Seventh Common Review Mission - Maharashtra

Objectives:

1. Review progress of National Rural Health Mission/National Health Mission with reference to the functioning of NRHM vis-à-vis its goals and objectives-Identify the changes that have occurred in last eight years and reasons for the current states and trend.
2. Review programme implementation in terms of accessibility, equity, affordability and quality of health care services delivered by public health systems including public private partnership (PPP).
3. Review of progress against conditionalities and the State's response to conditionalities.
4. Review follow up action on recommendations of last Common Review Mission.
5. Note additional outcomes other than those envisaged under approved plans.
6. Identify constraints faced and issues related to each of the components outlined and possible solutions.
7. Document best practices, success stories and institutional innovations in the states.
8. To identify strategies and outcomes in the State in addition to the ones envisaged by the Mission, both positive and negative.
9. Make recommendations to improve programme implementation and design.

Components

The components on which the CRM will do assessment and seek comments are stated below

1. Service delivery
2. Reproductive and child health
3. Disease control programmes
4. Human resources and training
5. Community processes and convergence
6. Information and knowledge
7. Health care financing
8. Medicine and technology
9. National Urban Health Mission
10. Governance and management

INTRODUCTION

Maharashtra is the third largest state in India (307,713 Sq.Km) and second largest by population according to 2011 Census (112,372,972). The state has the highest percentage of urban population at 45.23% (2011 Census) and 8.9% of the state's population is tribal. The districts of Gadchiroli and Nandurbar have highest tribal population at 38% and 65% respectively

A brief overview of the administrative units in the state;

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

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

7TH CRM TEAM (MAHARASHTRA)

Ratnagiri Team	**Organization**
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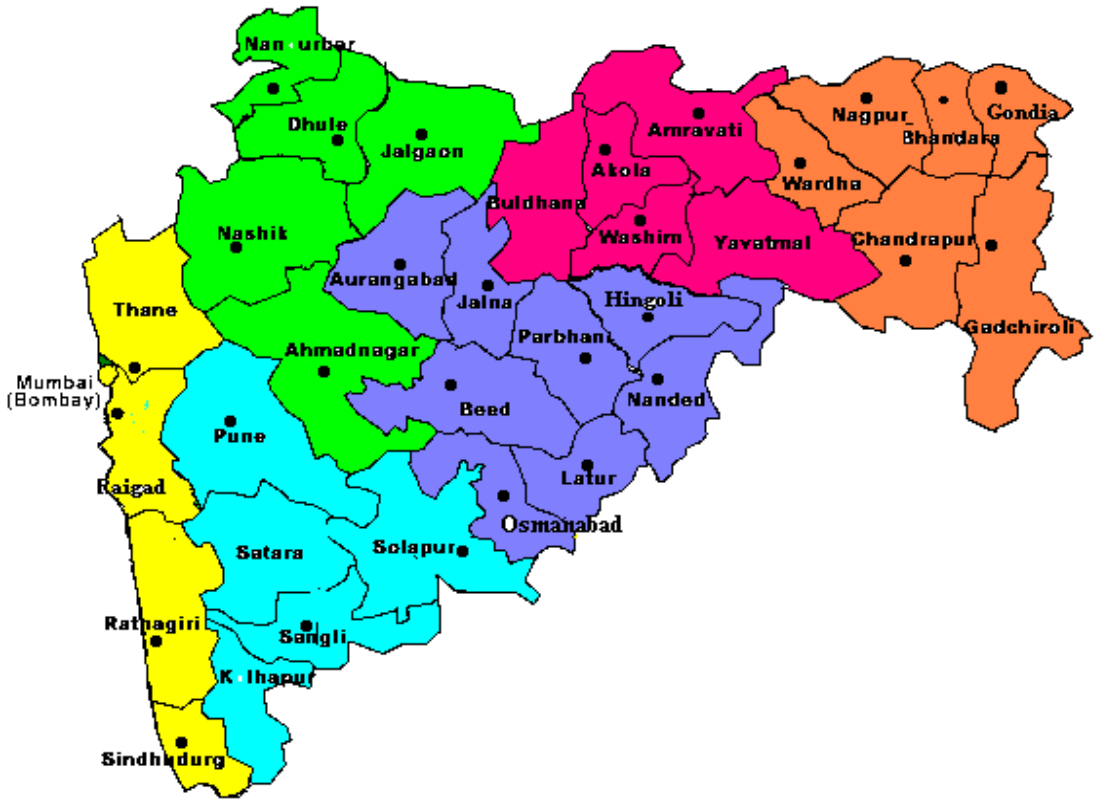
Dr. Suryavanshi	RNTCP
Dr. Faisal Shaikh	NRHM-I
Dr. G. C. Gaur	OT, Ayush,
Dr. Joyeta Ghoshal	TMSA
Dr. Anil Agarwal	UNICEF

