REPORT ON
7TH COMMON REVIEW MISSION
HIMACHAL PRADESH

Ministry of Health & Family Welfare, Government of India

9th – 15th November 2013

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

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EXECUTIVE SUMMARY

Key Observations

Service Delivery

There has been an increase in the trend of OPD and IPD patients in the State. The average OPD visits in 2012-13 were 1.4 visits per capita. Majority of health facilities are in the public sector, therefore the dependence on the private sector was not found to be dominant. 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. State could create infrastructure based on IPHS Standards matched with local needs. All the facilities visited were neat and clean, with patient amenities like drinking water and waiting area. However, under-utilization of facilities has been observed in the field, especially in Chamba district. There are 171 EMRI (108) ambulances for emergency response transport (National Ambulance Sewa) in the State with a centralized call centre at Shimla. There was wide awareness and acceptance of the 108 services in both the districts visited, as inferred from interactions in the community and 108 service numbers were displayed at many strategic locations. However, the condition of State run ambulances was a concerns as 6 out of 13 state run ambulances were not operating since last year. Choice of AYUSH systems of medicine has not been effective as AYUSH Medical officers posted under NRHM at co-located facilities were had to practice modern medicine due to lack of AYUSH drugs and supporting personnel. State do not have an IEC/BCC strategy plan in place and most of the IEC activities were geared around observation of key national days. Even the available state cadre for IEC work was not utilized fully for the stated works and demand generation of services.

Reproductive and Child Health

There are a total of 116 delivery points in the State. 74 out of 116 the delivery points (64 %) are 24x7 facilities, primarily the civil hospitals and CHCs. Tertiary care is provided at 26 facilities across the State, with all the DHs and Medical Colleges being CEmOC centres, in addition to 11 Civil Hospitals and 1 CHC. The lack of effective planning for up gradation of facilities for providing RCH services was evident in the field, in Chamba, with irrational distribution of physical infrastructure and equipment's. One PHC at Rajnagar was having 2 storied building equipped with operation theatre, but only a general duty doctor sanctioned and posted. Similarly, sonography machine was installed in a Civil Hospital, but has not been put to regular use for lack of personnel to operate it. There are 18 blood banks in the State, spread across the 12 districts; of these the maximum number are available at Kangra and Shimla, which have 4 blood banks each.

The percentage of ANC registered in the first trimester against the reported ANC registration has steadily increased, indicating an increasing mobilization over the years. Nevertheless, it still remains below 50% in the current year. The 3 ANC checkups as against the ANC registrations in Himachal Pradesh is reported as 80%. Appropriate tracking mechanisms to ensure that the women registered for ANC checkups are followed through up to their 3 ANC visit needs to be in place. The public facilities record more than 80% of the total Institutional Deliveries reported - 81% in both 2011-12 and 2012-13 and 84% in 2013-14. The home deliveries have been reduced by half in the last 5 years. Of greater concern is the fact that only 10% (as on 2013) of home deliveries were conducted by SBA trained personnel. Two Nutritional Rehabilitation Centres are being established at IGMC, Shimla and RPMGC Tanda where children up to 5 years with malnutrition are to be treated and nutritious food will be provided. ARSH clinics, known as the Yuva Pramarsh Kendra, have been established across all the District Hospitals in the State. The WIFS programme has been rolled out across the State and around 7 lakh children are covered. The Menstrual Hygiene programme, under which subsidized sanitary napkins are provided to adolescent girls was rolled out in four districts in the first phase – Mandi, Bilaspur, Hamirpur and Una. Under RBSK, the schools are divided into clusters and teams of 14-16 members visit the clusters on scheduled dates. There was good co-operation between the Anganwadi workers as well as the ANMs and school health teams for the administration of the WIFS tablets. School staff interacted with the team shared that the school health programme has been useful and that majority of the issues identified were managed at the team level itself.

The beneficiaries interacted with were well aware of the benefits of JSY and JSSK, as well as provision of free services for delivery under the flagship programme of JSY and JSSK in Kangra but the reverse was observed in Chamba where the awareness was very low. JSY benefit distribution was observed as very slow in Chamba district, and the attitude of the staff in providing the benefit to eligible beneficiaries informed was not supportive. Direct Benefits Transfer (DBT) was not yet operationalized in Kangra district, but has been functioning in 6 districts of Himachal Pradesh, including Chamba. Delay in payment for reasons including want of documents to open bank accounts, and instances of cash payments have been observed in Chamba district. JSSK is operational in the State. The beneficiaries interacted with at the hospital as well as the community was aware of the programme.

Disease Control Programmes

- IDSP has been operationalized in the State from March 2004 onwards. V- SAT had been installed at all the 15 sites in the State (12 Districts, 2 Medical Colleges & 1 State Headquarter). However, currently these are not functional because of hardware related reasons since a few years.

- Under NVBDCP, there was good availability of reagents and stains across majority of facilities visited. In addition, availability of drugs for chemoprophylaxis as well as for treatment ensures disease rates can be effectively controlled. Decrease in incidence of total Malaria and *P.vivax* malaria after 2011 was noted. Surveillance activities need to be improved so as to increase the current ABER rate from 7.4% to a target rate of 10%.
- The reason for concern however is diseases like scrub typhus and cutaneous Leishmaniasis. Since May 2013, 3027 cases of Scrub typhus have been suspected, out of which about 1/3 turned out to be confirmed.
- Global objectives of case detection and treatment success rate under RNTCP are being achieved by the State since last 7 years. There is provision of free diagnostic services through 180 DMTCs and free of cost treatment through DOTS centers in all health facilities including Ayurvedic facilities, Anganwadi Workers and community volunteers. Case-based web entry system of all diagnosed TB cases in NIKSHAY portal has been implemented in the State.
- Implementation of the NLEP programme was good with MDT medicines and equipments available at the facilities visited.
- Under the first phase of the NPCDCS programme, three districts of Chamba, Kinnaur and Lahaul &Spiti have been selected. In Chamba it was launched in 2010 whereas in Kinnaur and Lahaul & Spiti it was launched in 2011. Screening facilities for diagnosis and Hyper Tension are made available at Sub Centers. In addition, various camps for detection were conducted and the suspected cases were then referred. Awareness camps for early diagnosis and treatment were also conducted.

Human Resources and Training

The State continues to face challenges in terms of the rational deployment of staff across the facilities. State provides for incentives for the medical staff at extremely hard terrain areas and in order to encourage the posting of available contractual MOs and specialists, the govt. of HP has framed an incentive scheme in addition to the fixed salary. As per the HR status as on visit, there was a vacancy of 45% of MPW (males) and Lab technicians in the State, followed by 17% pharmacists, 14% staff nurses, 8% ANMs and 5% MO's. The greatest vacancy is present among the MPW (male) cadre. There have been no recruitments in the cadre in recent years and the last trainings for MPW (male) were conducted in the year 2002. It was observed that existing manpower at some of the facilities visited either have the skill sets but no support in terms of infrastructure or have the infrastructure in place but not the necessary manpower to carry out the same functions efficiently, therefore, rationalization in this areas in required.

Community Processes

- The PRIs were involved in Kangra and there was good involvement of the representatives in the functioning of the VHSNC, RKS and District Health society. However, the picture is the opposite in Chamba were no active involvement of PRIs was observed, especially in the case of VHSNCs.
- 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 VHSNCs were active in Kangra District. VHSNCs have been formed in all the 283 Panchayats in Chamba, however, the committees were not able to utilize the funds. The participation of Panchayats and other functionaries was minimal.
- Regular VHNDs were held at Kangra. The female health worker has a beat programme chalked out at the beginning of every month and carries out her activities as per this schedule.
- Community monitoring was lacking in all the sites visited by the team. Community has to be engaged to enhance their participation in planning and monitoring various government schemes.
- The State does not have the ASHA cadre in place, and recruitments are planned from December, 2013. The ASHA work profile and job responsibilities have been listed out based on the GOI guidelines. However, some of the functions of ASHA are currently undertaken by Anganwadi Workers in the State.

Information and Knowledge

Service delivery reporting is being done mainly through DHIS in the State, which has been integrated with the national HMIS indicators. Recently, State has initiated the process of shifting to facility based reporting in the National HMIS web portal. Accordingly, facility based reporting is being done in both districts visited. One of the good practices observed in the State was that mobile based reporting from the SC level is given a thrust. MCTS has been functional up to sub center level. However, State is yet to achieve 100 % reporting from facilities as shown in the table below. Printed registers have been observed at sub center levels in both districts visited by the team. Data entry to the web-portal was done at block level.

Health Care Financing

The functions of RKS have improved (GB Meeting, CA- Audit, and Representation from PRI in RKS meetings). Funds are transferred electronically from DHS to Blocks, thereby reducing the float time for clearance of funds. Most of the HR positions under Financial Management have been filled in. The State has maintained books of accounts in customized version of Tally ERP-9. At DHS also books of accounts have been maintained in Tally ERP-9.0. The State is regular in its Financial Reporting to

Ministry. However, the same regularity was missing at DHS and Block levels. Statutory Audit had been done in 2012-13 and State had submitted the Statutory Audit Report along with Audited UCs for the F.Y. 2012-13. The team did not go through the audit report as it was not mandated as per the TOR.

Medicine and Technology

State has prepared an Essential Drug List comprising of 314 medicines and consumables. The State has rolled out a free drugs scheme for BPL patients, which provides 38 medicines free of cost to all eligible patients across public facilities. This scheme was operational in both districts visited by the CRM team. There were no specific policies for assuring diagnostic services in the public facilities especially in remote areas like Chamba. The facilities were not able to assure lab services to public mainly because of the shortage of staff to provide lab services round the clock or even during the day shifts. State has taken actions such as outsourcing of diagnostic services post noon at zonal, regional and civil hospitals which have higher case loads. Availability of equipment's gives out a mixed picture as the team observed lack of equipment's in some facilities while found them lying idle in some other facilities. Drug procurement systems in the State is through 3 channels – the civil supplies, *Jan oushudhi* outlets and through local purchase. The team found lack of clarity on the drug procurement at various levels leading to increased lead-time resulting in non-availability of free medicines. Drug inventory management system at facilities needs attention from the higher levels. There was no proper recording of the drugs, including supply and distribution, under BPL free drugs scheme in facilities visited. The system of distribution of drugs to the user facilities (PHC, CHC, CH, etc) was found to be opaque.

National Urban Health Mission

Urban slum mapping has been done in Shimla and there are 35 slum areas notified as the high risk areas. Additional support has been sought in terms of the up gradation of 2 existing PHCs which cater to the slum population. Mobile health units have been proposed in order to render services to the urban slum community.

Governance and Management

The current programme management structure in the State includes State Programme Management Unit, District Programme Management Unit and Block PMUs. The DPMUs and BPMUs were found as weak with shortage of man power, especially in Chamba. State has created the Block Medical Officer position exclusively for management of public health interventions at Block level. District health societies have been functional in the State. Block and district health action plans have been developed. State has rolled-out supportive supervision in the districts and plan and formats for

supportive supervision visits have been communicated down to block levels. Visits have started taking place. However analysis and feedback from visits is yet to be initiated. Requirement of intensive monitoring from State level is felt in remote areas such as Chamba where progress under NRHM has been lagging. This is specifically required for ensuring delivery of maternal and child health services, utilization and accounting of funds, making people aware of the entitlements under various schemes, and for better functioning of VHSNCs and PRI involvement.

Key Recommendations

Service delivery

- Since the State has set up good infrastructure for many facilities, now it may focus more on providing the range of services envisaged for each type of facility. A clear road map with priority actions and timelines must be prepared at the earliest and action in this front shall be initiated.
- The pickup rate of 108 ambulance services has further scope for improvement. Local arrangements at current provider rates can be explored to ensure pick-up and drop back of pregnant women and children.
- Choice of different systems of health care needs to be fully provided to the patients by enabling the AYUSH Medical Officers posted at these facilities for practicing the system of medicine they are trained in.
- State has to develop a clear IEC/BCC strategy and IEC plans may be prepared accordingly. One of the key areas for focus can be demand generation for various services, especially RCH services.

Reproductive and Child Health

- Operationalization of FRUs and designated delivery points should be a priority. State may implement measures such as capacity building and rational deployment of staff, rational placement of equipments along with staff to operate them, etc, based on a clear plan for operationalizing these facilities.
- High risk pregnancy tracking and line listing of anemic women needs to be ensured at sub center level and should be monitored regularly.
- Development, dissemination and display at workstations of protocols and Standard Operating Procedures (SOPs) are essential for ensuring the basic quality of services provided at facilities.

- While the efforts for increasing the acceptability of institutional deliveries are to be paced up, State has to ensure that the home deliveries happening are 'safe' through scaling up SBA trainings and ensuring that home deliveries are attended by SBAs.
- State may ensure that micro- plans for immunization are prepared at sub- center level and are used in planning and mobilizing children for VHNDs.
- Mentoring support mechanism with support from medical colleges, streamlining of supportive supervision, exposure and cross learning visits with better performing districts in the State and other States, etc may be carried out for increasing the capacity of the local health systems in the state.
- Bio-medical waste management and iinfection prevention practices need to be improved.
- Public grievance redressal mechanisms should be streamlined and high case load facilities may be prioritized initially.
- District administration may explore the possibilities of interface with available banks in the vicinity to overcome the issue of delay in JSY benefit disbursement for lack of documents.

Disease Control Programmes

Rigorous use of IDSP data in planning process**,** improvement in surveillance activities to increase the current ABER rate from 7.4% to a target rate of 10%, sensitization and involvement of private health providers to increase TB, especially paediatric TB, detection and notification of TB cases, and study to understand the diabetic prevalence in hilly areas are suggested to increase the effectiveness of disease control programmes.

Human Resources

Filling up of regular vacancies, formulation of rational deployment policy to aid in deployment of staff at appropriate facilities, evaluation of existing incentive scheme for doctors and other HR, and setting up a mechanism for ensuring intended service delivery after key technical training such as SBA are recommended to ensure availability of staff and service delivery, especially in hard to reach areas.

Community Processes

- State needs to focus more on enhancing the community processes envisaged under National Health Mission such as PRI involvement in RKS and VHSNCs, functioning of VHSNCs, and involvement of community level health workers/volunteers such as Anganwadi Workers and ASHAs.

- Health Educators and other health functionaries need to be more involved in the activities of VHSNCs, and VHNSCs must be mainstreamed at higher level such as districts and the State.
- Better documentation of VHNDs is suggested along with proper monitoring of their outputs by different levels from PHCs to the State.
- State needs to have a clear strategy and work profile for the ASHAs, which are specific to the State's needs, as some of the functions of ASHA have already been undertaken by Anganwadi workers.

Medicine and Technology

- Mapping of existing equipment's and review of their usage may be completed and appropriate actions such as relocation of equipments lying idle to facilities where they could be used might be initiated.
- Medicines having shortage should be supplied to the facilities at the earliest or alternate arrangements for ensuring drug availability may be made. Facility level EDL must be prepared and the availability of drugs as per EDL must be ensured at all facilities.
- The IT enabled procurement and logistics management system for medicines and equipment's shall be set up on a priority basis to improve the procurement and supply of medicines and to ensure their availability for the public. The design must address the issues identified by both 5th and 7th CRM.

National Urban Health Mission

- Targeted approach and strategy to reach out to most vulnerable and hard to reach populations needs to be developed.
- Also, emerging health care issues of urban populations must be identified and proactively addressed.

Governance and Management

- Review and strengthening of District and block programme management units is essential to improve planning and monitoring activities.
- Regular monitoring of RKS financial performances is required to ensure that the funds are used effectively for intended purposes.
- Feedback from supportive supervision shall be provided to the facility at the end of each visit and a copy may be handed over to the concerned facility-in-charge. Progress made by the facility may be monitored in further visits.

- Apart from the existing monitoring mechanism of reporting and monitoring through video-conferencing with district health officials, State may intensify direct visits and explore options like mobilizing technical support for monitoring and technical support from Medical colleges in the region and development partners. State shall fasten the establishment of District level vigilance and monitoring committees and involve then in monitoring the progress in NRHM implementation in the respective districts.

INTRODUCTION

A. Schedule of CRM visit

- A 14 member team visited Himachal Pradesh from 8th November, 2013 to 15th November, 2013 for the 7th CRM.
- The CRM team reached Shimla on 9th November, 2013 where a debriefing meeting was held under the chairmanship of the Mission Director, NRHM, Himachal Pradesh.
- Following the presentation, the team proceeded to District Kangra. At Kangra, the team was divided in to two and one team proceeded to Chamba on 10th November, 2013.
- Between 10th and 13th November, the teams met with the respective district officials and visited various facilities in the districts (*Table 2*). Both the teams returned to Shimla on 14th November.
- A debriefing presentation on the findings by the CRM team was made on 15th November to the Mission Director and State officials.

Table 1: Team Composition

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

Table 2: List of facilities visited

Facility	Kangra	Chamba
District Hospital	Zonal Hospital, Dharamsala	Regional Hospital, Chamba
Medical College	Tanda Medical College	-
Civil Hospital	Palampur, Nurpur, Kangra	Chowari
CHC	Nagrota Bagwan, Shahpur	Bharmor, Sahoo
PHC	Chamunda, Tiara, Kheria	Rajnagar, Bathri, Banikhet
SC	Seerthana, Jadrangal, Sidhbari, Kohli, Baranda	Kalsui, Rajnagar, Kiani, Lahal, Sarol

Others	Regional Training Centre, Kangra Urban Slum, Dharamsala Villages	Anganwadi Rajnagar & Bharmor Govt. High School, Rajnagar Primary School, Bharmour

B. State Profile

Himachal Pradesh is a State in Northern India. It shares its borders with the States of Jammu and Kashmir on the north, Punjab on the west and south-west, Haryana and Uttarakhand on the south-east and the Tibet Autonomous region on the east. Himachal Pradesh is the least urbanized State in India with nearly 90% of the population living in the rural area, except for Shimla district, which has 25% of the people living in urban areas. There are 12 districts in the State, with the State capital located in Shimla. Himachal is administratively divided into 3 zones namely:

- **Shimla** – Shimla, Solan, Kinnaur and Sirmaur
- **Dharmashala** – Kangra, Chamba, Una and Hamirpur
- **Mandi** – Kullu, Mandi, Lahaul & Spiti and Bilaspur

Figure 1: Map of Himachal Pradesh

Himachal Pradesh fares better than the national average across all the health indicators. Both the districts visited are different from each other in various demographic and health parameters - while Chamba is an identified high priority district and larger in size than Kangra, the population density, at 80 persons per square km, is much lesser. The sex ratio of Himachal Pradesh is higher than the national average. Among the districts, although Kangra has a higher sex ratio than Chamba, its low child sex ratio is a matter of concern and this is similar to the trend observed in the adjoining States of Punjab and Haryana, with which it shares its borders.

Table 3 : Key Demographic Indicators

Indicator	Himachal Pradesh	Kangra	Chamba
Area (Sq Kms)	55,673	5,739	6,528
No. of Districts	12	-	-
No. of Villages	20,690	3,868	1,591
No. of blocks	70	15	7
Population – Male (Census, 2011)	34,73,892	748,559	261,320
Population – Female (Census, 2011)	33,82,617	758,664	257,760
Total Population (Census, 2011)	68,56,509	1,507,223	519,080
Population Density	123	263	80
Sex Ratio (females per 1000 males)	974	1013	950
Sex Ratio (0-6 yrs)	918	873	950
Literacy Rate (per cent)	83.78	84.69	73.19

Source: Census 2011

A similar trend is observed across the health indicators. The Infant Mortality Rate (IMR) and Under 5 Mortality Rates (U5MR) are much lower than the national average. Himachal also has a Total Fertility Rate (TFR) of 1.8, much below the replacement level of 2.1.

Table 4 : Key Health Indicators

Indicator	India	Himachal Pradesh
MMR (per 1000 live births) *SRS 2012*	178	NA
IMR (per 1000 live births) *SRS 2013*	42	36
U5MR (SRS 2012)	55	46
TFR (SRS 2012)	2.4	1.8

The key targets and achievements of the health indicators are set out by the State. The following table highlights the same:

Table 5: Targets and Achievement

Indicator	Expected Outcome	Achievement
Maternal Mortality Rate	100 per 100,000 live births	196 (as per ICMR Study) 156 (as per survey conducted by Techno pack commissioned by NRHM H.P in 2011-12)
Infant Mortality Rate	30 per1000 live births	36 SRS (2012)
Total Fertility Rate	2.1	1.8
Malaria Mortality Reduction Rate	60% by 2012	Achieved
Kala Azar Mortality Reduction Rate	100% by 2010 and elimination by 2012	No Deaths reported in 2012.
Dengue Mortality Reduction Rate	50% by 2010 and sustaining that level until 2012	NA
Cataract operations	2012-13 (21,000) 2013-14 (23,100)	2012-13 (161 %) 2013-14 (55 % till Sept.13)
Leprosy Prevalence Rate	Reduce from 1.8 per 10000 in 2005 to less than 1 per 10000 thereafter.	Achieved. Current Rate is less than 0.21
Tuberculosis	Maintain 85% cure rate through entire mission period and also sustain planned case detection rate.	Achieved Current Cure Rate is 88%

Source: NRHM Status, September 2013, HMIS, HP

C. 5th and 7th CRM Observations

Himachal Pradesh was one of the States visited during the 5th CRM. While the State has taken considerable initiatives to address the various concerns raised by the 5th CRM team, a few observations made during the 7th CRM are similar to that of the 5th CRM observations. The following table compares the observations made during the 5th CRM and the findings of the 7th CRM team.

