutrition etc. during VHND.
- There is poor monitoring and supervision and the data is not being used for taking corrective action.

ODISHA

DISTRICTS/INSTITUTIONS VISITED

District Jajpur	District Koraput
DH Jajpur	DH Koraput
CHC- Dhanagadi, Jajpur Road, Barchana	CHC- Jeypore, Rabanaguda, Laxmipur
PHC- Gobardhanpur, Kabatabandha	PHC- Badajeuna, Kudnder
SC- Ranagondi, Jakhapura, Neulpur, Kadei, Jaraka, Raipur	SC- Umri, Konga, Kakiriguma, Bhatargada, Kellar
GKS- Suliya, Chahata	GKS - Umuri
VHND-Jaraka village, Neulpur village	ASHA Training
ASHA training center- NISW	VHNDs

REVIEW TEAM

- Dr. Ajay Khera, Deputy Commissioner (Child Health and Immunization), MoHFW
- Dr. G.S Sonal, Addl Director, NVBDCP, MoHFW
- Dr. Renuka Patnaik, Consultant(Family Planning), MoHFW
- Dr. Dinesh Jagtap, Senior Programme Manager, PHFI
- Dr.Sai Shubhashree Raghavan, President, SAATHI
- Dr. Indranil Ghosh Mondal, Assistant Adviser(Homoeopathy), Department of AYUSH, GOI
- Dr. Neha Kashyap, Consultant (NRHM-Policy and Planning), MoHFW
- Dr. S. N Pati, Regional Director, MoHFW
- Mr. Alok Kumar Verma, Director (Statistics), MoHFW
- Dr. P. K Patnayak, National Consultant (Central Leprosy Division), MoHFW
- Dr.Sharad Kumar Singh, Consultant (Child Health), MoHFW
- Mr.Sumanta Kar, Consultant (Finance), MoHFW
- Dr. Anchita Patil, National Programme Officer, UNFPA
- Mr. Nishant Sharma, Consultant, NHSRC
- Ms. Deepika Karotia, Consultant, Planning Commission

POSITIVES

- The state has undertaken several measures to ensure a well-functioning ASHA programme. These include direct e- transfer of funds into the bank accounts of ASHAs on 10th of every month, social recognition of awarding the best performing ASHAs at District and Block level, using the ten indicator performance monitoring system, career progression to select ASHA as ASHA SATHIs and preference in admission into ANM and GNM courses.
- There has been a significant expansion in the reach of family planning services, with the doorstep delivery of contraceptives and motivation of women for IUCD insertion by ASHAs.
- Odisha has launched e-Blood bank facility, an innovation that enables electronic monitoring of blood collection, testing, storage, usage and disposal in 59 government blood banks across the state. It also allows the users to get blood group wise stock availability status in the Blood Banks.
- AYUSH MOs play many roles. In addition to managing AYUSH OPDs they also handle Adolescent Family Health Clinics (AFHCs), are trained in skilled birth attendance, and are involved in the outreach activities under NRHM.
- State has undertaken several measures for Dengue control, viz. Massive IEC campaign called “Malaria Dengue Diarrhoea”; regular multi stakeholder meetings; Involvement of District & Block Administration staff; deployment of volunteers in awareness, active surveillance & eliminating breeding sources; training of master trainers in Dengue vulnerable districts.
- Microfilaria Rate (Mf Rate) has been showing consistent decline from 2.5 in 2004 to 0.4 in 2011 which may be attributed to the increased compliance to drug consumption in the state over the last years.
- “Mo-Mashari” (*my mosquito net*) scheme for pregnant women, students and inmates in tribal residential schools and NidhiRath campaign for creation of community awareness about benefits of using mosquito nets show positive impact.

CHALLENGES

- Slow progress in completing infrastructure: Construction of MCH wing at DH Jajpur and Koraput has been sanctioned for over the last 2 years but no progress was seen.
- Many sub-centres function out of rented buildings where there is no residential accommodation for the ANM or where the space lacks basic amenities such as toilets, or a bathroom.
- Residential accommodation facilities for staff were not available even at the higher facilities like DH and CHC-FRUs in Jajpur and Koraput.
- Currently, only 11% of PHC serve as delivery points despite the availability of a fair number of trained staff, leading to high burden and overcrowding in the district hospital.
- Low uptake of PPIUCD was seen in Jajpur and no uptake was in Koraput despite the adequate availability of trained manpower.
- Only the District Hospitals and in select CHCs provide Comprehensive Abortion Care services, resulting in reduced access.
- There is a huge shortfall of staff in the categories of Staff Nurses, Radiographers, and Specialists with respect to population based IPHS norms. State needs to revise the number of sanctioned posts to catch up with the rising requirements.