Facilities Visited

Ratnagiri Team	Nadurbar Team
• DH-Ratnagiri • SDH-Kamthe • RH-Sangameshwar • RH-Rajapur • PHC-Shirgaon • PHC-Pawas • PHC-Sakarpa • PHC-Uni (24X7 Delivery Point) • SC-Nivegaon • SC-Kusumb • SC-Kalsavli • SC-Nivebudruk • VHND (also SC) -Karagir • VHND-Shantinagar • MMU - • HACC-Pune • Community visit – Shantinagar, Nivegaon, Manaskot, Karavali	• DH-Nandurbar • SDH-Taloda • RH-Dhadgaon • PHC-Somaval • PHC Bilgam • PHC Chinchpada • SC Saurat • SC Aamlad • SC Pati • SC Kakarda • MMU Dhadgaon • MMU Taloda • Boat dispensary-Dhadgaon •

MAHARASHTRA STATE



STATE PROFILE

Demographic Profile

Indicator	Maharashtra	India
Total Population (In crore) (Census 2011)	11.2	121.01
Decadal Growth (%) (Census 2011)	15.99	17.64
Crude Birth Rate (SRS 2011)	16.7	21.8
Crude Death Rate (SRS 2011)	6.3	7.1
Natural Growth Rate (SRS 2011)	10.3	14.7
Sex Ratio (Census 2011)	925	940
Child Sex Ratio (Census 2011)	883	914
Schedule Caste population (In crore) (Census 2001)	0.98	16.6
Schedule Tribe population (In crore) (Census 2001)	0.85	8.4
Total Literacy Rate (%) (Census 2001)	82.91	74.04
Male Literacy Rate (%) (Census 2001)	89.82	82.14
Female Literacy Rate (%) (Census 2001)	75.48	65.46

KEY INDICATORS

Sl. No	Indicators	Maharashtra	India
1	Infant Mortality Rate-IMR (SRS 2012)	25	44
2	Maternal Mortality Ratio (SRS 2007-09)	104	212
3	Total Fertility Rate (SRS 2011)	1.8	2.4
4	Under-five Mortality Rate (SRS 2011)	28	55

5	Institutional Deliveries (2012-13) (HMIS)	1726348	16461252
6	Full immunisation (In thousands) (2012-13) (HMIS)	1810	22225

Public Health Infrastructure

Rural Population (In lakhs) (Census 2011)	615.45
Number of Districts (RHS 2012)	35
Number of Villages (RHS 2012)	43663
Number of District Hospitals (RHS 2012)	23
Sub-district hospital (200 Beds)	3
Sub district hospitals (100 Beds)	23
Sub district hospitals (50 Beds)	56
Number of Community Health Centres (RHS 2012)	365
Number of Primary Health Centres (RHS 2012)	1811
Number of Sub Centres (RHS 2012)	10580
General Hospitals	4
Medical Colleges	18
Women Hospitals	11
Super Specialty hospitals	3
Health and Family Welfare Training Center (HFWTC)	7
Public Health Institute	1