Table 6

Sl. No.	Vth CRM Recommendations	VIIth CRM Observations
1.	Acute shortage of ANMs and nurses and paramedics could be overcome by expediting regular recruitment, and decentralizing contractual appointments to district level. Creation of nursing positions also urgently required.	Shortage of ANM and Male health workers as well as staff nurses persists in the State. State reported that it is considering the outsourcing of nursing cadre in the coming years to address the shortage of nurses.
2.	Responsive and transparent	The State had considered HP Medical Service

Sl. No.	Vth CRM Recommendations	VIIth CRM Observations
	procurement and supply chain management system based on the TNSMC model.	Corporation (HPMSC) along the lines of TNMSC. However, this was not approved by the State Cabinet. Jan oushudhi outlets providing 38 generic medicines for the BPL patients at a low cost have been opened at the facilities and are added to the existing procurement system. Despite the various channels for drug procurement, delay in procurement of medicines through the available channels was observed.
3.	There should be a coherent and actionable public health plan to address the emerging threats from Leishmaniasis and scrub typhus.	Leishmanias and scrub typhus continue to be a threat and no clear actionable plan to address this was noted.
4.	Need to strengthen mainstreaming of AYUSH to make a greater choice of systems of care available in the PHC, CHC and District Hospitals.	Mainstreaming of AYUSH continues to remain a challenge in the State, even though there is a natural inclination towards Ayurvedic and other systems of medicine. Though AYUSH doctors have been appointed on contract basis under NRHM, greater choice of systems of care at AYUSH collocated facilities was very limited due to reasons such as lack of AYUSH medicines at the collocated facilities, AYUSH doctors practicing allopathic medicine to fill in the gap of allopathic doctors, and lack of AYUSH pharmacists.
5.	Filling up vacant posts of AYUSH doctors & paramedics and to house AYUSH dispensaries in own government buildings need to be taken up on priority.	AYUSH functions under a separate directorate, and in the collocated facilities visited there was no involvement of the AYUSH doctors in the running of the national health programmes. Contractual AYUSH MOs engaged under NRHM were observed as involved mainly in task shifting of allopathic doctors. Further, shortage of AYUSH drugs and non-availability of AYUSH pharmacists have been observed as bottlenecks in ensuring availability of AYUSH services in the co-located facilities.
6.	The EMRI system needs to be supplemented with tie ups with local transport service providers.	EMRI has greatly improved the accessibility and there was very good awareness among the community with regard to the 108 ambulances. As informed, the State is in the process of getting more EMRI vehicles on board under the flagship programme of JSSK.
7.	Greater attention is required towards strengthening measures for reducing out-of-pocket (OOP) expenditures and user fees in public hospitals.	OOP expenditure persists and interactions with beneficiaries and the community elicited that this was primarily in terms of medicine purchase.

D. NRHM Conditionalities and Incentives

Table 7: Key Conditionality's and Incentives

CONDITIONALITIES AND INCENTIVES	STATE RESPONSE (September 2013)	REMARKS
1. Rational deployment of HR with the highest priority accorded to high priority districts and delivery points		
1.1 Comprehensive **Rational deployment policy** which would inter alia include: • Filling up of vacancies in high priority districts • Rational deployment of EmOC and LSAS trained doctors and specialists especially gynaecologists and anaesthetists in teams • Posting of staff on the basis of case load (OPD/IPD/Normal deliveries/C-sections).	• The vacancy position of MOs in State has reduced from 297 to 271 from 2012-13 to Aug 2013. This is reduction from 17.5% to 15.97%. Regular vacancies of doctors are being filled up through contractual posting. Walk in interviews are held every Tuesday. • The Vacancy position in HPD against 407 sanctioned posts has reduced from 114 in 2012-13 to 90 in Aug 2013.Regular vacancies of doctors/ specialists are being filled up through contractual posting. Walk in interviews are held every Tuesday. • OBG, Paediatrician and Anesthetist are available in Mandi and Kinnaur which are High Priority Districts. • 2 FRUs in Chamba and Lahaul and Spiti have no specialists. • Special incentives for Specialists in Tribal / HPD have been proposed. • The State has 61 FRUs. Prior to issue of orders on 28.09.2013, Vacancy position for O&G/ EmOC reduced from 34 to 24, whereas those of Paed and LSAS did not improve compared to 2012-13.	• **Partially done.** • No Rational Deployment Policy has been framed as yet. • G.O for redeployment of 5 LSAS and 12 EmOC has been issued on 28th Sept 2013 has been shared. • The vacancy status in HPD has reduced from 114 to 90 in 4 High priority districts against sanctioned posts (28% to 22.11%). This is 26.6%reduction in vacancy in HPD. For ANMs in HPD there is 70 % reduction in vacancies (from 48 to 28 against 260 sanctioned posts) and there is 22% reduction in vacancy status of SNs (66 to 54 against 260 sanctioned posts) • . The State has still not been able to recruit any specialists and ANMs in Lahaul and Spiti as yet. • **As per MH division:** State has 34 LSAS, of which 12 were posted at FRUs. • **As per State:** As per State report. Total LSAS= 34, Left for PG = 6, Posted at FRUs= 12, Posted at non FRUs= 16, Redeployed LSAS= 5. • **As per MH division**: out of 44 EmOC, 14 were irrationally deployed. The State has sent GO for

CONDITIONALITIES AND INCENTIVES	STATE RESPONSE (September 2013)	REMARKS
	• In HPD, vacancy status reduced only for O&G from 10 to 7 from last year. • LSAS have been rationally deployed. Orders to be put up on website. • Govt. orders have been issued for re-deployment of LSAS / EmOC trained doctors from Non-FRUs to FRUs (5 LSAS and 12 EmOC trained). Govt. orders attached as Annexure-A not shown in the above tables.	12 EmOC specialists. • State has shared the posting of the LSAS and EmOC doctors before the redeployment orders. • All have been redeployed within the same district and to CHCs, Civil Hospitals. None have been redeployed to Chamba and Lahaul and Spiti where the State reports the shortage of specialists is most acute. • The LSAS have not necessarily been redeployed to the facilities having EmOC and vice versa.eg. LSAS has been redeployed to PHC Sharda, Shimla while one EmOC has been redeployed from same PHC to a CHC. • State has shared the list of 94 delivery points that includes the 61 FRUs and the availability of LSAS and EmOC in them. Only 19 Facilities have the right complement of specialists.
1.2 Preparation of baseline data for HR (in particular, specialists, MOs, SNs, ANMs and Lab techs) including the current place of posting; system for updation(e.g. frequency/ when transfer/ posting orders are issued).	• The State has developed Personnel Management Information System and all transfers and postings are being done through this system. It is a web based application. The baseline data is available. • Preparation of baseline data for HR (in particular, specialists, MOs, SNs, ANMs and Lab techs) including the current place of posting; system for updation (e.g. frequency/ when transfer/ posting orders are issued) is done through PMIS which is a web based application.	• **Not Done.** • The PMIS is only for regular posts. The Baseline data for Facility wise HR not uploaded on the website. The System is password protected and hence cannot be accessed by everyone. • The current place of posting of EmOC and LSAS trained doctors after transfer orders for them were issued is not uploaded on the website.

CONDITIONALITIES AND INCENTIVES	STATE RESPONSE (September 2013)	REMARKS
1.3 Evidence of corrective action in line with the policy	• The State is focusing on strengthening DPs. • All delivery points and SC in High priority districts are fully staffed. The NRHM website has recently been launched and lists of updated LSAS and EmOC trained doctors with place of posting is uploaded on website. • The department is adhering to following norms: • For specialists the priority is all Zonal/ Regional/ Civil Hospitals with more than 200 beds – to provide 2 specialists in Gynae, Anesthesia, Peadiatrics and Medicine and in institutions with 100 beds to provide one specialist in each of 4 specialities. 19 institutions (L3 Delivery points) already have right complement of specialists and paramedics. EmOC and LSAS have been rationally deployed. Orders put up on website.	• **Partially Done.** • State has 61 FRUs. • 19 of them have right complement of specialists. • The State has identified 94 delivery points, • Around 30% of LSAS of those posted at lower facilities have been redeployed to higher facilities and around 90% EmOC of irrationally deployed EmOC have been redeployed. • List of EmOC and LSAS with place of posting and deliveries conducted not uploaded on website. • GO for redeployment of LSAS and EmOC have been issued on 28.09.2013.
2. Facility wise performance audit and corrective action based thereon.		
2.1 Facility wise reporting (infrastructure sheet and facility wise data) on HMIS portal by all facilities as a minimum for all HPDs (SC data if needed be uploaded from PHC)	• Already in Place.	• **Partially Done.** • Facility wise reporting is being done in District Bilaspur. • 4 more districts are doing more than 90 % reporting on R-HMIS and are about to be shifted to main HMIS portal. • Rest districts are doing this on a monthly basis consolidated district level data.
2.2 Action plan in place for corrective action	• The gap analysis of low performing delivery	• **Done.**

CONDITIONALITIES AND INCENTIVES	STATE RESPONSE (September 2013)	REMARKS
based on facility rating	points in the State has been carried out and show cause notices were issued to 5 CMOs. • Supportive Supervision and monitoring of Low performing districts and health facilities is being done. Regular periodic visits by SPO and DPO to the field institutions.	• Performance audit is conducted for all the districts every month on the basis of reports / data of HMIS and MCTS • This is done particularly for indicators of ANC registration, 3- ANC check-ups, and institutional deliveries. • State had shared the copy of letter of show cause notices issued to the CMOs for poor performance on health indicators with MoHFW
2.3 Corrective action (as a min in HPD) taken.	• All Delivery Point names have been matched with Facility Master of HMIS. • The performance of Delivery points is monitored on monthly basis for all delivery points in a meeting by Principal Secretary (Health) and corrective action is being taken up.	• The Performance monitoring is done on the basis of HMIS/ MCTS data with CMOs very month and copy of show-cause notices issued for districts with poor performance have been shared.
3.Performance Measurement system set up and implemented to monitor performance of regular and contractual staff		
3.1 System for performance measurement of regular and contractual staff in place.	• At present for Regular staff ACR and for Contractual staff- annual performance appraisal is being done. However, the State has started Daily performance diary / Logbook for all NRHM employees (Annexure – A). • As per GoI mandate, the appraisal process has been revised with structured annual Performance assessment system based on qualitative and quantitative indicators for each category of staff in lines with PIP target.	• **Done.** • A GO dated 3rd September was issued to all the CMOs regarding the performance measurement and monitoring of all regular and contractual staff working under NRHM. It was informed to the CMOs that each employee will maintain a diary to record the work carried out in the day to day basis and progress of the work will be verified by the immediate controlling officer. • Baseline assessment of the employee to be done by the controlling officer.

CONDITIONALITIES AND INCENTIVES	STATE RESPONSE (September 2013)	REMARKS
	• For each level of staff, reporting Officers has been identified for giving necessary remarks in the appraisal report. • The Renewal is given to only those who have satisfactory performance. • Daily Log Book / work dairy has been started for NRHM staff. The copy of letter is annexed at Annexure – C.	• Time frame for disposal of assigned work to be included in the diary. • The performance report of each employee is to be reviewed by the concerned CMO on monthly basis and compliance thereof will be intimated to MD NRHM by 10th of the following months. The regular and contractual staffs have been directed accordingly by the State.
3.2 Baseline performance targets set for all regular and contractual staff and shared	Yes Prepared.	• **Partially Done.** • The performance assessment forms of all the contractual staff have been prepared and shared by the State. They include the job deliverables • Not uploaded on the website.
3.3 Performance reviewed and action taken in line with the performance measurement system.	Yes Prepared.	
4. Baseline assessment of competencies of all SNs, ANMs, Laboratory technicians to be done and corrective action taken thereon		
4.1 Baseline assessment conducted and staff appropriately graded	• A DO has been written by the Principal Secretary (Health) to AS & MD (NRHM), Government of India, wherein it has been mentioned that baseline assessment would be completed by November end. • From the first week of August, Dr. Bulbul Sood, Country Director/ India, JHPIEGO was contacted on several occasions but the terms and conditions for assessment of skills were not clear to her and are not clear to them	• **Partially Done.** • The State has sent a copy of the letter to AS&MD stating that due to inability of the JHPIEGO to indicate how to carry the assessment, the Senior Supervisory Staff in the State will carry out the skills and knowledge assessment of ANMs and DPs and HSCs. Instructions have been given to all CMOs to complete it as early as possible. They intend to compile the information through CMOS and

CONDITIONALITIES AND INCENTIVES	STATE RESPONSE (September 2013)	REMARKS
	even today. On 16.9.13 a format has been received from MH division of Ministry of Health, GoI for conducting assessment of skills which has now been sent to CMOs for completing baseline skill assessment in next two month.	formulate an action plan for State accordingly. The process is likely to be completed by the end of November.
4.2 Action plan with time line to show improvement in staff competencies in place	• Department in touch with KSIH&FW for organizing various training programme for improving their competencies.	
4.3 Progress in implementation of plan. E.g. % target group trained	• Trained 20 employees on Skilled Birth Attendance. • Trained 5 Lab technicians on Blood Storage.	

E. Best Practices

During the visit to the State, some innovations and good practices were observed. These are further elucidated upon in the respective sections.

1. Incentives to Human Resources (HR) – The State has an incentive based deployment in place for retention of HR in hard to reach areas. This has improved the availability of doctors in hard to reach and difficult areas. However there are some deficiencies also, which are detailed in the HR related section of this report.
2. Mobile based reporting – The State has provided mobile phones to the male and female health workers for HMIS based reporting. This has enabled better reporting from the Sub Center level.
3. At tertiary care hospitals where security is an issue and lack of manpower was cited, the RKS funds were utilized for CCTV installation in common areas of the hospital.
4. Muskan - All family members of BPL family are being given free denture. And all elderly people above 65 years of age (BPL or APL) are being provided free denture (both full and partial) in the State.

Table 8: Achievements under Muskan

	Aug 2010 – Mar 2013	April 2013 - Sept 2013	Total
Full Denture	7059	1614	8673
Partial denture	1947	531	2478
Total Denture	9006	2145	11151
Senior Citizen	5717	1552	7269
Senior Citizen + BPL/IRDP	349	66	415
Others	2940	527	3467

Source: NRHM Status, September 2013, HMIS, HP

5. Engagement of the NGOs and Civil Society participation for public health initiatives was noted to be high at some of the facilities visited in Kangra district.
6. Highly motivated and dedicated staff members were encountered in the field. Ms Kousalya Devi, ANM at Sub Center, Kalsui, Chamba district has been providing 24x7 delivery services. Till 31.03.2013, she has carried out 1270 deliveries and 198 deliveries in 2013-14. She has been reported as handling even complicated pregnancies. Her services are remarkable especially at a context where Gynecologist's service has not been available in the whole district until recently and where there is high dependency on district level facility for delivery

services. It is also noted that she has been providing 24x7 delivery services, even without a landline telephone connection. She could also utilize the untied funds for mobilizing the support of a helper at the centre.

7. Career progression options for health workers were made available by the State e.g. At PHC Tiara and CHC Nagrota, Bagwan, 2 health workers were promoted to health educators after they underwent training at Calcutta. They have opportunities to be promoted to Mass Education and Information Officer (MEIO).

Ms Kausalya Devi, ANM, SC Kalsui

TOR I – SERVICE DELIVERY

A. Infrastructure and Adequacy of Facilities

The nomenclature for public health facilities in the State is Zonal hospital (ZH), Regional Hospital (RH), Civil Hospital (CH), CHCs, PHCs and SCs. Apart from 2 medical colleges, there are 12 tertiary level hospitals in the State – 3 zonal hospitals (1 for each zonal administrative area) and 9 regional hospitals.

There are a total of 2669 govt. health facilities in the State catering to a population of 58 lakhs. In Kangra, which has 22% of the State's population, there are 541 govt. facilities while Chamba, with 8% of the State's population has 229 govt. facilities.

Table 9: Total Number of facilities *

Type of facility	Number of facilities		
	Himachal Pradesh	Kangra	Chamba
DH(ZH/RH)	12	1	1
Medical College	2	1	-
SDH/CH	37	7	3
CHC	78	14	7
PHC	475	80	42
SC	2065	438	176
TOTAL	**2669**	**541**	**229**

**As on visit - November 2013, HMIS*

The average population served is slightly higher in the case of Sub Centers (SCs) with one SC serving an average population of 3,319, as against the national norm 3,000 population for hilly areas, and in the case of CHCs serving an average population of 90,217, as against the national norm of 80,000 population. In case of PHCs and District Hospitals, the average population served is lesser than the national norms (PHC per 20,000 population and DH per 10 lakh population), as indicated in the table no. 10 below. In Kangra, the District Hospital, which is the zonal hospital, serves a much larger population of 15 lakhs as compared to Chamba. Chamba with its low population density has lesser number of facilities as against the norm and in comparison to both the State average as well as Kangra district.

Table 10: Average population served per facility

Facility	Ntaional Norm	Himachal Pradesh	Kangra	Chamba

Facility	Ntaional Norm	Himachal Pradesh	Kangra	Chamba
Anganwadi Centre		369	366	365
SC	3,000	3,319	3,441	2,948
PHC	20,000	14,404	18,840	12,353
CHC	80,000	90,217	1,07,659	74,121
CH		1,80,434	2,15,318	172,948
DH	10,00,000	5,71,376	15,07,223	5,18,844

Based on population norms

An analysis of the geographical distribution of the facilities in Chamba highlights that there are 45 gram panchayats in the district without any health institution and 125 gram panchayats without sub centers, while 42 out of 176 sub centers cater to more than 3000 population which is the norm for hilly areas. In Kangra, however, the geographical spread of facilities is better. In addition to the Zonal/District hospital, there is a medical college at Tanda, which is a tertiary care hospital. Of the 12 health blocks in Kangra, 6 blocks have the tertiary level civil hospital and 2 blocks have the Zonal hospital and Medical college respectively. The 4 blocks of Bhawarna, Indora, Nagrota Bagwan and Nagrota Surian do not have a civil hospital but the CHCs act as the tertiary care facilities. Despite this, accessibility continues to be a bottleneck in the hilly terrains and remote areas of Chamba as well as remote and snow bound regions of Kangra such as the Mahakal block, which remain cut-off.

There are a total of 1536 sanctioned beds in the govt. facilities in Kangra against which 1051 beds are in position i.e. the sanctioned beds per 1000 population is 1.02 as against the in-position beds per 1000 population of 0.7. While in Chamba the total number of beds available is 510 i.e. the in-position beds per 1000 population is 0.98.

Since 2005 till date, there has been an increase in the number of CHCs by 18%, PHCs by 8% while there are 3 SCs less at present from 2005. (State PIP 2013-14). While there are no gaps in availability of PHCs and DHs, less number of Sub Centers and CHCs exist than the requirement calculated as per population norms, and thus these facilities cater to more population than the national norms for hilly areas.

From the start of NRHM until 2012-13, 455 infrastructure works for health facilities have been sanctioned (416 in non-high focus and 39 in high focus districts). Of these, 145 constructions have been completed which include 66 SCs, 66 PHCs, 4 CHCs, 6 SDHs and 3 DHs. Building for 231 facilities are under construction whereas in 79 facilities construction is yet to start. In addition to this, the setting up of MCH wings in large caseload facilities is under progress and 1 hundred-bedded MCH wing at Kangra and Chamba as well as 4 fifty-bedded MCH wings have been sanctioned at Mandi, Chamba, Sarkaghat and Rampur respectively.

Table 11: Infrastructure Gap Analysis - Himachal Pradesh*

Facility	Required	Available	Gaps
DH	7	12	-5
Medical College	-	2	-
SDH (Civil Hospital)	14	37	-23
CHC	86	78	8
PHC	343	475	-246
SC	2286	2065	221

**Based on population norms*

Table 12: Infrastructure Gap Analysis - District Kangra*

Facility	Required	Available	Gaps
DH (Zonal Hospital)	1	1	0
Medical College	-	1	-
SDH (Civil Hospital)	3	7	-4
CHC	19	14	5
PHC	75	80	-5
SC	502	438	64

**Based on population norms*

Table 13: Infrastructure Gap Analysis - District Chamba*

Facility	Required	Available	Gaps
DH (Regional Hospital)	1	1	0
SDH (Civil Hospital)	1	3	-2
CHC	6	7	-2
PHC	26	42	-16
SC	173	176	-3

**Based on population norms*

The directorate of AYUSH functions as a separate directorate in the State. Ayurvedic MOs have been posted at co-located facilities under NRHM. In Kangra, there are 8 facilities run solely by Ayurvedic MOs (AMOs) whereas in Chamba 15 AMOs have been appointed at co-located facilities, in addition to the 99 stand alone Ayurvedic Health Centers. There was no involvement of the AYUSH doctors in the running of the national health programmes. Contractual AYUSH MOs engaged under NRHM at co-located facilities were observed as involved mainly in task shifting of allopathic doctors. Further, shortage of AYUSH drugs and non-availability of AYUSH pharmacists have been observed as bottlenecks in ensuring availability of AYUSH services in the co-located facilities.

Table 14: List of AYUSH facilities

Facility	Kangra	Chamba
ISM Hospitals	4	2
Ayurvedic health centres	227	99
Homeopathic health centres	NA	02

Source: Data provided by the State.