Seventh CRM Report

- Although Monitoring & Supervision visits are being undertaken by District Accounts Manager and District Programme Manager, no reports were available for verification nor was there any ATR by CDMO for these visits. This needs to be addressed given that expenditure on this head is almost 80% of what is available.

UTTAR PRADESH

DISTRICTS/INSTITUTIONS VISITED

District Pratapgarh	District Mathura
District Hospital-Male & Female	District Combined Hospital, Mathura District Male Hospital, Mathura District Women's Hospital
CHC Kunda, Raniganj (Block CHC)	CHC Faraah, Goverdhan
PHC Babaganj, Mandhata (Block PHC)	PHC Chatta, Sonai
SC Besaihya, Baraipur, Jariyari	SC Ranhera, Lohaana, Ol, Ading
Urban Health Post Ajitnagar	Urban Health Post Sukhdeo Nagar
VHND Baraipur, Raipur Bhagdra, Kaithola Bazar	VHND Bahai
	ANMTC Mathura
FGD at ANM Meeting, ASHA Training, Home Visits, interaction with women –Post Natal Ward	

REVIEW TEAM

- Dr Himanshu Bhushan, DC (MH-II), MoHFW
- Dr A.K. Puri, ADG, Leprosy, MoHFW
- Dr. Biswajit Das, Dir (Evaluation), MoHFW
- Sh. Padam Khanna, Sr.Consultant, NHSRC
- Dr. Rajeev Vishnoi, RNTCP Consultant
- Dr G.P. Garg, Sr. Chief Chemist –Ayush
- Ms Chaitali Mukherjee, PHFI
- Ms Anagha Khot, USAID
- Dr Praveen Bhalla, BMGF
- Mr.Gurminder Singh Talwar, TMSA
- Dr Arpana Kullu, NRHM Consultant
- Dr Nimisha, FP Consultant
- Ms Isha Rastogi, FMG
- Sh. Vindhesh Kr. Singh, Cons, Finance, SCML, Communicable Disease

POSITIVES

- Out of 20,521 sub health centres, 3510 SHCs are conducting more than 3 deliveries per month (17%) and out of 417 (24/7) PHCs, 388 are functional as delivery points; conducting more than 10 deliveries per month (93%). The services including Out Patient, emergencies and delivery at delivery points were available round the clock.
- Training Sites and the trained staff for PPIUCD has been increased in the state and counselling was also made an important part of the training;
- RBSK and WIFS programme is integrated with the school health program in the state, and is functioning effectively with regular screening and good record keeping in schools.
- Services are provided to the community at their doorsteps through Village Health & Nutrition Day and wherein immunization, ANC and PNC check are being provided to beneficiaries.
- Around 988 GPS fitted ambulances are functional under 108 service and 972 ambulances (Non GPS fitted) are operating in the State under 102 service.
- In both the districts, ASHAs played a prominent role in motivating pregnant women for utilization of ANC services from government health facilities. Most of the ASHAs were found to be vibrant and active, for promotion of institutional deliveries and immunization, making regular visits to mothers/pregnant women in their villages and counselling them.

CHALLENGES

- The number of Delivery Points are inadequate and not uniformly distributed: 26.25% (Pratapgarh) and 18% in Mathura
- Inadequate EmOC services in both districts (C-section rate only 2% at Pratapgarh and 1.4% at Mathura) with no plans in place for improving EmOC services.
- Out-of-pocket expenses reported by beneficiaries on drugs/diet/blood/consumables.
- Weak outreach and home visits for ANC, PNC, identification of ARI, diarrhoea and malnourished children. No line listing of severely anaemic women and identification of high-risk pregnancies being done at SHC/PHC.
- Only one functional and well maintained NRC at DH Pratapgarh, however admission through outreach referrals was only 14% indicating poor detection and referral by frontline workers.
- High vacancy rate seen among critical staff. For instance, vacancies of SNs (regular staff) are 75% in Mathura and 72% in Pratapgarh. Majority of the staff nurses are hired on contractual basis and efforts for filling up regular positions.
- Timeliness and structured mechanism for drug replenishment was lacking. Nischay Kits were being purchased by ASHAs themselves to ensure that pregnant women accompany them for delivery.