Service Delivery progress (Source: HMIS, MoHFW)

Maharashtra					
S.No.	**Indicators**	**2009-10**	**2010-11**	**2011-12**	**2012-13**
1	Deliveries conducted at Public Institutions	744868	796263	869353	873496
2	Total no. of C-section deliveries performed at Public facilities	63849	64737	104121	116579
3	Total no. of patients admitted (Inpatients) during the month	10870	1125367	3824495	4098421
4	OPD attendance (All)	10648261	5506233	46601004	55646508
5	Operation major (General and spinal anaesthesia)	69674	18582	474966	629323

Services

Services	**06-07**	**07-08**	**08-09**	**09-10**	**10-11**	**11-12**	**12-13**
Male Sterilisation	20480	25611	38265	34511	26225	21642	20986 (HMIS)
Female sterilisation	574958	528673	501151	499400	451033	421628	559345 (HMIS)
Full immunisation (In Thousands)		1874	1766	1851	2004	1713	1810 (HMIS)

Reproductive and Child Health Programme (RCH)

a) Immunization Coverage

(*Figures in percentage*)

	NFHS 2	**NFHS 3**	**Coverage Evaluation Survey**		
Year	**1998-99**	**2005-06**	**2005**	**2006**	**2009**
Fully Immunized	78.4	58.8	58.9	72.7	78.6
BCG	93.7	95.3	95.6	92.3	94.7
OPV 3	90.8	73.4	68.1	73.0	84.2

DPT 3	89.4	76.1	81.0	73.0	85.8
Measles	84.3	84.7	82.3	74.3	91.2

b) Information on selected MCH indicators

Indicators	DLHS -2 (2002-04)	DLHS-3 (2007-08)
Child feeding practices (%)		
Children under 3 years breasted within one hour of birth	44.3	53.1
Children age 0-5 months exclusively breasted	NA	54.1
Children age 6-9 months receiving solid/semi-solid food and breast milk	NA	33.3
Awareness about Diarrhoea and ARI		
Women aware about danger signs of ARI (%)	31.2	27.7
Treatment of childhood diseases		
Children with diarrhoea in the last 2 weeks who received ORS	42.0	44.2
Children with diarrhoea in the last 2 weeks who were given treatment	81.9	77.9
Children with acute respiratory infection of fever in last 2 weeks who were given advise or treatment	78.1	81.0

Physical Progress of JSY

Year	Institutional Deliveries	JSY Beneficiaries
2005-06	1103000	5000
2006-07	1095000	97390
2007-08	1346000	375000
2008-09	1553000	224375
2009-10	1371000	347799
2010-11	1622964	354108