There is no separate civil works wing within the Directorate of Health Services. A junior assistant is the nodal person for civil works in the State. The PWD and BSNL are the nodal agencies responsible for constructions and up-gradation. Estimates of the proposals received for the constructions/renovations by the CMOs are drawn by these agencies and administrative approval from GOI is sought thereafter. Upon sanction of the works, the amount is released to the agencies. Chamba is the only district in the State where a junior engineer has been appointed through the Rogi Kalyan Samiti (RKS) by the CMO and the district has established its own system for technically managing the approved infrastructure projects. This wing, manned mainly by retired engineers from government service, acts as the technical support cum managing unit for infrastructure works in the district.

The pace of constructions was observed as slow, but given the constraints that the State faces in terms of its terrain, it cannot be compared with that of the plains. Constructions were faster in the lower Himachal regions as compared to the upper reaches, which remain cut off due to snowfall and delays of up to 6 months or more set in. Chamba district officials shared that they had faced difficulties in getting sanctioned works completed as the works were awarded to one agency only. This has been discussed at State level and another agency was identified. District officials reported that there was progress in works assigned after the new agency was allotted with works.

PHC Raj Nagar, Chamba district

Generally, there was good infrastructure across the State with the IPHS designs adapted to suit State requirements. However, some facilities such as Sub Center Kiani visited by the team were observed as urgently requiring infrastructure works. The roof of this facility was observed as damaged and posing dangers to the staff to work. Lack of staff quarters was observed from the Civil Hospital down to the SCs. As informed, the current sanctioned

works have included provisions for staff quarters.

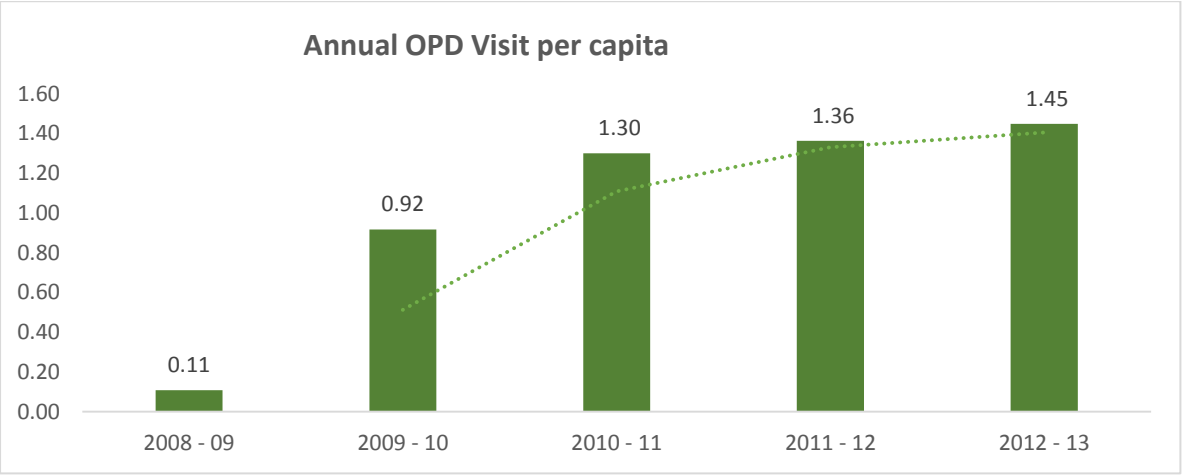
Clear gap was observed between planning of infrastructure works and operationalization of facilities and placing of required manpower and equipments. Facilities such as CH Chowari and PHC Raj Nagar in Chamba district were having good infrastructure, but they were lying under-utilized. One floor equipped with Operation Theatre and equipments itself has been lying idle for past 2 years in PHC Raj Nagar where only one MO is sanctioned and posted. Since the State has set up good infrastructure for many facilities, now it may focus more on providing the range of services envisaged for each type of facility. A clear road map with priority actions and timelines must be prepared at the earliest and action in this front to be initiated.

In Kangra the marginalized sections in the remote parts and snow bound parts of the districts remain cut off and to reach this population every year outreach camps are held where a team of lady doctor, staff nurses and lab technicians walk to these areas and provide services to pregnant women.

B. Utilization of facility based services

There has been an increase in the trend of OPD patients in the State. The total OPD visits in 2012-13 as per HMIS were 10,045,394. i.e. 1.4 visits per capita, much lower than the national average of 3.5. Majority of health facilities are in the public sector, therefore the dependence on the private sector was not found to be dominant. However, there was a large presence of private practitioners in many places. District Kangra has a much larger presence of the private sector, especially in Dharamshala which has a large influx of domestic and foreign tourists. The State does not allow for private practice by the public sector doctors, and because of adherence of this norm, doctors were present at the facilities. The OPD trend across the years shows a steady increase, with 8% increase in 2012-13 as compared to that in 2011-12.

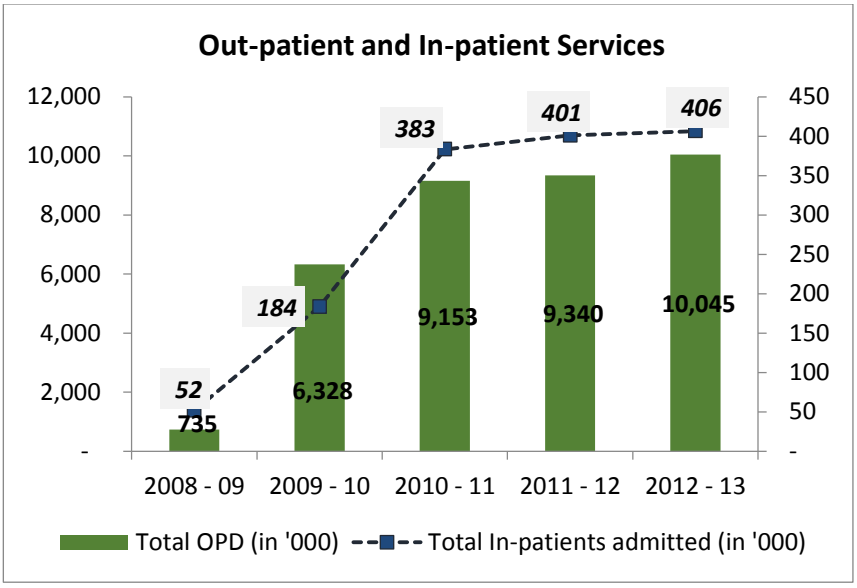
Graph 1



Source: HMIS

In Kangra, the case load is 1.5 OPD visits per capita, similar to the State figure, while in Chamba it is lower at 1.2 OPD visits per capita. The PHC and CHCs primarily function as general OPD clinics, for e.g. at Kangra, while some facilities record a high OPD attendance, there were others such as Block PHC Tiara, where utilization was not optimal - with 2 MOs and staff it has an average of 60 outpatient visits per day and 5-6 inpatients per month. Dental OPDs were found to be in place and functional in all the facilities visited in Kangra and some facilities like CH Chowari in Chamba district. Dental procedures were recorded for 75,351 in 2012-13 and till September, 56,055 dental cases have been seen. Fixed-day NCD clinics are held in the facilities, but doctors cite that as they cannot restrict general OPD cases, hence it does not remain a dedicated NCD clinic.

Graph 2



Source: HMIS

A steady increase in the number of IPD visits is observed over the years. In Kangra, there were 206 episodes per 1000 population, 3.5 times more than the State average of 59 episodes per 1000 population and in Chamba it was 14 episodes per 1000 population which is 4 times less than the State average. While this is the case, both in Kangra and Chamba, cases requiring a greater degree of hospitalization were referred to the tertiary level Zonal hospital at Dharamshala, the Medical College at Tanda and RH, Chamba respectively.

As informed, 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. The

duration of the camp is for 7 days with the first day being the pre-operative or screening day, second to fifth days the operative days and the last two days being a non-operative and patient care day.

Table 15: Status of multi-specialty camps

Activity	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14 (Up to Sept)
Camps	6	13	17	13	27	7	10
Surgeries	574	1308	1930	1311	2661	411	616

Source: NRHM Status, September 2013, HMIS, HP

C. Quality of Care

As reported by the State, it is in the process of constituting a Quality assurance committee. At the time of visit, NABH accreditation process for 5 hospitals had been initiated. The Zonal hospital at Dharamshala is an ISO certified hospital. The standard treatment protocols are yet to be formulated in the State and hence were not available at facilities visited. While this was so, at all the facilities visited in Kangra had signage, citizen charters and list of RKS members displayed. All the facilities visited were neat and clean, with patient amenities like drinking water and waiting area. Patient privacy was lacking at certain facilities in Chamba e.g. PHC Rajnagar with excellent infrastructure had no screens/curtains in the labour/examination room as well as in ARSH room. Security was cited to be an issue at the tertiary care facilities visited in Kangra, hence CCTV cameras purchased through the RKS funds had been installed at CH Palampur and the ZH, Dharamshala. This has minimized instances of pilferage and theft in the premises. There is also provision of free diet to the in-patients at all the facilities except facilities with minimal number of patients such as Raj Nagar PHC in Chamba, which do not provide diet to patients. The MO reported that all patients come from nearby locations and prefer to bring food from their own homes.

In Kangra, the bio-medical waste (BMW) management system was observed as outsourced to an agency in Pathankot, which regularly collects the bio-medical waste, whereas in Chamba infection prevention practices and bio-medical waste management were not satisfactory. Color coded bin system was available in Chamba, however not used properly. Deep burial pits were not available at CH Chowari and PHC Raj Nagar despite having good buildings. Staff nurses were observed as not following simple infection prevention practices such as appropriate hand wash techniques, single hand recapping of needles, appropriate handling of sharps, etc.

Grievance redressal mechanism was present in the form of complaint boxes observed at all the hospitals in Kangra and only at CH Chowari in Chamba. While this is the case, the effectiveness and regularity of collecting the grievances is a matter of consideration, for e.g. the complaint box was

found lying open at CH Chowari in Chamba. At the State level, as reported by the State officials, the grievance redressal committees are being set up to address the complaints in the hospital and bilingual forms are being developed for both the employees as well as patients.

Patients with whom the team interacted at facilities shared mixed opinion regarding the services. While most of them were happy about the availability of diet and transport services in Chamba, all of them unanimously complained about staff shortage. While some BPL patients at RH Chamba informed that they had received medicines and services free of cost, others wanted to have medicines like antibiotics and tonics at no or subsidized costs at the facilities itself.

D. Subcontracting

The ancillary and supportive services were sub-contracted out to agencies for e.g. Bio-Medical Waste disposal in Kangra to an agency in Pathankot, while in Chamba diet, cleaning and laundry services were outsourced. Diet was contracted from the CMO office for RH and CHs while local contracts are made for smaller facilities like CHC and PHC. The costs per meal vary accordingly. Provisions for Quality checks and corrective measures were in place in the CMO level contract. Facility level committees including doctor and ward sister have been formed for ensuring quality of food supplied. One PHC medical officer reported difficulty at times to arrange for local contracts, within the amount approved as the number of beneficiaries in his area was small. Contracting out has worked very well in terms of the cleanliness, diet provision and the BMW disposal.

Emergency Lab set up by RKS, ZH Dharamshala under PPP mode

Yet another area where services have been contracted out was diagnostics. The lab services at the DH/RH/CHs are outsourced to Dr Lal path labs. The partnership was entered in to provide services round the clock as after 12 noon as there were no diagnostic services being rendered after 12 noon due to non-availability of Lab technicians beyond morning shifts. Lal path lab provides services free of cost for the BPL patients and State health officials reported that the agency is to start home based services in Kangra, where the transportation charges would be borne by the hospital.

E. Ambulance & Referral Services

There are 171 EMRI (108) ambulances for emergency response transport (National Ambulance Sewa) in the State with a centralized call centre at Shimla. There are 21 and 17 ambulances under 108 in Kangra and Chamba respectively. In addition, there are 3 inter-facility transfer ambulances in Kangra, while in Chamba inter-facility transfer is carried out by the 108 services as there are not enough State owned ambulances in working condition (6 out of 13 State run ambulances have been off-the-road since the last two years).

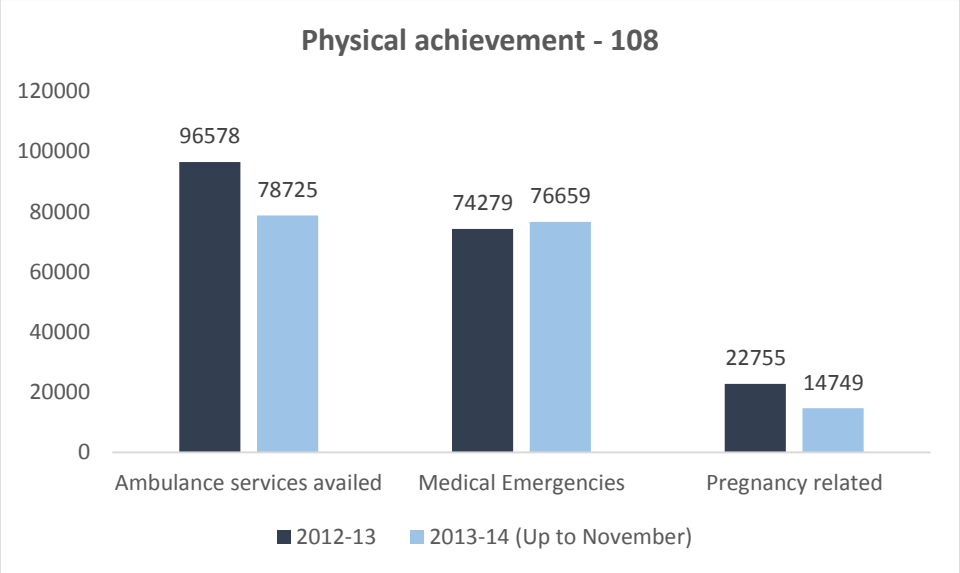
The State reported that it is in the process of procuring an additional 125 vehicles under JSSK, which are to be operationalized in the current financial year. Good liaison between 108 staff and facility staff was observed at various facilities. It was observed that 108 staff members were provided with arrangements for rest and refreshment at health facilities. Moreover, telephonic briefing about the condition of the patient being transported by the trained 108 staff to the facility medical officer and seeking advice from him/her on emergency management was observed as enabling the continuity of care at the facility.

108 EMRI Ambulance in Himachal Pradesh

Currently drop back services, 102, are not operationalized (expected to be operational by Jan 2014) and State/district has not done any empanelment of vehicles for drop back. The State provides reimbursement charges at the rate of Rs.8 per km to the beneficiary during the time of discharge. However, in Chamba, this was not provided at CH Chowari, as staff reported that reimbursement is not provided to those who do not avail 108 to come to the facility.

The concerned programme officer at State shared that district level review and monitoring mechanism includes review meetings by CMO with concerned EMRI staff at district level, and the Deputy Commissioner at each district has a review with the partner, GVK-EMRI's programme officers. Similar meetings with members of VHSNC are desirable.

Graph 3



Source: HMIS

There was wide awareness and acceptance of the 108 services in both the districts visited, as inferred from interactions in the community and 108 service numbers were displayed at many strategic locations. The average response time of EMRI is reported as between 20-45 minutes. Ninety-seven per cent of the services availed this year were medical emergencies, of which 19% were pregnancy-related cases. In 2012-13, of the medical emergencies, 30% were pregnancy related. With an operational cost of Rs.1 lakh per month, the average number of emergencies handled per ambulance is 114 per month. Also when interacted with a few women, although most were aware of 108 services, more than 90% had not availed it, mostly because of preference to use locally arranged vehicles at the time of emergency and thus had incurred OOP expenditure. Hence, although the State owned ambulances are underutilized and 108 fares better in terms of trained personnel and well-equipped ambulances, the pickup rate has further scope for improvement. Local arrangements at current provider rates can also be explored.

F. Mobile Medical Units (MMU)

Currently there is no provision of MMUs and the State is in the process of procuring MMUs, which would serve the difficult areas.

G. IEC/BCC

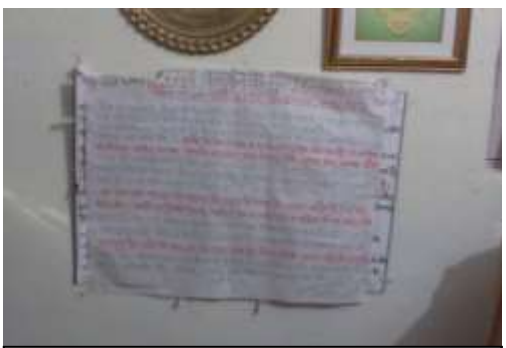
There is very good presence of State cadre for IEC/BCC – IEC cell at State level, MEIO at district level and the Health Educator at Block level. The cadre across levels was observed as very motivated and well qualified but not well trained to carry out IEC/BCC activities. Further, the contractual staffs appointed under NRHM at district levels for BCC/IEC work were observed as engaged in

administrative work thus not having enough time to do their stated core functions. There was a clear gap in terms of an IEC/BCC strategy in the State and there was not much focus on demand generation of services. As of the time of the visit, IEC/BCC activities were geared around various National and International Days (World Population Day, Childrens Days, etc) during which the district plans health camps. No major campaigns related to focus area of RCH have been undertaken at the State level in recent years. The issue of child sex ratio is quite prominent in Kangra yet for long years no focused campaign seems to have been undertaken except 'Beti Hai Anmol'.

At facility level IEC display seemed to be lacking- mostly there was display of only patient rights and other government schemes related information; however the display was very text heavy and quite outdated. Also, the display was not done in strategic locations within the facility. In Chamba, JSY/JSSK benefits have not been displayed adequately across the facilities, except few Sub Centers such as Kalsui and Rajnagar, where ANM or MPW took personal initiative to prepare posters and paste them on sub centre walls. The type of display was largely restricted to wall writing and flex banners with some out-dated posters in select facilities. There was limited presence of print materials but any form of audio visuals materials were not used anywhere.

IEC Material developed by IGMC Shimla on need of exercise displayed at a facility in Shimla

The Health Educators were largely involved in supporting service delivery functions and not oriented to carry out mid media and IPC activities. The Health Educators have not had any IEC/BCC training since they joined the programme. There was no outreach strategy to create awareness and enable behaviour change at community level. There was a big gap in supply and distribution of IEC materials and the existing materials were text heavy, very old and outdated. There was also no evidence of community exposure to mass media campaigns through TV, radio or Outdoor advertising. The State has provided mobile phones to male and female health workers for HMIS data collection, which is an excellent innovation on use of technology. The same medium could also be used for strengthening communication training activities as well. The rich cultural and folk forms of the State could also be tapped into to strengthen community outreach through



Handwritten poster on JSY and JSSK at Sub Centre, Kalsui, Chamba district

mid – media activities. IEC/BCC budgets under NRHM seem to be an area of concern for the State to plan out strategic and effective communication initiatives; hence strong advocacy initiatives are required to be undertaken by State leadership with NRHM, GOI to enhance the IEC/BCC budget in State PIPs.

Recommendations

- Since the State has set up good infrastructure for many facilities, now it may focus more on providing the range of services envisaged for each type of facility. A clear road map with priority actions and timelines must be prepared at the earliest and action in this front to be initiated.
- Patient privacy was lacking in some facilities. Facilities may ensure that patients' privacy is protected through arranging screens, curtains, etc, in appropriate locations.
- The pickup rate of 108 ambulance services has further scope for improvement. Local arrangements at current provider rates can be explored to ensure pick-up and drop back of pregnant women and children. Reimbursement of travel expenses for pregnant women who had not availed 108 services for reaching the hospital needs to be ensured by the State.
- Choice of different systems of health care needs to be fully provided to the patients by enabling the AYUSH Medical Officers posted at these facilities for practicing the system of medicine they are trained in. While posting of Ayurvedic pharmacists and ensuring availability of AYUSH drugs at these facilities are two important steps for the same, prominent display of information regarding availability of AYUSH services at strategic locations within and outside the facility is required to increase awareness among the people about these services.
- Current IEC/BCC programme in the State is very weak, even though there is a good presence of State cadre staff for IEC/BCC. State has to develop a clear IEC/BCC strategy and IEC plans may be prepared accordingly. One of the key areas for focus can be demand generation for various services, especially RCH services, and entitlements under the National health mission. Further, State has to utilize mid and mass media for taking the messages to the people. Use of audio-visual media is also suggested. The rich cultural and folk forms of the State could also be tapped into to strengthen community outreach through mid – media activities. Updating of messages and capacity building of IEC personnel are also required.

TOR II – REPRODUCTIVE AND CHILD HEALTH

A. Planning

There are a total of 116 delivery points in the State, including 19 in Kangra and 8 in Chamba. Sixty four per cent of the delivery points are 24x7 facilities, primarily the Civil hospitals and CHCs. Around 8 PHCs are delivery points, which do not provide round the clock services and are level 1 facilities. Tertiary care is provided at 26 facilities across the State, with all the DHs and Medical Colleges being CEmOC centres, in addition to 11 Civil Hospitals and 1 CHC. In Kangra, there are 4 level 3 facilities providing CEmOC services, whereas in Chamba only the RH provides CEmOC services. Chamba district hadn't have a Gynecologist until recently. One of the pregnant women interacted with there had a history of having two continuous still births in past 3 years even after being admitted at the facility well in advance to her EDD, clearly indicating the effects of non-availablity of CEmOC services in the district in the recent past.

Table 16: Categorization of facilities as per Level 1,2 and 3

Facility	No.	Level 1	Level 2	Level 3
DH	12	0	0	12
Medical College	2	0	0	2
SDH	37	1	20	11
CHC	78	6	55	1
PHC	475	8	0	0
SC	2065	0	0	0
Total	**2669**	**15**	**75**	**26**

Source: HMIS

The lack of effective planning for up gradation of facilities for providing RCH services was evident in the field, especially in Chamba, with irrational distribution of physical infrastructure and equipment's. Labor tables were found lying unused since years at SC Kiani and SC Rajnagar. Operation theatres with high cost equipments at PHC Raj Nagar and CH Chowari were not being utilized for attending complicated pregnancies. Similarly, Sonography machine in Chamba was used

only during the Multi-speciality camp with special permission of CMHO, as there was no technical person to handle the same.