2011-12	1635675	302040

Progress of NRHM

<table>
<tr><th>Sl. No</th><th>Activity</th><th>Status</th></tr>
<tr><td>1</td><td>24x7 PHC</td><td>Out of 1811 PHCs, only 425 PHCs are functioning on 24x7 basis</td></tr>
<tr><td>2</td><td>Functioning as FRUs</td><td>157 health facilities (23 DHs, 66 SDHs and 68 CHCs) are functioning as FRUs.</td></tr>
<tr><td>3</td><td>ASHA Selected</td><td>58855 ASHAs selected, 58608 ASHAs have been trained in 1st module, 58091 ASHAs have been trained in 2nd Module, 56958 ASHAs have been trained in 3rd Module, 55792 ASHAs have been trained in 4th Module & 50434 ASHAs have been trained in 5th Module and 15288 ASHAs have been trained in round 1, 8568 ASHAs have been trained in round 2 & 3391 ASHA have been trained in round 3 of 6th & 7th Module.</td></tr>
<tr><td>4</td><td>ANMs at SCs</td><td>Out of 10580 SCs, 6261 are functional with second ANMs.</td></tr>
<tr><td>5</td><td>Contractual appointments</td><td>1007 Doctors (GDMOs), 539 Specialists, 583 AYUSH Doctors, 84 AYUSH Paramedics, 840 Staff Nurses, 1149 Paramedics & 6362 ANMs are positioned under NRHM.</td></tr>
<tr><td>7</td><td>Rogi Kalyan Samiti</td><td>3101 facilities (23 DH, 458 CHCs, 15 Other than CHCs & 1810 PHCs and 795 other health facilities) have registered RKS.</td></tr>
<tr><td>8</td><td>Village Health Sanitation & Nutrition Committees (VHSNCs)</td><td>Out of 43663 villages, 39872 constituted VHSNCs.</td></tr>
<tr><td>9</td><td>MMUs</td><td>40 MMUs are operational in 33 Districts.</td></tr>
<tr><td>11</td><td>VHNDs</td><td>490328 VHNDs were held during 2012-13.</td></tr>
<tr><td>12</td><td>Infrastructure Strengthening</td><td>
<table>
<tr><th rowspan="2">Facility</th><th colspan="2">New Constructions</th><th colspan="2">Renovation/Upgradation</th></tr>
<tr><th>Sanctioned</th><th>Completed</th><th>Sanctioned</th><th>Completed</th></tr>
<tr><td>DH</td><td>0</td><td>0</td><td>11</td><td>2</td></tr>
<tr><td>SDH</td><td>0</td><td>0</td><td>15</td><td>2</td></tr>
<tr><td>CHC</td><td>10</td><td>6</td><td>265</td><td>121</td></tr>
<tr><td>PHC</td><td>92</td><td>22</td><td>454</td><td>72</td></tr>
<tr><td>SC</td><td>962</td><td>564</td><td>3844</td><td>2823</td></tr>
</table>
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13	New Born Care Units established	Sick New Born Care unit (SNCU)	34
		New Born Stabilization Unit (NBSU)	177
		New Born Care Corner (NBCC)	1014

7TH COMMON REVIEW MISSION: TERMS OF REFERENCE

1. Service Delivery

It is observed that the overall adequacy of health facilities in terms of number and their geographical distribution is good. In 5 sensitive districts out of the 15 tribal areas the state has started the following schemes:

- Hardship allowances
- Coordination cell at Hospital
- Medical officer at CHC/PHC (Special Plan)
- Health Shelter in Nandurbar Dist.
- MMU -
- Floating ambulance in Nandurbar Dist. (Narmada Sarovar)

The infrastructure facilities are found to be in good shape. However, setting up of MCH wings in facilities is to be looked into on priority basis.

As regards to utilization of facility based services, it was noticed that diagnostic services at PHC level was found weak as no lab technician was found at the facilities visited.

Quality of care as regards to signage, citizen charter is in place but needs to be placed prominently and in a readable format. Biomedical waste management system is found at various levels of facilities.

Ambulance services are functioning well. Inter-facility transfers are in place with a functional call center.

To attain good coverage of health care delivery in hard to reach areas state has implemented Mobile Medical Unit (MMU) in all 33 districts by deploying 40 MMUs through PPP model. As per the visit to chiplun block in Ratnagiri district, the impact of service delivery of MMU was found weak. There was a gap in mobilization of the patients due to lack of publicity with the involvement of ASHA and PRI.

During the current year the state has utilized 31% of the budget allocated for MMU.

Role of Asha in outreach services needs to be strengthened.

Involvement of PRI in planning and monitoring of health care services was found to be weak. PRI needs to be sensitized about the program planning and monitoring. Similarly with the involvement of PRI, ASHA will also be sensitized as ASHA is not effectively mobilizing the community.

VHSNC component needs to be strengthened by effective involvement of PRI and ASHAs.

Supportive supervision needs to be increased at facility and grass root level. The district health officials need to be involving more in providing supportive supervision to district and facility level officials. The medical officers at PHC should be trained in effective planning, monitoring and supervision.