In Kangra, the regions where health facilities remain inaccessible due to snowfall and where the highest home deliveries are recorded, proposal for establishing a waiting home at the nearest facility is being considered by the State(at CH Baijnath in Mahakal block). The emphasis is on the MOs to plan for the women who are due, in order for them to come to the waiting home near the time of their delivery.

There are 18 blood banks in the State, spread across the 12 districts. Of these the maximum number are available at Kangra and Shimla, which have 4 blood banks each. Chamba has 1 blood bank, located at the RH Chamba. At the CH, Palampur in Kangra the blood bank has been operational since 2004, however, no blood bank staff positions have been sanctioned. One technician, hired from the RKS funds was appointed to run the blood bank. Difficulties in running the blood bank were cited due to lack of staff and other patient amenities. Blood collection was through small frequent camps, where 15-20 units of blood are collected. In addition, an average of 3 blood donations takes place per day at the facility and with the approved amount of Rs.10 for refreshments; the doctor cited they couldn't buy even a pack of juice from the same. At the time of visit, there were 40 units of blood. In case of non-usage, units of blood nearing expiry are shifted to the Medical College at Tanda for use there. Also, Blood storage units (BSU) were observed as functional at Manali and Nurpur in Kangra district. In Chamba district, blood storage facilities were available at CHC Bharmour and CH Chowari. Other designated FRUs (2 CHs and 1 CHC) were not having blood storage facilities. However, Emergency Obstrectic care was only available at RH Chamba in the district as the team of Anesthetist and Gynecologist has been present only at this facility. State reported that BSUs have been further proposed at 21 locations and the process of their setting up is underway. However no progress from the observations of the 5th CRM has been noted.

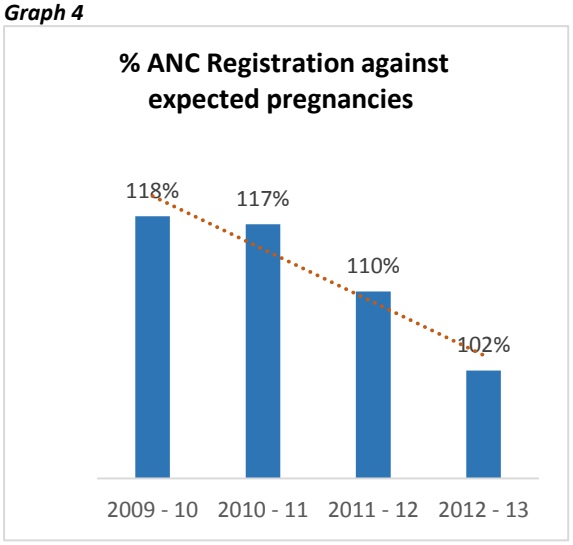
Donor bleeding area at Blood Bank, Civil Hospital, Palanpur, Kangra district

B. Care of mother and child

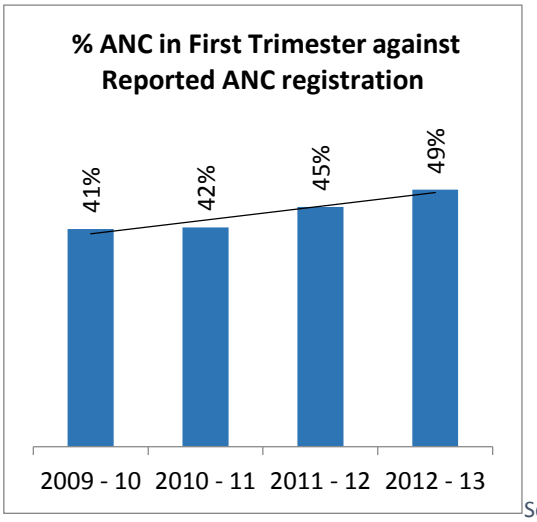
Mother and baby visiting a Sub Center, Chamba District

The ANC registration as against the expected pregnancies in the State was recorded above 100% since 2009-10 in the HMIS. While this can be attributed to errors in reporting such as double reporting, this has reduced over the years as the mechanism of reporting has become more robust.

Graph 4



Graph 5

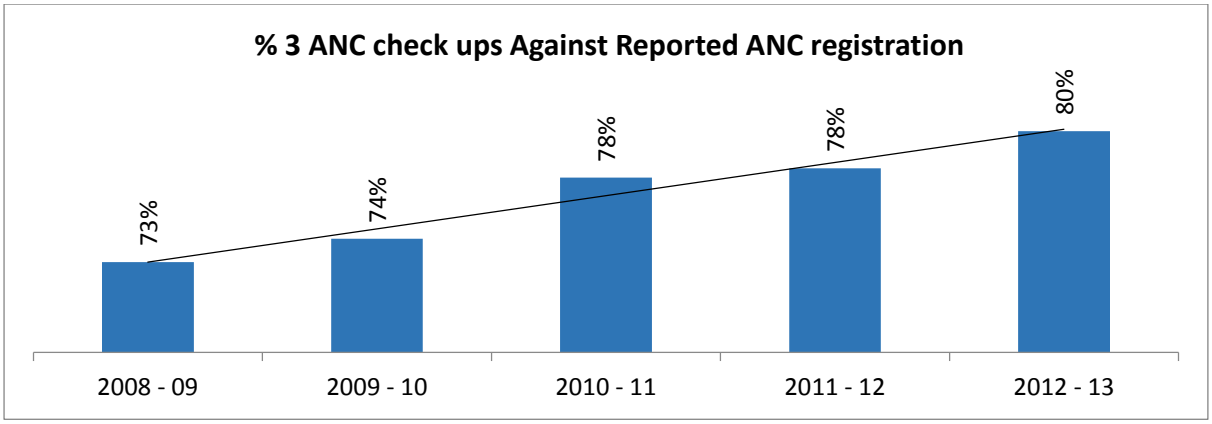


Source: HMIS

The percentage of ANC registered in the first trimester against the reported ANC registration has steadily increased, indicating an increasing mobilization across the years. Nevertheless, it still remains below 50% in the current year.

The 3 ANC checkups as against the ANC registrations in Himachal Pradesh in 2012-13 was 80%. At 82%, the 3 ANC checkups against the ANC registrations in Kangra was slightly more than the State average whereas at 68% it is much lower in Chamba. Appropriate tracking mechanisms to ensure that the women registered for ANC checkups are followed through up to their 3 ANC visit needs to be in place.

Graph 6



Source: HMIS

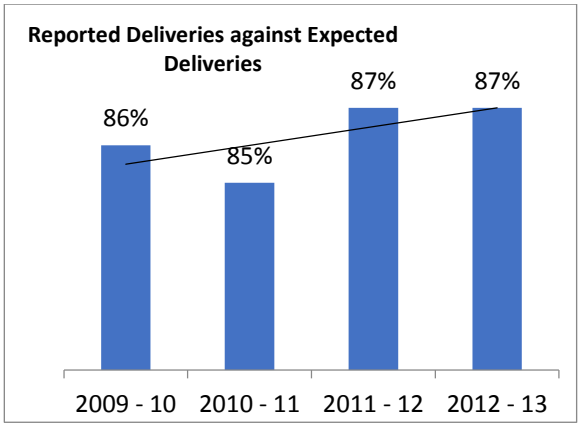
In terms of quality of care during ANC visits, around 85% of the women registered for ANC have received 100 IFA tablets, at the State as well as districts Kangra and Chamba. While this was the case, a shortage of IFA tablets was observed in Chamba, where the last supply was given a year ago. The hypertensive cases detected at the institution are a dismal 1.4% at the State and 1.8% and 1.4% at Kangra and Chamba respectively. The ANC registered women having Hb levels less than 11 gm/dl is 60% at State. In Chamba it is much lower at 46%, whereas in Kangra double reporting can be attributed to the 114% recorded, especially due to the presence of the zonal hospital and the medical college, which caters to patients from other regions as well. The ANC women having severe anemia, of Hb less than 7 gm/dl, is again very low at 0.8% for the State, 2% for Kangra and 0% in Chamba. This indicates that there is very less reporting and as a consequence, much fewer women than in need are being detected and followed upon. Both in Kangra and Chamba, provisions for Hb testing were available at majority of the facilities (except a few like PHC Bathri and PHC in Chamba where there was no means for Hb/urine for albumin/sugar testing), and the ANMs interacted with had knowledge of measuring the Hb. While this was so, there was no line listing of the severe anaemics and mechanisms of tracking the high risk mother for anemia/hypertension was lacking.

Haemoglobin test kit at PHC Chamunda, Kangra

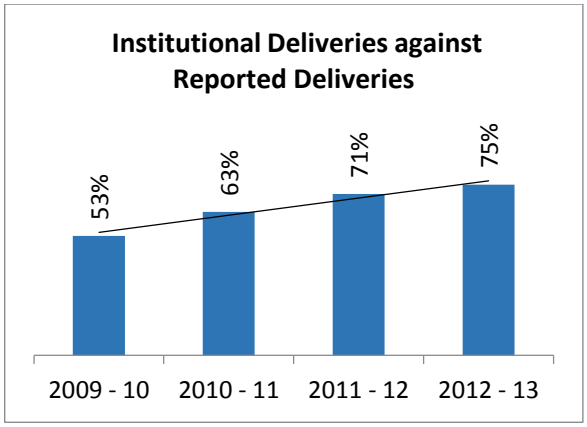
The reported deliveries as against the expected deliveries are 87% and there has been a steady increase in the institutional deliveries as against the reported deliveries over the years. Interpretation of the data can lead us to make the following inferences:

- The public facilities record more than 80% of the total institutional deliveries reported - 81% in both 2011-12 and 2012-13 and 84% in 2013-14.
- In Himachal Pradesh more than 50% of the total institutional deliveries are reported from the 12 district hospitals and 2 medical colleges combined together which is not surprising, given the lack of a large private sector. Kangra district, with the maximum population and a Zonal hospital at Dharamshala as well as a Medical College at Tanda, reports the highest institutional delivery followed by Shimla which also has a zonal hospital and a medical college. The rate of C-section has increased from 16% in 2011-12 to 18% in 2012-13. Majority (60%) of the C-sections are reported from the public facilities.

Graph 7



Graph 8



Source: HMIS

Table 17: Distribution of delivery load

S.No.	Facility	2011-12	2012-13	2013-14 (2nd quarter)
1	DH/Medical College	37669	39170	19186
2	Civil Hospital	9758	11446	7613
3	CHC	7642	8159	4456
4	PHC	1669	1397	689
5	SC	1120	697	265
	Total deliveries conducted at govt. facilities	**57858**	**60869**	**32209**
6	Accredited Private Facilities.	13,723	14,248	6205
	Total deliveries conducted at all facilities (govt. + pvt.)	**71,581**	***75,117***	***38,414***
7	***Total home deliveries***	***28,769***	***24,382***	***10,939***

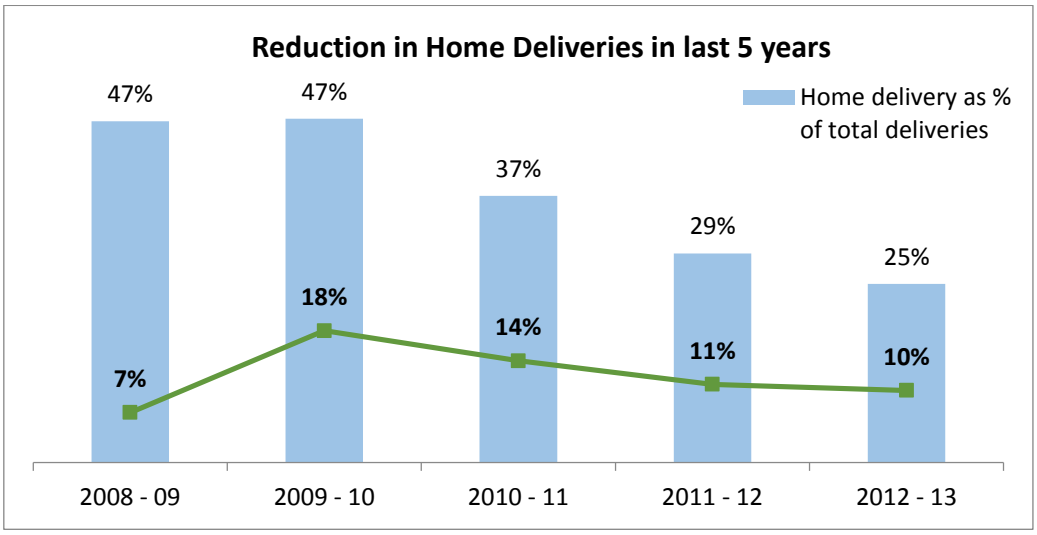
Source: HMIS

Labour room at CH Palampur, Kangra District

- On the other hand, the total institutional delivery as against the total reported delivery is above 70%. The home deliveries have reduced by half in the last 5 years. Of greater concern is the fact that only 10% (as on 2013) of home deliveries were conducted by SBA. The remaining were being delivered by non-SBA i.e. 21,944 deliveries which is a significant population of mothers (and newborns) who might be at risk of suffering morbidity and mortality for e.g. Kangra with the highest reported institutional delivery also reports the 3rd highest home deliveries in the State, second to Mandi and Chamba.

- While challenges of difficult terrain and remote areas are present, lack of assured transport and facilities to cater to this population is a stumbling block in the delivery of services. For e.g. in Kangra, the MOs are being mobilized to encourage the pregnant women, to shift to a birthing/waiting home proposed at CH Baijnath (in Mahakal block which reports the highest home deliveries) in the last month before their due date.

Graph 9



Source: HMIS

- All designated Delivery Points have not been conducting adequate deliveries. For instance, while there 8 facilities designated as delivery points in Chamba district, adequate number of deliveries have been conducted at RH chamba and SC Kalsui only in 2012-13.

- None of the SCs are designated delivery points, but they catered to about 2% of the deliveries in 2011-12 due to the presence of highly motivated and skilled ANMs e.g. Female health worker at SC Kalsui, District Chamba has conducted 198 deliveries till 10.11.2013 in the current FY and in total 1270 deliveries since 2005 at the SC, that too in the district in which the percentage of institutional deliveries is around 52%. As against her area of 18 villages, patients from around 35 villages in the vicinity come to her. All the eligible women (54) till 10.11.2013 were paid the benefit under JSY. In the facility, we were informed that anticipated excess medicines in this facility were diverted to other centres well in time before the expiry date.

Sign Board, Sub Center, Kalsui, Chamba district

- The reduction in the number of SCs recording deliveries to about 1% in 2012-13 is attributed to the retirement of the concerned ANMs from the SC where deliveries were conducted. In the current year 2013-14, there are no deliveries recorded at the SC in Kangra, as the ANM posted there has retired.

There are 8 SNCUs and 59 NBCCs available in the State. Kangra has 4 SNCUs, all of which are functional. There were no admissions at the Zonal hospital, Dharamsala at the time of visit. In addition, there is a fully functional SNCU at the Medical College, Tanda. The SNCUs at Medical College, Shimla and Tanda are being upgraded and facility based new born care is an area of special focus especially across the L3 and L2 delivery points. Operational issues and bottlenecks were observed at a few institutions with regard to the SNCUs for e.g. at CH Palampur, 4 radiant warmers had been supplied in June 2013, but were not being used as the staff had not received any training for the same. Standard protocols and SOPs, especially in the labour room and new born care corners were not observed at any of the facilities visited in Kangra. Meanwhile in Chamba, there is only 1 SNCU and there are no NBSUs. The newly established 6 bedded SNCU at RH Chamba was manned by the paediatrician and staff nurse from RH. The staff nurse deputed from RH to the SNCU has not received any FBNC training so far. Also, the SNCU didn't have any power back up facility. During the visit, only one child was admitted at the SNCU. The availability of this facility is yet to be publicized in the district, especially when majority of the sick children in the district are dependent on the paediatrician at the RH.

Two Nutritional Rehabilitation Centres are being established at IGMC, Shimla and RPMGC Tanda where children up to 5 years with malnutrition are to be treated and nutritious food will be provided. There is no NRC in Chamba district.

C. ARSH & School Health

ARSH clinics, known as the Yuva Pramarsh Kendra, have been established across all the District Hospitals in the State. There are 96 ARSH clinics in the State, with 160 MOs and 226 paramedical staff trained under ARSH.

Table 18: Status of ARSH

S.no.	PARTICULARS	2012-13	2013-14 (Up to September)
1	Total no. of clients registered	11139	24626
2	No. of clients seen this month	7353	11561
3	Counselling services given		
	Nutrition	3606	3698
	Skin diseases	1174	1879
	Pre-Marital Counselling	767	502
	Sexual Problems	562	352
	Contraceptive	582	448
	Abortion	197	152
	RTI/STI	1280	1241
	Substance Abuse	323	337
	Learning Problems	81	168
	Stress / Anxiety	534	423
	Depression	139	284
	Suicidal Tendency	53	68
	Violence	142	68
	Sexual Abuse	348	19
	Other Mental Health Issues	75	41
	Others	710	1595
4	**No. of Clients Referred**		
	RTI/STI Clinic	653	730

S.no.	PARTICULARS	2012-13	2013-14 (Up to September)
	Skin OPD	167	529
	Psychiatry OPD	68	144
	OBG	72	74
	Others	212	112
5	**Outreach Activities**		
	Direct in schools/colleges	18375	10185
	Teen Clubs	520	295
	Youth Festivals	350	367
	Health Mela	288	70
	Others	1892	1649

Source: NRHM Status, September 2013, HMIS, HP

ARSH clinics have been set up in the both Chamba and Kangra, and outreach sessions have been initiated. ANM and MPW were aware about the programme and reported conducting outreach at schools and anganwadis. School children interacted during the visit shared that they have been told about menstrual hygiene, adverse effects of tobacco, need of taking Iron Folic Acid tablets, alcohol and drug use and HIV/AIDS during these sessions. However, the programme is yet to progress on its desired outputs - Adolescents have not yet started sharing their issues openly with designated staff or ANM, even though mechanisms such as question boxes are set up at schools.

The WIFS programme has been rolled out across the State. Various promotional IEC related to the "Solid Bano India" campaign were observed across all the facilities visited in Kangra. As per State report, both the adolescent boys and girls in government schools, approximately 7 lakh children, are covered in the State.

The Menstrual Hygiene programme, under which subsidized sanitary napkins are provided to adolescent girls was rolled out at four districts in the first phase – Mandi, Bilaspur, Hamirpur and Una. This is set to be expanded across all the districts to cover an additional 4 lakh girls in this financial year.

Table 19: Total Adolescent girls reached under The Menstrual Hygiene Programme

Time Period	Mandi	Una	Hamirpur	Bilaspur	Total
July 12 – March 13	229371	191897	151904	174871	**748043**
April 13 – September 13	151058	139323	96302	69603	**456286**

Source: NRHM Status, September 2013, HMIS, HP

State officials shared that strengthening of de-addiction centres is being undertaken with psychologists and psychiatric social workers who are being trained at NIMHANS, Bangalore and that they would be deployed with the Medical Officers for efficient service delivery.

Table 20: Service Delivery at De-Addiction Centres (OPD & IPD)

Substances Abused	OPD		IPD	
	2012-13	2013-14 (Up to Sept.)	2012-13	2013-14 (Up to Sept.)
Tobacco	1379	1243	99	1130
Alcohol	1570	1578	329	1669
Opium and its derivatives	150	123	23	20
Marijuana and its derivatives	304	158	39	47
Solvents/Inhalants	92	104	7	13
Medicines Misused	171	207	16	11
Multiple/Others	343	3	0	0
Total	**4009**	**3416**	**513**	**2890**

Source: NRHM Status, September 2013, HMIS, HP

Under RBSK, the schools are divided into clusters and teams of 14-16 members visit the clusters on scheduled dates. The team members consist of the MO, AMO, MO (BDS), Health Educator, Female Health Supervisor/ Male Health Supervisor, Ophthalmic Assistant, Dental mechanic, pharmacist (allopathic and ayurvedic), Male health worker and 4 Female Health Workers. The schedule details upon the name of the cluster, date of visit, number of children and names of the team members. The following table highlights the details of the activities under the RBSK programme in the State:

Table 21: Activities under the RBSK Programme

S.no.	Particulars	Total
1	Number of cluster camps organized	2191
2	Number of children examined	468842
3	Number of students referred	39424
4	Anemia	66099
5	Skin Disease	16408
6	Dental Disease	66498
7	ENT Disease	25023
8	Eye disease	23766
9	Mental Illness	481
10	Cardiac illness	372
11	Physical disabilities	513
12	Others/non classified	90458

Source: NRHM Status, September 2013, HMIS, HP

Both WIFS and RBSK are operational in Kangra and Chamba. There was good co-operation between the Anganwadi worker as well as the ANM for the administration of the WIFS tablets, as well as the school health teams. School staff interacted with the team shared that the school health has been useful and that majority of the issues identified were managed at the team level itself. Interactions with children in the communities visited also affirmed this as the children reported that they received the iron folic tablets in their respective schools. The children screened were referred to

higher health facilities and the child along with 1 attendant was taken to the facility for further follow up. CRM team could meet with a boy of 3rd standard in Chamba district who has been supported by school health programme for a kind of skin degenerative disease. CRM team applaud such effort as well as exhort the local health administration to keep up such good work. A round up of district-wise RBSK achievements for years 2012-13 & 2013-14 (from Apr-Sep 2013) is given below.

Table 22: District-Wise Status of RBSK (2012-13)

S.no.	District	Camps held			Children Covered		
		Target	Achievement	%age	Target	Achievement	%age
1	Chamba	262	228	87.02	106950	68480	64.03
2	Kangra	651	588	90.32	194412	200127	102.94
	State	**3427**	**3336**	**97.34**	**1046842**	**869785**	**83.09**

Source: NRHM Status, September 2013, HMIS, HP

Table 23: District-Wise Status of RBSK (2013-14) [Apr.-Sep. 2013]

S.no.	District	Camps held			Children Covered		
		Target (Apr-Sep 2013)	Achievement	%age	Target (Apr-Sep 2013)	Achievement	%age
1	Chamba	157	234	149	54694	66440	121.50
2	Kangra	330	359	108.80	96918	62878	64.90
	State	**1909**	**2373**	**124.30**	**524908**	**559881**	**106.70**

Source: NRHM Status, September 2013, HMIS, HP

As on date of visit, there was no District Early intervention center (DEIC) established at either Kangra or Chamba. One doctor in Chamba has been trained in DEIC related matters.

D. Community Level Care arrangements

Post-partum visits of the mother and new-born continue to remain an area of concern in the State. Post Natal Care between 48 hrs and 14 days of deliveries is 55% in the State, 80% in Kangra and 50% in Chamba. Home based new born care is also performed to a limited extent by Anganwadi workers and ANM. The quality of these services is a concern as the Anganwadi worker has received no or limited inputs for the same. No incentive was received by Anganwadi worker in this regard.

E. Family Planning

The TFR of the State is 1.8 (SRS 2012), much lower than the national average of 2.4. The total unmet need for family planning in Himachal Pradesh is 14, with a higher unmet need for limiting (9.1) than spacing (4.9). The same trend was reflected in Kangra and Chamba.

Table 24: Achievement of Kangra district under Family Planning Programme

Method	2010-11	2011-12	2012-13	2013-14	
				Q1	Q2
IUCD Insertions	3165	3137	3380	601	951
PPIUCD insertions (subset of IUCD)	DNA	DNA	DNA	DNA	DNA
Sterilization:					
Female Sterilisation	4071	4242	4289	160	179
Male Sterilisation (NSV)	95	94	83	2	7
Condom Users	11077	10654	14412	3281	3510
Oral Pill Users	3388	6098	5188	422	940

Source: District HMIS, Kangra

PPIUCD training for the master trainers is reported as under way at the State level and this will be taken up at the respective districts. Fixed day IUCD services are available across the facilities from the DH down to the SC level. Laproscopic sterilisations (83%) form the majority of the sterilisations. Spacing methods account for 85% of all the reported family planning methods. 53% are reported to be condom users, while IUD accounts for 13% of the reported methods. District wise annual calendar for camps are drawn up at the districts. There were 4 MOs and 638 ANM/SNs providing IUCD services in Kangra. In addition, there were 4 laparoscopic surgeons and 3 NSV surgeons. 9% of the total funds received for compensation for sterilization have been utilized at Kangra.

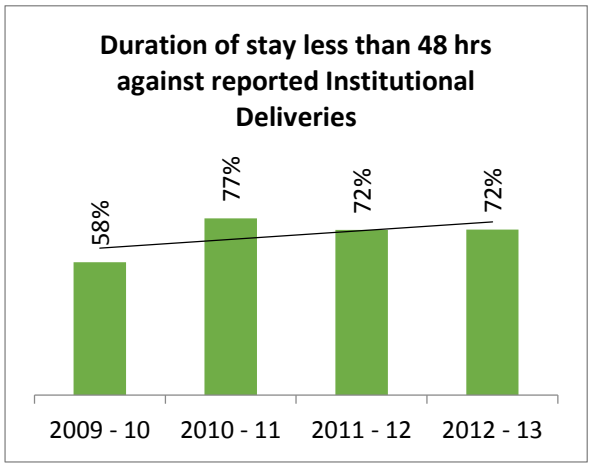
F. Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK)

The beneficiaries interacted with were well aware of the benefits of JSY and JSSK, as well as provision of free services for delivery under the flagship programme of JSY and JSSK in Kangra but the reverse was observed in Chamba where the awareness was very low. Direct Benefits Transfer (DBT) was not yet operationalized in Kangra district, but has been functioning in 6 districts of Himachal Pradesh, and account payee cheques were given in Kangra. Chamba meanwhile, has a mixed picture for mode of JSY benefit with all modes of payment- direct cash payment (CHC Bathri), bearer cheque (SC Kalsui), account payee cheque and DBT being the payment methods. Long delay for issuing the transfer has been observed in DBT cases due to the requirement of documents. While beneficiary interacted SC Kalsui confirmed the receipt of JSY benefit through bearer cheque, at CHC Chowari, it was observed that no single beneficiary was paid JSY benefit since January 2013, and at

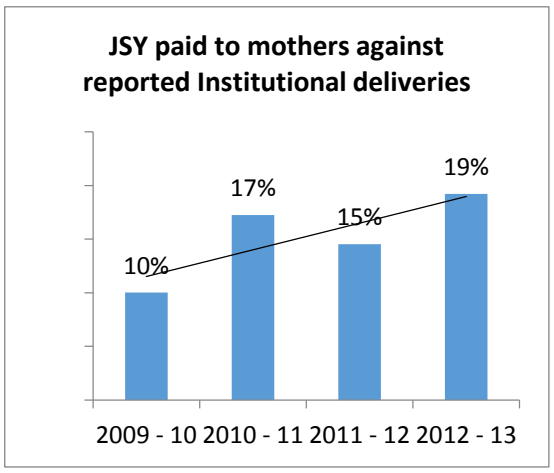
RH Chamba, out of 47 identified beneficiaries in October, 2013 only 2 were paid the benefits. Though zero balance account and relaxed KYC norms were prescribed for savings accounts, non-opening of accounts due to non-availability of branches nearby and procedural cost in terms of number of visits and documents required was very common. It is observed that this is leading to non-disbursement of JSY benefits. District administration may explore the possibilities of interface with available banks in the vicinity to overcome this problem. In contrast, facilities which were not selected for DBT were disbursing JSY benefits through cheque or by cash.

While the women interacted with in Kholi village in Kangra, who had institutional delivery, reported receiving JSY benefits, the women interacted with in the urban slum of Dharamsala, who had undergone home deliveries reported not receiving JSY benefits. Similarly, in Chamba, at SC Rajnagar, the home delivery cases were not provided with JSY benefits. The JSY benefits were given to the SC/ST women who underwent institutional delivery and for home deliveries as well in case of BPL beneficiaries. Moreover, in Kangra, in the current year, 2013-14, as against the target of 2899, only 50% of the beneficiaries have been provided with the JSY benefits. The duration of stay less than 48 hrs was high at 72%, due to the beneficiaries not willing to stay in the facility post the delivery and correspondingly only 19% of the institutional deliveries have been paid JSY benefits.

Graph 10



Graph 11



Source: HMIS

JSSK is operational in the State since its launch. There was display of boards with the JSSK entitlements listed out which were available at the facilities visited in Kangra district, but this was lacking at most facilities (except Sub Centers) in Chamba. The beneficiaries interacted with at the hospital as well as the community were well aware of the programme. Diet services under JSSK were provided at all the facilities which are designated delivery points, except one facility in Chamba. The diet provision included very hygienic food prepared as was observed by the team. All the beneficiaries (with children under 1 year of age) interacted with in the communities in Kangra said that they incurred OOPs primarily on medicines, followed by transportation. On the other hand, 8 of the ten delivered mothers interacted with in the institution at Kangra, reported OOPs only on transportation. The remaining 2 women had availed 108 services to reach the facility. The transportation amount was reimbursed at the facilities at Rs.8 per km, but all the women interacted with in the institutions said that they intended to take private vehicles back to their homes. There was no separate grievance redressal mechanism for JSSK. All the facilities at Kangra had complaint box which functions as the grievance redressal mechanism for the patients, while at Chamba there was no complaint boxes at some facilities and were non-functional (unlocked, etc) at places where they were installed.

Complaint box at CH Palanpur, Kangra

G. Maternal and Infant death review

Facility based maternal and infant death reviews were being conducted in Kangra and Chamba. For e.g. in CHC Nagrota bagwan, the maternal death review committee – with the nodal officer, MO, ward sister and a trained Dai held its last meeting on 30.09.2013. However, verbal autopsies were not observed in all the cases as observed in the case of a pregnant woman who passed away at RH, Chamba in recent past.

Table 25

	2011-12	2012-13	2013-14 (Up to September)
Maternal deaths reported	35	24	14
Maternal death reviews conducted	35	24	14

Source: HMIS

H. Immunization Services

The full immunization for 0-11 months is reported to be 112% as against the reported live births in the State. Similarly, in Kangra and Chamba this figure stands at 111% and 110% respectively. There is double reporting leading to the inflated figures. The number of immunization sessions held as against the number of sessions planned is 98%. All the facilities visited in Kangra district had functional ILRs and deep freezers with temperatures being maintained. Mobilization of the children due for vaccinations was done by the Female Health Worker. The MCP card was used by the beneficiary and referred to by the ANMs in order to track the children due for immunization. While this is so, the health workers interacted with did not have a definite tracking system for dropouts in place in both districts. Upon being asked the same, the health workers responded that they kept track of the children by their register entries and reminded these families about the next immunization session during their field visits. This seems to be an issue as all the health workers interacted with had hand-written registers and these entries during field visits are then copied out to their respective registers in the facility. This can result in errors in the tracking information. Moreover, no micro plan was noticed at any of the sub-centers visited in Chamba district. The drop-out rate from BCG to measles is 8% in the State and 11% in Kangra.

Recommendations

- All designated Delivery points were not equipped to provide comprehensive range of RCH services due to various bottlenecks including non-availability of human resources, lack of mentoring support, lack of essential medicines and equipment, etc. Action plan development at lower levels needs to be strengthened to plan and operationalize all designated delivery points. PIP development workshops may be conducted for the same and hand-holding support may be provided to Block level officers.
- High risk pregnancy tracking and line listing of anemic women needs to be ensured at sub center level and should be monitored regularly. Available mechanism such as MCTS should be used more effectively for the same. Measures such as sensitization of health workers, color coded cards, separate OPD services, Birth Preparedness and Complication Readiness plans, etc, shall be explored for better care of High risk pregnancies.
- Quality of Care for pregnant women and new born is an areas of concerns as there were no Standard Operating Procedures (SOPs) developed and followed across CH, CHC and PHCs and as partographs were not being used. These were reflected in birth asphyxia and poor management of complications. State should ensure that partographs are used. Protocols and SOPs should be developed and disseminated among the facilities and their display at work stations across all facilities should be ensured.

- Quality of sick newborn & childcare was also facing hurdles in terms of protocols, trained manpower & operational issues. Training of existing human resources needs to be synchronized with up gradation of facilities and equipment, pool of mobile training resources for facility level support.
- While the efforts for increasing the acceptability of institutional deliveries are to be paced up, State has to ensure that the home deliveries happening are 'safe'. SBA trainings should be scaled up systematically to cover all ANMs and Staff Nurses, and mechanism must be established to ensure that home deliveries are attended by SBA. Differential planning is required to address District and block specific issues and hurdles, and to increase the acceptability of SBAs in the community.
- State may ensure that micro- plans for immunization are prepared at sub- center level and are used in planning and mobilizing children for VHNDs.
- Skills and Competency assessment of existing human resources needs to be conducted so as to enable in the operationalization of facilities.
- Mentoring support mechanism needs to be established across various levels. Medical Colleges can be engaged formally in such endeavors through CME and facility mentoring visits. Further, findings of Supportive Supervision exercise initiated by State at various levels need to be analyzed, feedback provided to the facilities and progress reviewed through Action Taken Reports as part of the monthly CMO review meetings.
- Exposure and cross learning visits shall be organized with better performing districts in the State and other States.
- Bio-medical waste management is an area of concern in the State. The system in the district of Kangra appears to be a good initiative and options may be explored to replicate the same in other parts of the State.
- Infection prevention practices need to be improved with training of health personnel on basic infection prevention practices.
- Public grievance redressal mechanisms should be streamlined - Initially, high case load facilities need to be prioritized and public grievance redressal mechanisms established, widely displayed and patient satisfaction surveys conducted.
- A well-defined strategy for outreach activities through health workers, AWW and ASHAs (to be recruited) needs to be developed to increase acceptability and utilization of ARSH services.
- District administration may explore the possibilities of interface with available banks in the vicinity to overcome the issue of delay in JSY benefit disbursement for lack of documents.

TOR III – DISEASE CONTROL PROGRAMMES

The targets and achievements under Diseases Control Programmes over the years is as follows:

Table 26: Targets and Achievements in various Disease Control Programs as per

Parameters	NRHM Target	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14 (Up to 30.9.13)
Malaria mortality Rate (NVBDCP)	To be reduced by 50% by 2010 & additional 10% by 2012	0 death	0 death	0 death	0 death	0 death	0 death
No. of Malaria cases (NVBDCP)		144	192	210	247	216	118
Cutaneous Leishmaniasis (NVBDCP)		-	161	227	139	146	149
Visceral Leishmaniasis (NVBDCP)		-	-	Nil	6	1	Nil
T.B. Case Detection Rate (RNTCP)	To maintain at more than 70%	83%	82%	80%	82%	76%	88%
T.B. Cure Rate / success through DOTs (RNTCP)	To maintain at more than 85%	87%	88% / 90%	89%	89%	88%	90%
Leprosy Prevalence Rate (NLEP)	To be reduced from 1.8/10,000 in 2005 to <1/10,000 by 2012	0.25	0.21	0.26	0.25	0.25	0.21
Cataract Operations (NPCB)	Op. at rate of 300/1,00,000 population	27012 (Target 30000)	29181 (Target 30000)	29377 (Target 30000)	33035 (Target 40000)	23878 (Target 21000)	12803 (Target 23100)

A. National Iodine Deficiency Disorders Control Program (NIDDCP)

Salt testing is carried out at the State.

Table 27: Comparison of Salt Sample Testing Report under NIDDCP

2012-13				2013-14 (up to Sep. 2013)			
No of salt samples tested	**No. of salt samples with Nil Iodine**	**No. of salt samples with inadequate iodine (less than 15ppm)**	**No. of salt samples with adequate iodine (above 15 ppm)**	**No of salt samples tested**	**No. of salt samples with Nil Iodine**	**No. of salt samples with inadequate iodine (less than 15ppm)**	**No. of salt samples with adequate iodine (above 15 ppm)**
1429	0	0	1429	767	0	0	767

Source: HMIS

It was cited that the IDD kits were last supplied in 2009 and centralised supply was sought for the same.

B. Integrated Disease Surveillance Program (IDSP)

Integrated Disease Surveillance Programme has been operationalized in the State from March 2004 onwards and under this programme surveillance is being done for the different diseases. For purpose of good and timely communication from State to central IDSP command centre V- SAT had been installed at all the 15 sites in the State (12 Districts, 2 Medical Colleges & 1 State Headquarter), however, currently these are not functional because of hardware related reasons.

Table 28: District wise Percentage for the month of September, 2012 and September, 2013

District	Total Reporting Units (RUs)	September-12		September-13	
		Reported RUs	%age	Reported RUs	%age
Bilaspur	153	142	92.81	149	97.55
Chamba	229	121	52.95	152	66.38
Hamirpur	185	156	84.19	182	98.38
Kinnaur	58	48	81.90	51	87.07
Kangra	540	394	72.92	540	100.00
Kullu	124	114	92.14	119	95.97
Lahaul & Spiti	63	46	73.41	51	80.95
Mandi	387	329	85.08	347	89.60

Solan	226	179	79.31	205	90.60
Shimla	354	293	82.70	283	79.87
Sirmaur	193	149	77.33	180	93.01
Una	161	130	80.59	146	90.53
Total	**2673**	**2119**	**79.28**	**2403**	**89.91**

Source: HMIS

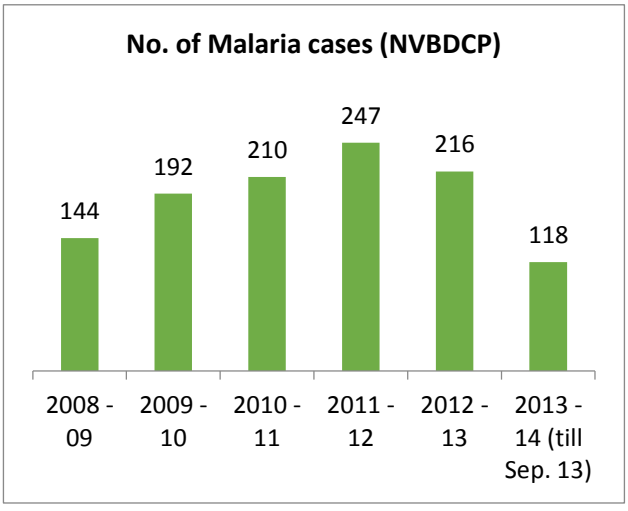
Recommendations

District/block action plan need to use IDSP data more rigorously for better and more effective planning and implementation of various disease control programmes. Also the data collected from IDSP needs to be reviewed in monthly and quarterly review meetings.

C. National Vector Borne Disease Control Program (NVBDCP)

In general, there was good availability of reagents and stains across majority of facilities that team visited. In addition, availability of drugs for chemoprophylaxis as well as for treatment ensures disease rates can be effectively controlled. Decrease in incidence of total Malaria and *P.vivax* malaria after 2011 was noted; even though there was an increase in incidence of these from 2009 to 2011. API in the State was 0.1 in 2012 and is 0.02 for 2013 (till Sep.). However, surveillance activities need to be improved so as to increase the current ABER rate from 7.4% to a target rate of 10%.

Graph 12



Source: HMIS

The State has reported some cases of dengue that have been on the increase since last 2 years.

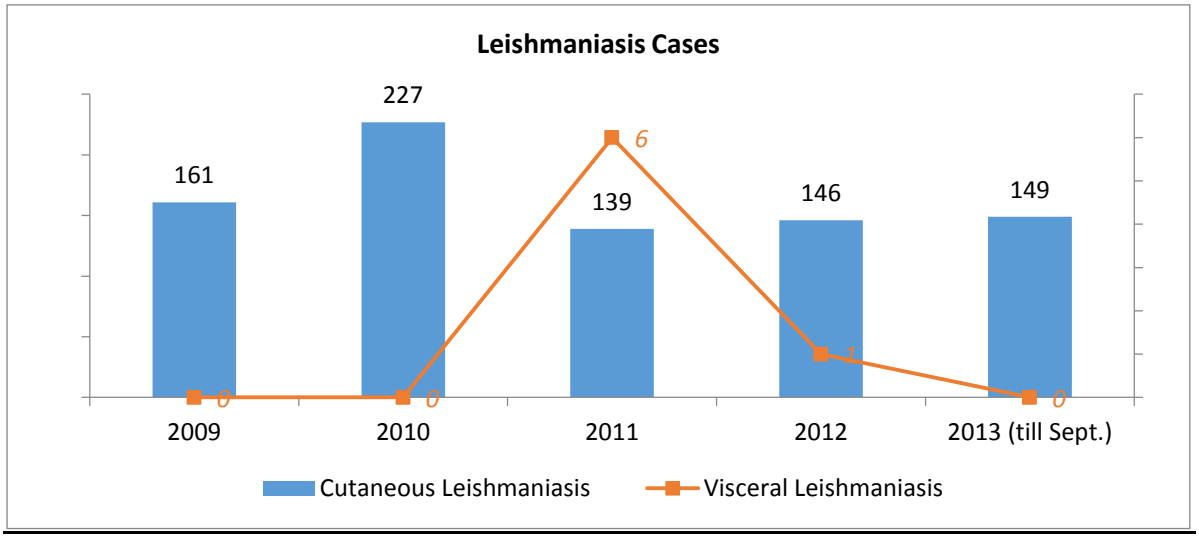
The team didn't find any specific mechanism in the facilities visited to record and report/notify cases of Dengue. Chikungunya or Japanese encephalitis on the other hand have never been reported for last 5 years.

The reason for concern however 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. Moreover, health department has also issued a directive to medical officers for treatment of all cases of suspected scrub typhus with doxycycline/ azithromycin unless contraindicated.

Cases of cutaneous Leishmaniasis have been increasing in the State since 2009, and this form of Leishmaniasis was introduced to the State via migrant workers. Now local transmission of disease has been established. Although health department's concentrated efforts have borne fruits in terms of reducing the number of cases since 2010 but still a lot needs to be done.

Graph 13



Source: HMIS

Recommendations

Coherent and actionable plans to address the emerging threats from Leishmaniasis and Scrub Typhus in the State are required due to the increasing incidence of these cases. Better IEC/BCC activities for this purpose and engagement with migrant worker population will help in stemming the increase in number of cases. Also, review meetings of NVBDCP are to be conducted as per the extant guidelines with proper follow up of the agreed upon action plan in these meetings.

Surveillance activities should be improved so as to increase the current ABER rate from 7.4% to the target rate of 10%.