AYUSH services were found at various levels of facilities. It will take time to increase the utilization of AYUSH services at DH/SDH/CHC/PHC.

State and district specific BCC strategy plan was not found. There is a need to strengthen IEC activities at facility level as well as public places in the district. Display of information on free entitlements and services available must be more prominently displayed at strategic points at the facility level as well as public places.

To improve the service delivery through IEC/BCC, state may initiate the Bulk SMS facility through MCTS system to each registered pregnant woman for providing information on the availability of various services available as well as the availability of MMU (day and place of visit).

Overall number of subcentres, outreach services and secondary health institutions are good in terms of their number and distributions amongst the districts in the state. Mobile medical units are functional and VHND are being organized regularly in the state. Efforts are also made to use technology through using telemedicine to improve access to services for certain specialized services in the state.

However as per the 2011 Population there is a deficit of around 28% Subcentres, 28% of PHC and 33% of CHC/ RH in the state. This is estimated only for the rural population, if urban population is added then the deficit is likely to increase substantially. Most of the facilities are accessible accept for Functional First referral units across the state and 24X7 PHCs and Subccentres in Dhargaond and Akalkua blocks of Nandurbar District. Access to functional health facilities providing all range of services is more important than the just access of Physical infrastructure. There are still many villages where in pregnant women have to travel more than 2 hours for availing services of delivery care.

Area specific, need based outreach clinics/ subhealht centre need to be sanctioned. The most deprived pockets in the state should be given the utmost priority and a differential package to retain the skilled human resource in the difficult areas be developed.

Nandurbar district has total 290 subcentres, 58 PHCs and 11 Rural Hospitals and one District Hospital. However there are pockets and Blocks particularly in Dhadgaon and Akalkua, which needs special attention due to difficult geographical terrain the population norms would not suffice to ensure the access. The state is making efforts through the Mobile Medical Units, Floating Dispensaries and through organizing camps

to ensure access to curative services to people in the District. Primary Health Care access is the major issue in these two blocks and needs to be ensured.

For these difficult areas in these two blocks mobility support through a 4 wheel drive be provided to ANMs and frequency of fixed day fixed side outreach services be increased from once a month in a village to once in every hamlet in at least in a month if not in a forthnight. At strategic locations 4 Wheel drive ambulances be based so that a women in need can transported at least one week before the expected date of delivery to the Maher Ghar.

District and state wide plans for comprehensive infrastructure are available and are on the basis of needs . The quality of constructions is good. The construction is being conducted by PWD and monitored by the civil wing.

However there is a need for better coordination between the Civil wing and Doctors, It was observed that in Nanadurbar District OT constructed in the SDH is not as per the norms, labour room in sub-centres and PHCs were separate from the main building without any connective corridors.

Toilets in most of the institutions particularly subcentres and PHC gets neglected and the should be given a special attention during the planning for any health facilities and its execution.

Nandurbar District Hospital is being run in old building still well maintained and new building is under construction. MCH wing is also being constructed in the District Hospital and is likely to be put to use by end of this financial year.

OPD at Public Health facilities has increased by 56% over the last six years. Increase in OPD at PHCs is 95% from 2007-08 to 2012-13, Overall IPD has increased by 85% while increase in IPD in PHC's is over 100% from 2007-08 to 2012-13. Subcentres are providing basic outreach services and selected subcentres are functioning as delivery points. PHCs are providing services related to basic diagnostic tests and also treatement for minor ailments and primary management of complicated cases. CHC called Rural Hospitals are of 30, 50 and 100 Bedded Hospitals. Hospitals are providing most of the secondary level care services particularly district hospitals . xx% Rural Hospitals are also providing services related to management of complications and surgical facilities.

Though facilities are being utilised, but if see the amount of investment and utilisation level particularly in Rural Hospitals, it is suboptimal level.