D. Revised National Tuberculosis Control Programme (RNTCP)

Global objectives of case detection and treatment success rate under the programme are being achieved by the State since last 7 years. District TB Officers are in place in all districts, as are trained contractual staff for fieldwork. There is provision of free diagnostic services through 180 DMTCs and free of cost treatment through DOTS centers in all health facilities including Ayurvedic facilities,

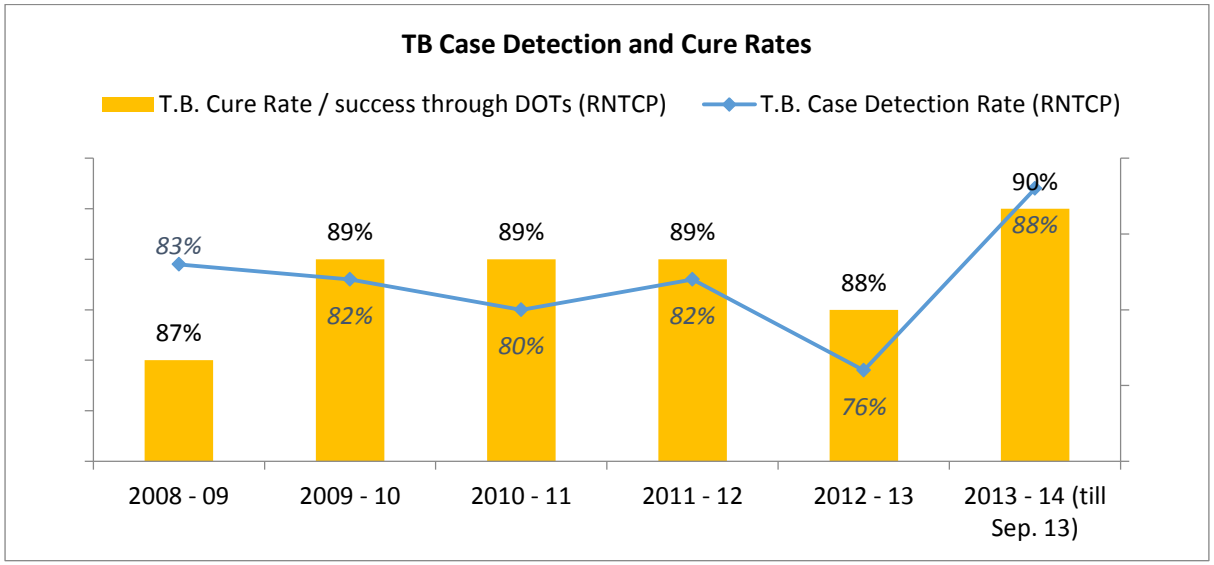
Anganwadi Workers and community volunteers. The motivation of field staff as well as awareness amongst population was quite high which was reflected in the State's progress in TB goals.

Table 29: Achievements in RNTCP

Parameters	Year 2008	Year 2009	Year 2010	Year 2011	Year 2012	Apr-Jun 2013	Jul-Sep 2013	Oct-till Nov 2013
Total pts. regd. for treatment	13618 (82%)	13743 (83%)	14179 (82%	13501 (77%)	13615 (76%)	3446 (77%)	3936 (88%)	3553 (79%)
NSP (New Smear Positive) pts. registered for treatment	5091 (83%)	5057 (82%)	5133 (80%)	4748 (73%)	3060 (77%)	1316 (79%)	1502 (91%)	1319 (79%)
New smear negative pts. regd. for treatment	2541	2374	2438	2214	2146	505	559	525
New EP (extra-pulmonary) pts. regd. for treatment	2921	3223	3363	3259	3222	856	1050	888
3 months conversion rate of NSP	92%	92 %	91%	91%	89%	92%	92%	91%
Cure rate of NSP	87%	88 %	87%	88%	87%	87%	87%	88%
Success rate of NSP	89%	90 %	89%	89%	89%	89%	90%	90%
Deaths in NSP pts.	224 (4%)	176 3%)	185 (3%)	187 (4%)	173 (3%)	42 (4%)	50 (3%)	49 (4%)

Source: HMIS

Graph 14



Source: HMIS

Diagnosis of Multi Drug Resistant (MDR)-TB is done through intermediary reference lab at Dharmapur by solid culture and LPA culture and DST lab at IGMC Shimla through liquid culture. GeneXpert® has been established to further strengthen the programme along with free treatment and follow-up for all MDR-TB cases. Case-based web entry system of all diagnosed TB cases in NIKSHAY portal has been implemented in the State.

Recommendations

Even though public health facilities have done a commendable work in checking TB in the State, sensitization and involvement of both private health providers needs to be ensured to further improve the reach of programme, esp. for paediatric-TB case detection. Culture and DST lab at Medical College Tanda needs to be made functional at the earliest to ensure timely diagnosis and treatment for TB cases. There also is a need for improving collaboration and engagement of private providers along with strengthening of notification of TB cases by them for better case detection. Human resource at State TB cell, Drug resistant TB Center, IRL and State drug store also needs strengthening. Trainings/ Sensitizations in General Health system/ Medical Colleges are to be planned and undertaken at large scale as different categories of staff are not aware of recent changes in the programme.

Supervision, Monitoring and evaluation of the programme at State/district/block level needs to be strengthened as State/ District level officers are having multiple job functions.

E. National Leprosy Elimination Programme (NLEP)

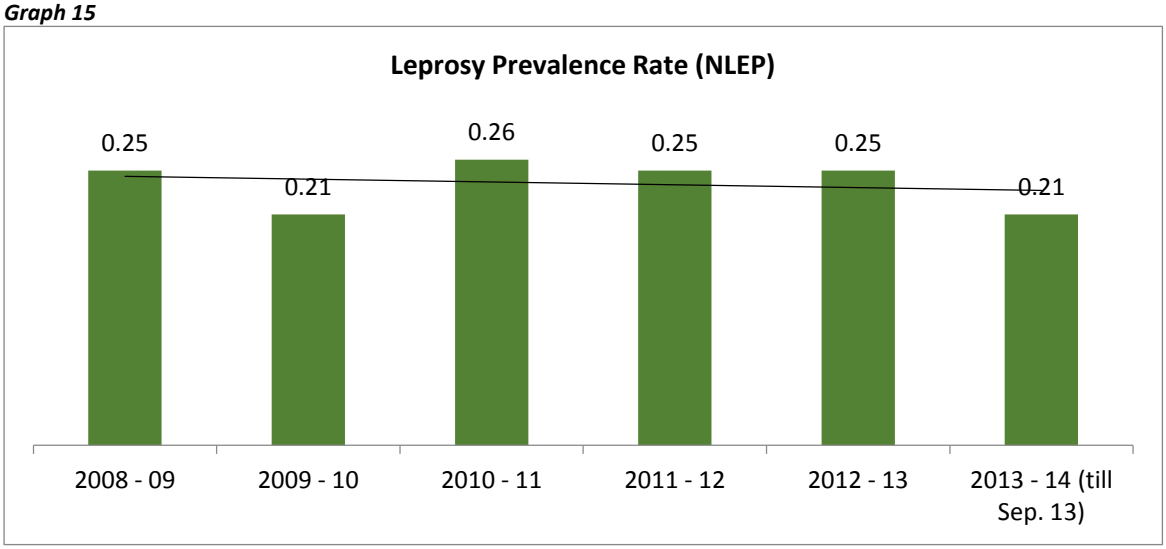
In general, the team found implementation of programme good with MDT medicines and equipments were available at the facilities visited. However, an area of improvement that State needs to address at the earliest is the training of district programme officers for NLEP to enable them to have better implementation of NLEP in the State.

Table 30: Achievements in National Leprosy Eradication Programme (NLEP)

1.		**Cases detection and Treatment (2012-13)**	**Cases detection and Treatment (Apr.–Sep. 2013)**
i)	New cases detected	166	91
ii)	ANCDR (Annual New Case Detection Rate)	2.81/100,000	2.36/100,000
iii)	Cases under Treatment	148+11 Others	161+12 others
iv)	Prevalence Rate	0.21/10,000	0.21/10,000
v)	No. of cases deleted	191	79

Source: HMIS

Graph 15



Source: HMIS

F. National Programme for Control of Blindness (NPCB)

State achieved more than its target for cataract surgery and intra-ocular lens implantation at 61% and 67% more than target for year 2012-13. However, the respective numbers have decreased to 55% and 58% in 2013-14.

Vision testing aids at Sub Centre, Kalsui, Chamba district

Table 31: Achievements for 2012-13

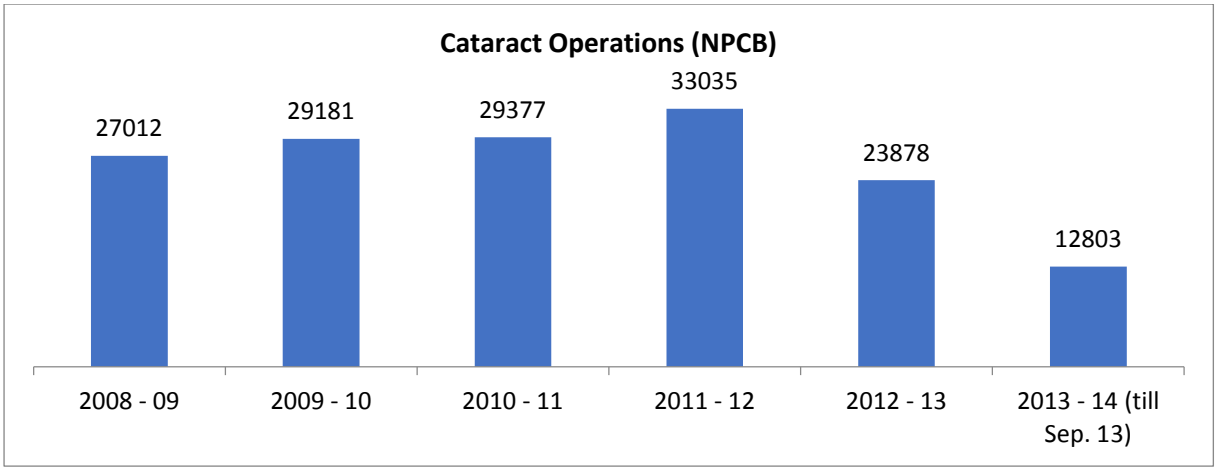
Cataract Surgery Done			IOL Implantation			School Children Screened			Refractive Error Detected			Free Specs Provided To Poor Children		
Target	Ach	%Age	Target	Ach	%Age	Target	Ach	%Age	Target	Ach	%Age	Target	Ach	%Age
21000	**33911**	**161.48**	**19950**	**33270**	**166.76**	**120000**	**267496**	**222.91**	**7200**	**8848**	**122.88**	**3000**	**2879**	**95.96**

Table 32:Achievements for 2013-14 (April 2013 to September 2013)

Cataract Surgery Done			IOL Implantation			School Children Screened			Refractive Error Detected			Free Spects Provided To Poor Children		
Target	Ach	%Age	Target	Ach	%Age	Target	Ach	%Age	Target	Ach	%Age	Target	Ach	%Age
23100	**12804**	**55.40**	**21945**	**12638**	**57.60**	**120000**	**167881**	**139.90**	**7200**	**3215**	**44.65**	**3000**	**836**	**27.87**

Source: HMIS

Graph 16



Source: HMIS

It was noticed that the eye specialist posted at a Civil Hospital in Chamba district had to carry out eye surgeries without the assistance of refractionist. State may ensure that such instances are avoided and ophthalmic assistant/refractionist, etc are ensured at facilities where eye surgeons are available.

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

Under the first phase of this programme, three districts of Chamba, Kinnaur and Lahaul &Spiti have been selected. In Chamba it was launched in 2010 whereas in Kinnaur and Lahaul & Spiti it was launched in 2011. As informed, a team of female and male health worker from the Sub centre measure B.P and glucose at camps and their facilities. Various camps for detection were conducted and the suspected cases were then referred. Awareness camps for early diagnosis and treatment were also conducted. Staff shared that drugs were provided up to 2 – 4 weeks for those diagnosed with the Hyper Tension or Diabetes.

The CRM team found that screening facilities for Diabetes and Hypertension were available even at sub-centres and PHC level which is a very good start for this programme. Also, critical care units have been established at district level facilities. Facility for cancer screening and treatment though, needs to be made available in the districts and speedier implementation of phase II of the programme is also needed.

Male Health Worker conducting the screening test for diabetes at SC, Kiani, Chamba district

It is estimated that the overall prevalence of diabetes,

hypertension in India is 62.47 and 159.46 respectively per 1000 population or 6.24% (diabetes) and 15.9% (hypertension). As can be seen from table below, these figures range from 4.2% - 11.4% (diabetes) and 4.8% - 8.6% (hypertension) for the districts in Himachal Pradesh.

From the table one alarming finding is the high prevalence of Diabetes even in this difficult mountainous terrain that offers plenty of physical exercise & labour, the benefits of which can be seen in the figures for hypertension that are almost ¼ - ½ of all India figures.

Table 33: District wise progress (January - September 2013)

Name District	No of person screened	Suspected for diabetes (% of screened)	Suspected for Hypertension (% of screened)
Chamba	24892	1162 (4.66%)	1479 (6.0%)
Kinnaur	2707	309 (11.41%)	233 (8.6%)
Lahaul & Spiti	19581	830 (4.23%)	948 (4.84%)
Total	**47180**	**2301 (4.88%)**	**2660 (5.64%)**

** Hypertension defined as diastolic blood pressure of >90mm of Hg*

Source: HMIS

The doctors and nodal officers were trained at the medical colleges. Moreover, a surveillance project with the medical college is ongoing where Kinnaur district is attached to the Shimla MC, Chamba and Lahaul and Spiti are attached with the Tanda Medical College for analyzing the morbidity data and supporting the districts. Inclusion of the gynaecology departments for screening of Cervical Cancer is reported as in pipeline.

One issue brought to the notice of CRM by the nodal officer was the supply of glucose strips. The supply of glucose strips was made directly to the district and there were wastage of the strips as the supply was in excess of the requirement.

Recommendations

- The high prevalence of diabetes (esp. in Kinnaur) needs to be further studied and accordingly appropriate IEC/BCC activities to be planned and implemented with special emphasis on IEC. Screening of school children so as to teach and catch them young before they fall prey to diabetes is also required.
- Supply of glucostrips and other consumables may be made need-based.

TOR IV – HUMAN RESOURCES AND TRAINING

Female Health workers and Health Educators at PHC Tiara, Kangra District

A. Generation of Human Resources

There are 2 medical colleges in the govt. sector in Himachal Pradesh – IGMC, Shimla and Medical College, Tanda (in Kangra district). A private medical college was opened at Solan district in the current financial year and another ESI medical college is to be set up for the next academic year. There are 100 seats each in the govt. colleges and 150 seats in the private college. Post graduation seats in the govt. colleges number up to 138. There are 6 recognized GNM and B.SC Nursing institutes in the State. In Chamba there are 3 private nursing training institutes with a total of 90 seats.

B. Availability

The following table highlights the status of Human Resource for Health in the State.

Table 34.a: Status of HRH in 2007

HRH Parameter	2007				
	Required [R]	Sanctioned [S]	In Position [P]	Vacant [S-P]	Shortfall [R-P]
❖ ANM (at SCs)	2071	2213	1836	377	235
❖ MPW/ Male HW (at SCs)	2071	2008	1270	738	801
❖ Health Assistant Male at PHCs	443	413	361	52	82
❖ Health Assistant Female at PHCs	443	351	283	68	160
❖ **Staff Nurse at DH**	-	-	-	-	-
❖ Staff Nurse at PHCs & CHCs	940	1199	484	715	456

HRH Parameter	2007				
	Required [R]	Sanctioned [S]	In Position [P]	Vacant [S-P]	Shortfall [R-P]
❖ Lab. Techs. PHCs & CHCs	514	443	318	125	196
❖ Radiographers at CHCs	71	66	54	12	17
❖ Pharmacists at PHCs & CHCs	514	443	303	140	211
❖ MOs at PHCs	443	628	628	0	*
❖ Specialists total at CHCs	284	NA	NA	NA	NA
– Physicians at CHCs	71	NA	NA	NA	NA
– Surgeons at CHCs	71	NA	NA	NA	NA
– Obstetricians &Gynaecologist at CHCs	71	NA	NA	NA	NA
– **Anaesthetist at CHCs**	-	-	-	-	-
– Paediatrician at CHCs	71	NA	NA	NA	NA
❖ Block extension educators at PHCs	NA	84	60	24	NA

Source: RHS 2007

Table 35.b: Status of HRH in 2012

HRH Parameter	2012				
	Required [R]	Sanctioned [S]	In Position [P]	Vacant [S-P]	Shortfall [R-P]
❖ ANM (at SCs)	2065	2213	1694	519	371
❖ MPW/ Male HW (at SCs)	2065	2008	1183	825	882
❖ Health Assistant Male at PHCs	472	413	22	391	450
❖ Health Assistant Female at PHCs	472	350	61	289	411
❖ **Staff Nurse at DH**	-	-	-	-	-
❖ Staff Nurse at PHCs & CHCs	1004	546	376	170	628
❖ Lab. Techs. PHCs & CHCs	548	352	195	157	353
❖ Radiographers at CHCs	76	71	72	*	4
❖ Pharmacists at PHCs	548	614	368	246	180

HRH Parameter	2012				
	Required [R]	Sanctioned [S]	In Position [P]	Vacant [S-P]	Shortfall [R-P]
& CHCs					
❖ MOs at PHCs	472	582	436	146	36
❖ Specialists total at CHCs	304	NA	5	NA	299
– Physicians at CHCs	76	NA	2	NA	74
– Surgeons at CHCs	76	NA	1	NA	75
– Obstetricians &Gynaecologist at CHCs	76	NA	0	NA	76
– **Anaesthetist at CHCs**	-	-	-	-	-
– Paediatrician at CHCs	76	NA	2	NA	74
❖ Block extension educators at PHCs	NA	87	0	87	NA

Source: RHS 2012

From the above tables the following points can be inferred:

Table 36

HRH Parameter	Required	Sanctioned	In position
	% change from 2007-12	% change from 2007-12	% change from 2007-12
❖ ANM (at SCs)	0%	0%	-8%
❖ MPW/ Male HW (at SCs)	0%	0%	-7%
❖ Health Assistant Male at PHCs	7%	0%	-94%
❖ Health Assistant Female at PHCs	7%	0%	-78%
❖ Staff Nurse at PHCs & CHCs	7%	-54%	-22%
❖ Lab. Techs. PHCs & CHCs	7%	-21%	-39%
❖ Radiographers at CHCs	7%	8%	33%
❖ Pharmacists at PHCs & CHCs	7%	39%	21%
❖ MOs at PHCs	7%	-7%	-31%

Note: - indicate decrease from 2007

From 2007-2012, while the requirement has increased uniformly by 7%, the sanctioned posts has increased only for the radiographers and pharmacists, and decreased for staff nurses, lab techs and MOs. Meanwhile, there has been a decrease across all the category of staff in position, except radiographers and pharmacists.

Table 37

Indicator	2007	2012
SCs without an ANM	18%	18%
SCs without MPW (male)	36%	40%
SCs without ANM/ MPW	2%	11%
PHC without MO	7%	6%
PHC without lab tech	28%	44%
PHC without pharmacist	32%	41%

Source: RHS 2012

Moreover, the facilities without a MPW and those without either ANM/MPW has increased. Similarly, PHCs without lab tech and pharmacist has also increased.

As per the HR status as on visit, there was a vacancy of 45% of MPW (males) and Lab technicians in the State, followed by 17% pharmacists, 14% staff nurses, 8% ANMs and 5% MOs. A similar trend was observed in Kangra district where there was vacancy of 47% MPW (males) and 40% LTs, followed by 24% pharmacists, 20% MOs, 8% staff nurses and 2% ANMs. In Chamba, there is only one Gynaecologist, one Anesthetist and 2 Paediatricians in the entire district. There have been changes over the NRHM period due to the incentives - monetary and non-monetary benefits such as reduced service years for PG seats in in-service quota and choice posting after specific tenure at difficult areas for doctors. The vacancies in the facilities in tribal and remote areas of Bhramour and Kinhar, vacancies of MOs at CH Dalhousie have been filled recently. Similarly, gynaecologist at the RH, Chamba joined in the current year.

Table 38: HRH status as on date of visit

	Regular		Contractual			Total in position
Category/ type of personnel	**Sanctioned posts**	**In position**	**Sanctioned posts**	**In position (through State/other sources)**	**In position from NRHM**	
ANM	2213	1697	0	4	326	2027
MPW/ Male HW	2008	1107	0	1167	203	1107
Staff Nurse total	2437	736	0	1167	203	2106
DH	366	385	0	0	0	385
FRU	339	292	0	0	0	292
24X7 PHCs	101	102	0	0	0	102
LTs	674	433	0	0	36	372
DH	97	75	0	0	12	87

	Regular		Contractual			
Category/ type of personnel	**Sanctioned posts**	**In position**	**Sanctioned posts**	**In position (through State/other sources)**	**In position from NRHM**	**Total in position**
FRU	100	75	0	0	0	75
24X7 PHCs	88	41	0	0	0	41
Pharmacists	871	495	0	105	126	726
MOs total	1697	1173	0	444	0	1617
Specialists						
Obstetricians &Gynaecologist	0	35	0	0	0	35
Anaesthetist	0	23	0	0	0	23
Paediatrician	0	30	0	0	0	30

Source: HMIS

The greatest vacancy is present among the MPW (male) cadre. There have been no recruitments in the same in recent years and the last trainings for MPW (male) were conducted in the year 2002. The work profile of the MPW (male) was also not clear, as most of them were functioning in a supportive capacity to the ANM. They were responsible for blood slide collection and identification of TB patients as well as being DOTS providers. In Kangra, there were 4 Gynaecologists, 3 Anesthetists and 8 Paediatricians posted across the DH and Civil hospitals. In 18 of the PHCs in Kangra district there were no MOs. State officers shared that regular walk-in interviews, every Tuesday, were conducted at adjoining district of Pathankot as well in order to recruit MOs. Of the 438 SCs in Kangra, 6 of them did not have any health worker posted. As reported, staff recruitment has been done through the regular post, on a contractual basis and through RKS contractual staff.

C. Deployment

The State continues to face challenges in terms of the rational deployment of staff across the facilities. Every 2-3 months an exercise is undertaken whereby stock of the existing trained manpower vis a vis the postings are reviewed. In the preceding month, 21 employees were re-deployed based on their skills and requirement at the facilities. There is no policy at the State level with regard to the postings and transfers.

Medical Officer at CHC, Bharmour, (Tribal area) Chamba district with a patient

It was observed that existing manpower at some of the facilities visited either have the skill sets but no support in terms of infrastructure or have the infrastructure in place but not the necessary manpower to carry out the same functions efficiently. For e.g. at Nagrota Bagwan CHC (Kangra District) there was one Gyneacologist and 4 SBA trained nurses, with an average of only 12 deliveries performed in a month. The reason cited was the proximity of the medical college, which was 8 kms away from the CHC. Similarly, the blood bank at Palampur had no sanctioned post of technician and at the time of visit, 1 technician had been employed through the RKS funds in order to operationalize the blood bank. Of the 7 Civil Hospitals in Kangra, only 2 were recording C-sections. In Chamba, the LSAS trained doctor was posted at the RH. Placement of SBA trained staff nurses and ANM was not ensured at all facilities conducting delivery. As per the reports available with MoHFW, a total 710 ANM have been given SBA training in the State since 2011-12, however, only 1% of total reported deliveries in 2012-13 were conducted at Sub Centers, clearly indicating non-performance of the desired functions after training. In Chamba, deliveries were conducted at only one Sub Center in 2013-14. The reasons for the same need to be ascertained and corrective actions need to be initiated with utmost priority.

D. Workforce management

Himachal Pradesh provides for incentives for the medical staff at extremely hard terrain areas of the State and in order to encourage the posting of available contractual MOs and specialists, the govt. of HP has framed an incentive scheme in addition to the fixed salary. Incentive to MOs have been revised upward from Rs. 10000 – Rs. 25000 and for MO (Specialist) revised from Rs 20,000- Rs 40,000. There is 66% reservation for PG seats to General Duty Medical Officers having done mandatory service ranging from 2-3 years as against 5 years for other areas. A choice place of posting can also be exercised after mandatory service. In addition to this, there is provision of retaining Government Accommodation at State or District Headquarters for family during hard area posting. However, district officers in Chamba reported that the policy of choice posting is exercised with great difficulty due to the clause that those who complete the tenure can get relieved only after the joining of the replacement, which takes abnormally longer period. Similarly, they informed that the incentives for many areas in Chamba are inadequate as they are fixed at the same levels of that in difficult areas of

Pharmacist at CHC Bharmour, Chamba district

lower terrain while it is a more difficult area at upper terrain, and staffs are generally reluctant to serve in these areas.

Table 39

Area	Mandatory service period for PG	Monthly incentive	
		MO	Specialist
Chamba – Pangi & Bharmaur, Tissa **Lahaul & Spiti**- All Medical Blocks **Kinnaur** – Sangla & Pooh, Nichar (Except bhabanagar) **Shimla** – Chirgaon, Nerwa & Tikker **Mandi** – Chohar valley of Padhar block	2 yrs	Rs.25000	Rs.40000
Kinnaur- Bhabanagar of Nichar Block, **Kullu** – Nirmand & Anni **Mandi** – Karsog & Janjheli **Chamba** – Pukhari, Choori, Kihar & Samote **Sirmaur** – Shillai & Sangrah **Kangra** – Mahakal **Shimla** – Nankhari, Matiana, Kotkhai & Kumarsain	3 yrs	Rs.20,000	Rs. 30,000
Other Medical Blocks of the State (excluding the above and below) and NRHM office.	4 yrs	Rs. 10,000	Rs.20,000

Table 40

HRH	Kinnaur			Chamba			Lahaul & Spiti		
	Sanctioned	**Positioned Before Policy**	**Positioned after policy**	**Sanctioned**	**Positioned Before Policy**	**Positioned after policy**	**Sanctioned**	**Positioned Before Policy**	**Positioned after policy**
No. of MO	58	24	48	17	9	15	48	15	31
ANMs	15	7	12	34	22	31	30	10	22
Staff Nurses	45	19	34	13	7	10	29	20	26
No. of Gyneacologist	1	Nil	1	1	Nil	1	1	Nil	Nil
No. of Paediatrician	1	Nil	1	1	Nil	2	1	Nil	Nil
No. of Obstetrician	-	-	-	-		-	-	Nil	Nil
No. of Surgeons	1	Nil	2	1	Nil	2	1	Nil	Nil

Source:HMIS

E. Training and capacity building

There are two training centres in the State – the SHFWTC Parimahal at Shimla and the RHFWTC at Kangra. In Kangra, in 2012-13, 3 doctors were trained in EmOC, 26 doctors and 16 staff nurses in SBA, 1 doctor in LSAS. Apart from these trainings on MCTS & HMIS for BMO, doctors, health workers and health supervisors was conducted. Immunization training for 80 female health workers and training on menstrual hygiene programme was conducted for 11 BMOs/Doctors, 394 health workers and 4 health supervisors.

Table 41: Status of training, Kangra, 2013

Sl.No.	Name of training	Category	Total trained
1.	BEmOC	Medical Officer	3
2.	EmOC	Medical Officer	3
3.	SBA	Staff Nurses	3
4.	HMIS & MCTS	Block MIS operators, MHS, FHS, FHW, MPW	39
5.	LSAS	Medical Officer	2 (in progress)

Source: District HMIS

Recommendations

- State may fill-up the vacancies in regular positions.
- Policy for rational deployment of existing HR needs to be formulated with utmost priority and needs to be adhered to. Current positioning of trained manpower such as specialists and EmoC and LSAS trained doctors, SBA trained nurses and ANM, etc shall be reviewed against the plan for operationalizing facilities and appropriate repositioning or contractual appointment to ensure the presence of trained manpower at required facilities should be carried out.
- Implementation of the incentive scheme for working in hard to reach areas needs to be reviewed and limitations must be addressed by the State. To ensure the fixed tenure at very hard areas, MOs may be rotated after completion of required tenure and they shall be given choice posting after serving in very hard areas.
- Deployment after training on specific inputs such as EmOC, LSAS and SBA must be ensured at appropriate facilities. State should also implement mechanisms for ensuring the performance of desired duties post training by the staff.

TOR V – COMMUNITY PROCESSES AND CONVERGENCE

A.PRI

The PRIs were involved in Kangra and there was good involvement of the representatives in the functioning of the VHSNC, RKS and District Health society. The Rogi Kalyan Samitis were functioning very well in Kangra. Records of meetings and accounts audit reports were available. In a few hospitals such as CHC Palampur and Kangra Civil Hospital, the RKS has been able to mobilise community funds and these have been put to good use within the hospital. However, the picture is the opposite in Chamba were no active involvement of PRIs was observed, especially in the case of VHSNCs.

B. VHSNC

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 VHSNCs were active in Kangra District. Meeting with the *up Pradhan* at the SC Seerthana indicated that the community was active in putting forth their requirements, which are aimed at improvement of health related activities. The female health workers interacted with in Kangra reported that the VHSNC committees were active and regular meetings were held. While this was the case, the records of the meetings were not available with the female health workers as the VHSNC committee meeting registers were maintained by the *Up Pradhan* of the committee. As both the up Pradhan and the female health worker are joint signatories to the account and expenditure activities, it was reported that at a few SCs the activities and expenditure were primarily decided by the *Up Pradhan*.

VHSNCs have been formed in all the 283 Panchayats in Chamba, however, the committees were not able to utilize the funds judiciously. The participation of Panchayats and other functionaries was minimal. As the VHSNCs were not able to furnish the utilizations, the funds were not allocated to them in this year's PIP. Some of the Panchayats have undertaken sanitation work and were providing safe water to the communities. It is recommended that the Health Educator along with other functionaries take a lead in the functioning of the committees. VHSNCs need training in maintaining Expenditure records. Further supportive supervision inputs should be provided on VHSNC. There is an urgent need to mainstream the activities of VHNSCs at the higher level. Meetings similar to the ones for EMRI, where in State and district officials review EMRI programme with respective programme officers from the partner agency on a monthly basis, may be conducted for VHSNCs also. Also, VHNSCs should be pro-actively involved in the District Health Planning processes.

C. VHND

A total of 31,943 anganwadis reported having conducted the VHNDs in 2012-13, whereas in 2013-14 (till the date of visit), a total of 16,487 anganwadis reported having conducted the VHNDs.

Regular VHNDs were held at Kangra. The female health worker has a *beat programme* chalked out at the beginning of every month and carries out her activities as per this schedule. As reported, the VHNDs are held on fixed days every month for e.g. at SC Seerthana the VHND is carried out on the 1st Tuesday, while at SC Sidhbari it is scheduled for the 1st Friday and other villages are covered as per the schedule. The female health worker and the anganwadi worker were involved in the VHND activities. They mobilize the women as to the upcoming VHND dates. However, as reported by the ANM, it is primarily a platform for counselling and guidance sessions – a meeting with the mother. All the VHNDs were reported to be attended by the *Up Pradhan* who presides over the meeting.

In Chamba, VHNDs were being conducted on Tuesdays; however, the participation of other departments (Water and sanitation, Education) was below expectations. Therefore, convergence is an issue in the area. The Aanganwadi in Barhmour block has not kept any records of the VHNDs. There was no proper reporting and monitoring mechanisms for the activity in State as the team couldn't find any documentation or record with the Aanganwadi regarding the VHNDs in the village. IEC/BCC initiatives have not been undertaken to raise awareness among people about the services being offered at the VHNDs. There was general lack of awareness among service providers on the services to be made available on VHND.

The service providers need to be given an orientation on the functioning of VHNDs. It is recommended that to generate the demand for services the Health Educator along with other functionaries should carry out IEC/BCC initiatives in the area so that people can avail the services during the VHNDs. Mid-Media can be very used to send across the messages.

Community monitoring was lacking in all the sites visited by the team. Community has to be mobilized to enhance their participation in planning and monitoring various government schemes. Various IEC/BCC activities can be undertaken to raise awareness and mobilise people to avail services. In areas like Barhmour which is a tribal area, mid-media can be used effectively for improving the participation of people in monitoring and availing the services provided by the government.

D. ASHA

The State does not have the ASHA cadre in place, and recruitments are planned from December, 2013. The ASHA work profile and job responsibilities have been listed out based on the GOI guidelines, but no other outline was available at the State.

With a full time paid Anganwadi worker also carrying out a multitude of health related functions which would be assigned to the ASHAs once they are in place, the State needs to have a clear strategy and work profile for the ASHAs, which are specific to the State's needs. A detailed strategy including ASHA training calendar, ASHA resource center, and co-ordination mechanisms with FHW and AWW needs to be developed to capitalize on the opportunity of creating a new cadre at the community level.

E. Convergence

Convergence amongst the health department, the ICDS and the education department was observed in Kangra district. This was reflected in the fact that the Anganwadi workers along with the female health workers form a strong link in service delivery. VHNDs and immunization camps are held at the AWCs, whereas along with the education department, the roll out of WIFS is being implemented.

Recommendations

- PRI involvement in RKS and VHSNCs needs improvement.
- In order to enhance the functioning of VHSNCs, measures such as Health Educator along with other functionaries taking lead in the functioning of the committees, mainstreaming the activities of VHNSCs at the higher level such as districts and State, pro-active involvement of VHSNCs in district health planning process, etc are suggested. VHSNCs need training in maintaining Expenditure records also. Further supportive supervision inputs should be provided on VHSNC. Meetings similar to the ones for EMRI, where in State and district officials review EMRI programme with respective programme officers from the partner agency on a monthly basis, may be conducted for VHSNCs also. Also, VHNSCs should be pro-actively involved in the District Health Planning processes.
- VHNDs need to be better documented and properly monitored from different levels to achieve the intended outputs. Demand generation of VHNDS along with widening the range of services available also is required.
- State needs to have a clear strategy and work profile for the ASHAs, which are specific to the State's needs, as some of the functions of ASHA have been undertaken by Anganwadi workers.

TOR VI – INFORMATION AND KNOWLEDGE

A. HMIS

Health information snapshot of the block at CHC Nagrota Bagwan, Kangra district

Service delivery reporting is being done mainly through DHIS in the State, which has been integrated with the national HMIS indicators. Recently, State has initiated the process of shifting to facility based reporting in the National HMIS web portal. Accordingly facility based reporting is being done in both districts visited. Block MIS operators have been recruited through outsourcing and were placed at every block. They ensured uploading of the data related to their blocks. The Sub Center health workers fill the requisite formats for data collection and then submit the reports at the block which is then entered into the web portal.

One of the good practices observed in the State was that mobile based reporting from the SC level is given a thrust. All the Sub Center ANMs have been provided with a mobile and the HMIS reporting format is loaded in the handset. The ANM is to fill up this format and send it across through an SMS. District TOTs were conducted with the block MOs, Statistical assistants and health workers. Also ANMs were given 50 paise per sms from the Untied fund pool. Average monthly cost incurred by the health worker was Rs.2 and a total of 8-10 messages were required for sending the format. While this is an innovative by the State, it is in its initial stages and is overcoming the challenges such as reluctance of the health workers to use the mobile application and technical difficulties like the non-uniform short codes across mobile/telephone service providers.

It was observed that there are systems in place for checking and validating data at the data entry points. Periodic meetings were conducted at district and block level where HMIS/MCTS data is used for taking corrective actions by giving evidence-based feedback to the blocks/facilities. Efforts to improve information system management were also evident such as implementation of Hospital Information System at big facilities.

B. MCTS

MCTS has been functional up to sub center level. However, State is yet to achieve 100 % reporting from facilities as shown in the table below.

Table 42: Status of reporting of data related to pregnant women and children for the month of October, 2013

S. No.	Reporting Unit	Total mapped facilities	Pregnant Women		Children	
			Reporting facilities	%	Reporting facilities	%
1	Districts	12	12	100.0%	12	100.0%
2	Blocks	70	70	100.0%	70	100.0%
3	Health Facilities	601	497	82.7%	492	81.86%
4	Sub Facilities	2,690	2,096	77.92%	2,032	75.54%

Printed registers have been observed at sub center levels in both districts visited by the team. Data entry to the web-portal was done at block level. However, the MCTS register used by the State didn't have provisions for recording Hb level in ANC care, thus missing a crucial link for line listing and tracking of pregnant women who are aneamic.

C. SHSRC & SIHFW

State does not have a State Health Resource Center, however the roles envisaged for SHSRC are currently played by the SIHFW.

There is 1 SHFWTC at Shimla and 1 RHFWTCs at Kangra and the CRM could visit RIHFW in Kangra district. The capacity of this institute was not exploited to the maximum because of a vicious cycle of understaffing and poor quality of facilities. The facility was facing problems like old infrastructure, lack of connectivity, dysfunctional library, lack of connection with on-the job trainings and out-dated aids and equipment's.

State has recently initiated sharing of formats, new information, orders, etc. to district and block level officials by uploading them on the website. Use of this provision was observed in the field mainly in case of government orders. State may design a methodology for reviewing the extent of use and exploring maximum potential of this initiative.

SIHFW and RHFW have identified list of experts from a range of governmental, educational and civil society organizations for tapping their expertise for public health planning and management.

Recommendations

- In order to tackle the resistance to transition to use of computers, staff at various levels may be sensitized about the long-term benefits of use of such technologies and conduct capacity building exercises to improve their computer skills.
- Higher level of analysis of HMIS data can be undertaken to identify and address emerging problems (e.g. identify pockets of increasing prevalence of NCDs that need corrective action).
- State must ensure that all PHCs and Sub-centers are correctly and completely mapped in MCTS to achieve universal reporting of registration of pregnant women and children. Also, it must be ensured that all health facilities report registration and service delivery data in MCTS on a regular basis.
- State may solicit support of technical organizations/experts and develop strategic intervention plans e.g. PGI is assisting Haryana State.

Mobile phone based reporting of HMIS data by ANMs at Sub-Centre Seeerthana, Kangra district

- Updating of practitioners' , especially of doctors, technical knowledge is a critical area that needs immediate attention as the team could observe that many of the doctors interacted were not aware of new treatment guidelines and advancements in the public health arena. Apart from ensuring the participation of doctors in CMEs, forums and e-based groups for knowledge sharing (e.g. communities of practice started by designated experts, bulletin boards, etc.) may be created so that even remotely located health practitioners have access to current knowledge. Links with existing public service material made available by development partners (e.g. WHO, National Mental Health Programme, etc.) as well as the latest GOI guidelines may be provided on the website.

Information and Knowledge

- State must ensure that all PHCs and Sub-centers are correctly and completely mapped in MCTS to achieve universal reporting of registration of pregnant women and children. Also, it must be ensured that all health facilities report registration and service delivery data in MCTS on a regular basis.

- State may solicit support of technical organizations/experts and develop strategic intervention plans e.g. PGI is assisting Haryana State.
- Updating of practitioners' , especially of doctors, technical knowledge is a critical area that needs immediate attention as the team could observe that many of the doctors interacted were not aware of new treatment guidelines and advancements in the public health arena.

TOR VII – HEALTH CARE FINANCING

There is a need to ascertain the proper mobilizing of funds, allocation of funds taking into account specific regions and population groups, funds for specific types of health care and overall to reduce out of pocket expenditure under NRHM. The financial power and administrative power have been delegated to SHS and DHS levels.

Major observations

However, during the visit, few areas of strength and some areas for improvements have been noticed.

- The functions of RKS have improved (GB Meeting, CA- Audit, and Representation from PRI in RKS meetings).
- Funds are transferred electronically from DHS to Blocks, thereby reduces the float time for clearance of funds.
- Most of the HR positions under Financial Management have been filled in.

However, few shortcomings have been noticed during the District visit, which needs immediate attention.

(1) Shortcomings under JSY:

a) Low pace of financial progress under JSY has been noted. Facilities with examples are as follows:

Table 43: Status of JSY payment at selected facilities

Facilities	Period	Total No. of Deliveries	Eligible Deliveries (say 30% for BPL, SC,ST)	Payments made
District Hospital - Chamba	October-2013	156	47	2 (Two only)
Civil Hospital-Chowari (Dist.-Chamba)	Jan to Nov-2013	24	6	Nil

b) No Line listing of Backlog under JSY Payments was available at any of the facilities visited in Chamba district, even though there were due lists prepared for eligible JSY beneficiaries. Since there were no listing/systematic identification of the eligible beneficiaries who hadn't received the JSY benefit, facilities hadn't taken measures for understanding the reasons of and addressing the issue of poor achievement under JSY. Moreover, this acts as a hindrance for taking the benefits to the intended beneficiaries and enhancing their utilization of the health care services.

c) Cash Payments to JSY beneficiaries was noticed in the field. In facilities like CHC- Sahoo of District-Chamba, the beneficiaries were being paid in Cash, which is against the norm of making JSY payments to beneficiaries.

d) Payments were made to beneficiaries of JSY only on demand**:** At Chamba District it was observed that the efforts were missing to ensure that JSY eligible women get their benefits before leaving the hospital. These were observed in all the facilities where the team visited in Chamba District.

(2) **Non-Maintenance of Bank Accounts as per GoI guidelines**

At DHS Chamba, it was noted that NRHM funds were not being maintained in the bank accounts as per GoI guidelines. RCH funds under few activities have been kept in the RKS account. E.g. RBSY funds were kept in RKS bank account.

(3) Inadequate Functionalities of RKS:

a) High unspent balances with RKS have been noted in many facilities as given in the table below

Table 44: Balance of Funds with RKS Accounts

Name of RKS	Balance as on 30.9.2013	Remarks
RH-Chamba	96,24,722.00	Very High Balance. Out of which Rs.80.88 lakhs related to RSBY.
CH-Dalhousie	27,79,371.00	High
RH-Chowari	15,58,855.00	
CH-Tissa	53,05,957.00	
CHC-Salooni	60,13,501.00	
CHC-Bharmour	73,77,516.00	
CHC-Killar	37,05,911.00	

There were facilities with skewed/ irrational Financial Utilization under RKS. Substantial portion of the RKS funds were utilized only for major civil works at CHC-Sahoo, and that to for beautification of rooms of Medical officer In charge and Office rooms, whereas the CHC was not having any signage, display board on health entitlements, Inverter for labour room, functional weighing machine, etc. At CHC-Sahoo, high value of construction works has been carried out, whereas from RKS fund basic patient welfare works had not been carried out. Taking cue from the CHC Sahoo, the State may verify the requirements of service delivery facilities with high unspent balance.

b) RKS remained non- functional and unaccounted withdrawals from the bank account have been noted at PHC-Bathri**.** During the visit it was observed that the earlier Medical Officer in Charge (MOIC) has not handed over charge to the present MOIC for operating the funds from RKS. The earlier MOIC has retired in May-2013 (as Stated by present MOIC) however withdrawals from

the bank account have been taken place even after his retirement. From the bank Statement and last year Audit Report it was observed that there were withdrawals of Rs. 385,493 which remained unexplained. The present MoIC had not communicated the bank authorities of the change in the signatory until the time of visit. Due to absence of charge handover, no Executive Committee meeting was held for the past 6 months and the RKS had remained non- functional in the period.

Table 45: Statement showing RKS Fund Position at PHC Bathri

Particulars	Amount
Op. Balance (1/4/2012)	149,337.00
Add: Fund Received (including User Charges) [F.Y. 2012-13, 2013-14]	10,64,325.00
Closing Balance (7/11/2013)	460,465.00
Balance available for Expenses	753,197.00
Expenses as per the AR of F.Y. 2012-13(after adjusting Depn.)	197,610.00
Further withdrawn / expenses (F.Y. 2013-14)	170,094.00
Balance i.e. Withdrawals/ Expenses whose evidences could not be made available.	385,493.00

The concerned authorities may verify and take suitable action to trace the above mentioned amount of Rs.385, 493.00 at the earliest.

4. Lack of adequate Utilization of UF (VHNSCs):

It is noted that in many cases Gram Pradhan and AWWs were not aware/ involved in the utilization of funds. Intermediary health functionaries were not involved in routing the funds. The funds were routed through Rural Development Authority and they are directly submitting the Utilization Certificate (UC) to the States. Nil utilization under Untied for VHNSC was reported during the year 2012-13. As a result during the F.Y. 2013-14 while giving approvals, no approvals has been under this activity head. The State may look for an alternative to improve utilization under this activity head. It is desirable to engage the VHSNC in order to utilize the funds on the desired objects.

5. Poor utilization of AMG and Untied Funds

In some HSCs it was observed that ANM was not proactive to utilize the funds although there were no essential equipments like baby weighing machine, BP apparatus, etc, in the centers such as SC

Sarol. State may initiate efforts to improve the fund utilization at Sub Center levels in a phased manner.

6. **AMG grant was given to Sub Centers functioning in non-government building in** Chamba district.

7. **Unnecessary Parking of funds:**
   a) SHS level: Funds received from GoI on 1.6.2013 disbursed to DHS on 12/7/13 and 24/8/2013.
   b) District level: DHS-Chamba, till date extra holding of funds meant for sub district level to the tune of Rs. 71,55,900.00

Human Resources

Most of the positions in the State under Finance have been filled except very few. The position of Director –Finance was being monitored by Jt. Controller of Accounts, who is from regular State service. The position of District Accounts Managers was filled up. At Block levels out of 70 Blocks, the positions of 69 Block accountants have been filled up. However, the position of State Accounts Manager has been vacant for more than a year. The State should fill up the vacant position at the earliest to improve the financial position. Process of performance appraisal financial management staffs for continuation has been observed.

It was observed that capacity of finance personnel at various levels needs improvement and adequate number of training are required to be organized. During the debriefing, the State Mission Director also acknowledged the need of training at various levels.

Maintenance of Records /Books of Accounts /Reporting

The State has maintained books of accounts in customized version of Tally ERP-9. At DHS also books of accounts have been maintained in Tally ERP-9.0.

Reporting / Monitoring / Utilization Trending

The State is regular in its Financial Reporting to Ministry. However, the same regularity was missing at DHS and Block levels. The financial monitoring within the State was observed as very weak. The Statutory Auditor in its Audit Report for the F.Y. 2012-13 has also flagged the matter of poor monitoring. The visit reports and findings of the supervisory visits/ field visits were not made available during the visit and could not be reviewed.

Due to poor monitoring, the utilisations under many activities were low and prudent utilisations of RKS funds have not been reflected.

During the F.Y. 2012-13, it is noted that few activities have been reported low pace of Utilisation. These are as follows:

Table 46

Activities	Approval (Rs. in Lakhs)	Utilization (Rs. in Lakhs)	% of Utilization
MMU	602.5	0	0%
Tribal RCH	40	10.87	27%
Vulnerable Groups	76	8.77	12%
Maternal Health	2977.19	1129.22	38%
Prog. Management	1897.11	467.6	25%

In addition, during the year 2012-13, nil expenditure under the Untied Funds for VHNSC was reported and as a result in no approval for untied funds were given in the 1st Phase for the F.Y. 2013-14.

The State had furnished the Audited UCs for the F.Y. 2012-13 along with Statutory Audit Report for funds given under NRHM pools to the Ministry. However, the pending UCs under SCOVA are yet to be received at the Ministry.

Strengthening of financial management is recommended to improve the pace of utilisation and better reporting of the same. Specific efforts are also required to monitor and evaluate the financial systems.

Fund Flow

It was observed that funds from SHS to DHS units and from DHS to Blocks were transferred electronically as directed by the Ministry. However, funds were transferred by SHS to the Districts on lump sum basis under the flexible pools, not activity wise as desired. Delays in distribution of funds and parking of funds at head quarter level have been noticed. The funds received from GoI on 1st June-2013 were distributed by the State on 20th July, 2013 and 5th August, 2013 for fund under Mission Flexible Pool. Similarly at DHS Chamba during the visit an extra holding of fund of Rs.71,55,900 was noted at Head Quarter level, which must have been distributed to Block and its peripheries.

Internal Control

Financial Management Indicators were not strictly complied with at various levels. Monitoring and Evaluation by PMU (State, District, and Block) was weak and there were minimal field visits. No

monitoring reports were available at different levels, including facilities. It was noted that monitoring of Expenditure are done by SHS and DHS on the basis of FMRs only which had resulted in less reporting of expenditure than what have been incurred. Ageing of Advances were not being done. It is observed that internal control system needs to be strengthened in respect of Fixed Assets, Stocks, Consumables, and Medicines. Lack of Inter-unit reconciliation of funds was informed by respective authorities at Chamba.

Auditing

- Statutory Audit had been done in 2012-13 and State had submitted the Statutory Audit Report along with Audited UCs for the F.Y. 2012-13 to the Ministry. However, the CRM team hadn't reviewed the reports.
- Concurrent audit was implemented in November 2013 for the SHS which was delayed by 7 months. However no concurrent audit was conducted in DHS Chamba or DHS Kangra. Further, no reports have been shared with the Ministry. It is recommended that concurrent audits to be conducted on time so that its purpose is served to the desired extent.
- As informed, AG Audit for year 2012-13 has been initiated at SHS.

The Quality of RKS audit by CA firms needs to be improved, as along with financial utilization the prudence of utilization has to be also considered.

Recommendations

- Shortcomings identified by the CRM must be addressed at the earliest.
- Monitoring of financial management needs to be strengthened. Direct visits from various level shall be carried out for providing hand-holding support and reviewing the performances.
- Capacity building of finance personnel is recommended to improve the financial performance as well accounting and reporting.
- Delay in funds transfer from State to down levels and facilities, pendency of funds at facilities, etc, should be avoided.

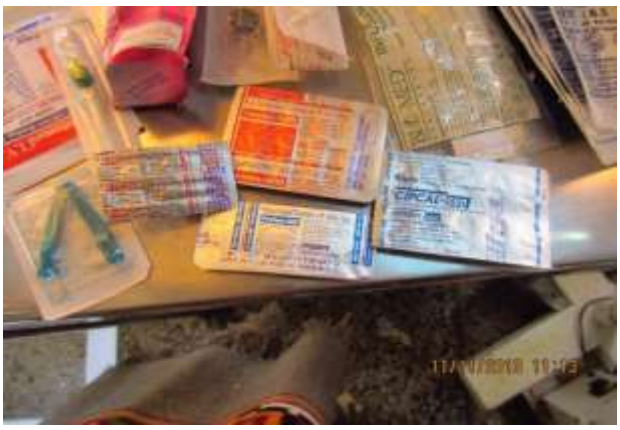
TOR VIII – MEDICINE AND TECHNOLOGY

Drugs, diagnostics and equipment's are three major areas of concern in the State of Himachal Pradesh and require immediate actions from the State authorities.

A. Drugs, equipment's and diagnostics

State has prepared an Essential Drug List comprising of 314 medicines and consumables. However, no facility wise EDL was available.

The State has rolled out a free drugs scheme for BPL patients, which provides 38 medicines free of cost to all eligible patients across public facilities.



This scheme was operational in both districts visited by the CRM team. No out of pocket expenditure on medicine has been noted from BPL patients interacted by the team in Chamba as either they are provided with medicines at the facility from the stock or from the Jan Oushadhi outlet or reimbursed from RKS. However, other patients had to buy medicines on their own. Instances of purchase of medicines including anti-biotics and tonics from private chemist shops by patients have been observed in both districts.

Jan aushadi shops- shops run by State Civil Supplies Corporation to provide generic medicines at subsidized cost- were present in the regional and civil hospitals visited by the team. There were no specific policies for assuring diagnostic services in the public facilities especially in remote areas like Chamba. The facilities were not able to assure lab services to public mainly because of the shortage of staff to provide lab services round the clock or even during the day shifts. State has taken actions such as outsourcing of diagnostic services post noon at zonal, regional and civil hospitals which have higher case loads. However, non- availability of even basic diagnostic services during morning shifts due to lack of lab technicians have been observed at below sub-district level facilities such as CHCs and PHCs (eg: Haemoglobin & urine for Albumin/Sugar in PHC Bathri) despite having necessary infrastructure, equipments and consumables. Recruitment of LTs or task shifting may be carried out to assure lab services. Lab Technician training for youth from the districts shall be facilitated to overcome the challenges on long run.

Availability of equipment's gives out a mixed picture as the team observed lack of equipment's in some facilities while found them lying idle in some other facilities (PHC Rajnagar and CH Chowari in

Chamba district). Also advanced diagnostic equipment's such as Sonography machine in CH Chowari were used once or twice in a year. While the major reason can be cited as shortage of staff, this is an evidence of irrational distribution of equipment's. State needs to do a mapping of available equipment's, review their usage and relocate them to appropriate facilities if required. Also creation and filling of posts like Radiographer is required to ensure that designated services are provided at facilities, especially at RH Chamba, and installed equipment's are put to use. Maintenance of equipment's was done at local level only and no mechanism of AMC was observed in the field. Mapping of existing equipment's and review of their usage may be done by the State and appropriate action such as relocation of equipment to right facility or redeployment of necessary staff from facilities not having scope of using the equipment shall be completed on a priority basis.

Lab Staff at work at PHC, Tiara, Kangra district

B. Procurement

Drug procurement systems in the State is through 3 channels – the civil supplies, Jan oushudhi outlets and through local purchase. The rate contract for the drug purchase is decided at the State level. Equipment's are procured through the HP Gen. Industries corporation (GIC) and HP State electronic development corporation. The budget flow is from the DHS to the CMOs and down to the BMOs. The Block MOs are the indenting officers as well as the chairman of the RKS committee. Online indenting for medicines is done. The MOs put up an order for procurement to the civil supplies, and in case of non-availability of drugs they procure it from the Jan Oushudhi outlets (which provides 38 generic drugs for BPL patients at low cost). In the event of this not being feasible, the MOs go in for local purchasing of the drugs. Additionally, seed money of Rs. 50,000 is available with the MOs for local purchase of drugs.

State had initiated steps for setting up a corporation like TNMSC for procurement and supply chain management of drugs and equipment's. However, the State cabinet did not approve the same on

the ground that the quantum of procurement does not justify a separate corporation. Hence, as informed, State is currently moving to set up an IT based drugs and equipment procurement mechanism under the State Civil Supplies Corporation which does all government procurements and distribution. This is certainly a welcome move and State must ensure that the design of this mechanism does address the issues identified by CRM and other issues such as difficult terrains and problems in physical and web connectivity.

The team found lack of clarity on the drug procurement at various levels leading to increased lead-time resulting in non-availability of free medicines.

C. Storage and supply

Lacunae's have been observed in both districts visited in terms of supply chain management and drug inventory management system at facilities.

Shortage of essential drugs was observed, especially in Chamba District. Shortage of IFA tablets was observed across the district of Chamba where last supply was one year ago, which has been informed as done by the WCD department. Drugs such as IFA syrup with dispenser, Zinc tabs, Injection Magnesium Sulphate, Misoprostol tablets, Mifepristone, etc were found out of stock in facilities. Wherever Zinc tablets were available, they were having expiry date in December 2013. It is recommended that medicines having shortage be supplied to the facilities at the earliest or alternate arrangements for ensuring drug availability be made. Facility level EDL must be prepared and the availability of drugs as per EDL must be ensured at all facilities

It is also noted that distribution of medicines has remained supply driven against demand driven as observed by the 5th CRM. Some of the facilities (e.g. Block PHC Tiara in Kangra) has adopted measures such as relocation of drugs nearing expiry to facilities, which require them. At the same time, there have been instances of discarding medicines at facilities due to non-requirement of them at the supplied quantity (e.g. 1210 tablets of a particular drug were discarded at CH Chowari).

Drug inventory management system at facilities needs attention from the higher levels. There was no proper recording of the drugs, including supply and distribution, under BPL free drugs scheme in facilities visited. These medicines were entered in the same register and distributed in the same pool as that of other general drugs. No mechanism was existing for monitoring the dispensing of drugs to the intended beneficiaries.

Facility and district store's staff had to prepare the drug registers manually, as printed registers were not available. These manually prepared register were not having provisions critical information such as manufacture and expiry dates, batch number and these were not recorded in the stock registers.

Condition of drug stores was very poor as observed by the team in both districts. Drug boxes and shelves were not arranged properly, list of medicines were not available/exhibited, and windows of rooms were broken/not in condition to close were only a few of the observations.

Drug Store at CH, Chowari, Chamba district

A quality assurance mechanism for drugs is existing, as informed by the State officials.

Recommendations

- Recruitment of LTs or task shifting shall be carried out to assure lab services. Lab Technician training for youth from the districts shall be facilitated to overcome the challenges on a long run.
- State needs to do a mapping of available equipment's, review their usage and relocate them to appropriate facilities if required. Also creation and filling of posts like Radiographer is required to ensure that designated services are provided at facilities, especially at RH Chamba, and installed equipment's are put to use.
- It is recommended that medicines having shortage be supplied to the facilities at the earliest or alternate arrangements for ensuring drug availability be made. Facility level EDL must be prepared and the availability of drugs as per EDL must be ensured at all facilities.
- The IT enabled procurement and logistics management system for medicines and equipment's shall be set up on a priority basis to improve the procurement and supply of medicines and to ensure their availability for the public. The design must address the issues identified by both 5th and 7th CRM.
- Facility level formats for drug inventory management shall be prepared and all pharmacists and store in-charges to be trained in proper inventory management. Supervision and monitoring structures for supply management shall be developed and implemented with designated responsibilities for each level of reporting.

TOR IX – NATIONAL URBAN HEALTH MISSION

Urban slum mapping has been done in Shimla and there are 35 slum areas notified as the high risk areas. Additional support has been sought in terms of the up gradation of 2 existing PHCs which cater to the slum population. Mobile health units have been proposed in order to render services to the urban slum community. 5 mobile units have been planned for Shimla(1), Sirmour(1), Una (1) and Solan (2). The industrial belts and regions of Sirmour, Una and Solan have been identified for the operation of NUHM. Outreach programmes are also envisaged for the ASHAs who will be recruited in this financial year.

Slum Dwellers and Community Health Worker, Dharamshala, Kangra district

The team interacted with the community at Chirankhat slum in Dharamshala. The slum population consists mainly of migrants from Rajasthan and Maharashtra. All of them were engaged as daily wage labourers. There was provision for water and electricity in the slum area – which was initiated by a local Tibetan NGO 'Tong Leng'. Common health problems faced by the respondents were fever, cold, joint pain, worm infestations etc. Apart from the health worker (posted through the NGO CORD at the Zonal hospital Dharamshala), other workers in the area were from the local NGO. As reported by the community, the community health worker visits the identified slum pockets for rendering immunization services and basic emergency care. There was an Anganwadi centre where the children attend. The preferred hospital for ailments was the Zonal hospital, Dharamshala. However, one person interacted with at the slum, whose hands were broken, hadn't got any treatment for the same. Upon asking he revealed that generally they do not get services from the hospitals in the area since they are from a different state.

Recommendations

CRM team identified that the following challenges need to be addressed proactively by the State

- Increasing prevalence of NCDs,
- Increasing prevalence of substance abuse and dependence in the slum areas,
- Potential for emotional health problems (e.g. psychosomatic disorders, health complaints of wives of men having substance abuse problems, domestic violence experienced by these women) which were noted in the interactions with the slum dwellers,
- Existing and emerging groups of vulnerable populations – construction workers, tourists and migrants.

Slum Dweller with his broken hand at

There was no specific programme wherein the health needs of most vulnerable groups are addressed (e.g., use of public health services among slum dwellers of Chirankhat was limited to tertiary care; some women who delivered at public facilities reported not receiving JSY payment)

In addition, a targeted approach and strategy to reach out to most vulnerable and hard to reach populations needs to be developed. State may identify specific health problems (e.g. fractures due to falls in Chirankhat) and develop targeted public health interventions for the same.

TOR X – GOVERNANCE AND MANAGEMENT

A. Programme Management

The current programme management structure in the State includes State Programme Management Unit, District Programme Management Unit and Block PMUs. SPMU is headed by the Mission Director and is largely manned by officers from regular cadre. DPMUs and BPMUs were observed as weak structures, mainly due to the non-availability of staff such as DPM. In Chamba, DPMU is staffed by a BPM acting as DPM, two accountants and an IEC/BCC coordinator. Review and strengthening of District and block programme management units is essential to improve planning and monitoring activities. State may fill up vacancies and ensure that majority of the staff time is dedicated for the identified core functions.

State has not yet notified the creation of Public health cadre. However, presence of doctors trained in epidemiology and public health has been observed in the field. These are doctors from government service who received public health training under NRHM at National Institute of Epidemiology, Chennai. While some of them were posted as State programme officers or District Epidemiologists, others were to be engaged meaningfully to utilize their skill sets for public health programmes.

State has created the Block Medical Officer position exclusively for management of public health interventions at Block level. While this is certainly a good move, it has not been implemented effectively as in many cases; CHC or PHC Medical Officers were playing this role along with their clinical responsibilities. This has been observed as creating additional burden for medical officers who have to provide clinical care and leads to compromises on both functions. District officials also pointed out that many times practicing doctors are reluctant to join such administrative positions. Options may be explored to engage doctors interested in public health management at this position than continuing it as a promotion based position.

State may meaningfully engage the public health doctors in government service to tap this resource. Also, options may be explored to post doctors interested and trained in public health as BMOs and take away or reduce their clinical responsibilities at facilities.

B. Institutional mechanisms for governance

District health societies have been functional in the State. Block and district health action plans have been developed.

Rogi Kalyan Samitis were in place and were having regular general body meetings and getting accounts audited. However, it is also found those Executive committees meeting were not regular resulting into ex post facto approvals. In some of the hospitals such as Palampur and Kangra Civil Hospitals RKS has been able to mobilise community funds and these have been put to good use. It is suggested that in order to increase the effectiveness of hospitals RKSs, the leadership at the facilities may be strengthened as in the case of Palanpur CH. Further, programmes may be carried out to enhance community participation like that in Kangra. Some of other good initiatives taken under RKS include setting up of dental clinic at CH Chowari and RKS engineering wing at RH Chamba.

There were 3 major sources of revenue for the RKS namely – User charges, GIA and RSBY. In most of the facilities it is found that there was a lot of money which was lying in the bank account. Further there was an overlapping of utilization of funds from RKS, AMG and untied funds for the various purposes. Substantial portion of the RKS funds were utilized only for Major Civil Work as observed in CHC Sahoo in Chamba district. Also financial irregularities such as unaccounted withdrawals (as mentioned in the section on Health care financing) and non-functioning of RKS (PHC bathri, Chamba district) have been observed in Chamba. All these indicate lack of monitoring of RKS functioning from various levels, including the SPMU.

Dental Unit set up by RKS at CH Chowari, Chamba district

C. Supervision and monitoring

State has rolled-out supportive supervision in the districts and plan and formats for supportive supervision visits have been communicated down to block levels. Visits have started taking place. However analysis and feedback from visits is yet to be initiated. MOs were paid Rs.250 per visit per month to visit Sub Centers, which was, as informed, based on an order issued for the same. It is recommended that feedback from supportive supervision is provided to the facility at the end of each visit and a copy may be handed over to the concerned facility-in-charge. Progress made by the facility may be monitored in further visits.

Requirement of intensive monitoring from State level is felt in remote areas such as Chamba where progress under NRHM has been lagging. This is specifically required for ensuring delivery of maternal

and child health services, utilization and accounting of funds and also for better functioning of VHSNCs and PRI involvement.

D. Accountability

Accountability measures such as social audit has not been observed and State may pay a special attention on the same.

Recommendations

- Review and strengthening of District and block programme management units is essential to improve planning and monitoring activities. State may fill up vacancies and ensure that majority of the staff time is dedicated for the identified core functions.
- Options may be explored to engage doctors interested in public health management at the position of Block Medical Officer position than continuing it as a promotion based position so as to enhance its effectiveness in managing public health programmes in the block.
- Leadership at the facilities may be strengthened as in the case of Palanpur CH to utilize RKS fully for the development and management of the facilities with enhanced community participation, and regular monitoring of RKS financial performances.
- Feedback from supportive supervision shall be provided to the facility at the end of each visit and a copy may be handed over to the concerned facility-in-charge. Progress made by the facility may be monitored in further visits.
- Apart from the existing monitoring mechanism of reporting and monitoring through video-conferencing with district health officials, State may intensify direct visits and explore options like having technical support from Medical colleges in the region and development partners. District level vigilance and monitoring committees can also play a great role in ensuring desired progress in NRHM implementation in the districts and State shall fasten the process of establishing them.