There is a scope for improvement in systematically plan few rural hospitals to be strengthened with it's community linkages particularly for the hard to reach areas..

In Nandurbar District OPD has seen more than 3 times increase and almost 3 times increase in IPD service between 2008-09 to 2012-13. Other services like surgeries have also seen a tremendous improvement in the district in last 5 years.

The State has made an effort to outsource the hospital management services for ensuring cleanliness and security of the hospitals. In CSSD is functioning very well in the District Hospital Nandurbar. Biomedical waste has been out sources to Common Treatment Disposal (CTD).Supportive services like diet, laundry are also outsources and functioning very well in district hospital Nandurbar and Sub Divsional Hospital Taloda. Citizen charter in Marathi was displayed in District Hospital and RH Taloda in Nandurbar District. Patient and there relatives were satisfied with the services provided by the District Hospital Nandurbar and a gerievience redressal mechaninsm in place.

At most of the places standard treatment protocols are not being followed though they were printed and posted in SDH Nawpura and but they were lacking in most of the places. The available protocols are also not being followed. Privacy for pregnancy women in ANC clinics and also in an issue and needs to be given special attention, at none of the facilities visited there was a provision for the privacy of the pregnant women except for the PHC Chinchpara. Biomedical waste segregation is an issue in most of the health facilities right from PHC to the District Hospital level.

The state has most of the things in place except for the mechanism to track the monitoring of observance of standard treatment protocols at every level. Particularly in labour rooms, operation theatre, post operative wards in terms of infection prevention and management, rational use of Antibiotics, segregation of biomedical waste at source and it's safe disposal.

Health facilities particularly secondary level health care facilities are very clean and diet is being served to the patients and their relatives. Cleanliness of the facilities has being seen as a major value addition of the subcontracting of these services. The monitoring of services provided by the contractor is in place and is being monitored by the staff.

So far Ambulances are provided through the department and almost every 24X7 PHC and also with the support of UNICEF in most deprived blocks of Dhadgaon, Taloda and Akalkua. Most of the Ambulances have GPS installed to track the flow and status.

So far there is no central control room and is being established at the state level and total 937 additional Ambulances will be deployed during this financial year in the State. A referral transport system is in place and is being utilized both for bringing Pregnant Mother, Newborns and Children from home to the facility and from hospital to home.

There are 4 ambulances of the hospital and 2 exclusively for JSSK. There is a centralized call centre available at the hospital which has toll free number of 102 and ….. the ambulances are currently fitted with GPS but not functioning as GPS enabled. The ambulances are currently manned by a driver and have provision for oxygen cylinders in the vehicle. However both ambulances inspected by the team did not have O2 cylinders in place at the time of the visit. Training status of drivers was ambiguous and no formal training for use of ambulance or basic first aid was noted to have been provided to drivers.

Drop back is availed by almost 100 % of patients but pick up is still to increase.

Average time for pick up from home is 30-45 minutes and for facilities which are far people prefer to local transport.

1. District Nandurbar:

- 1 MMU of Dhadgaon block and 1 MMU of Taloda Block was visited by the team. This ambulance was operated by a local NGO s. It was manned by a team BAMS doctor and 2 paramedical staff and 1 driver.
- Both the MMU had 2 units which consisted of a large van and a smaller vehicle (Sumo). The 2 vehicles were provided by the Maharashtra government and staff recruitment and purchasing of drugs and consumables was done by the NGO using funds provided under NRHM (21.18 lakhs/year). Total cases seen per day were an average of 80-90/day. Types of cases handled included ANC,PNC,delivery cases, general OPD. Also basic lab tests like HB, Urine, UPT, VDRL, malaria tests, sickle cell (solubility tests) etc were done.
- It had a scheduled Advanced Tour Plan (ATP) and operated in underserved and remote locations. Although the dates of MMU visit varied, one Fixed day services was provided in a month every village.
- It served 30 -40 villages in the area. A day before the scheduled visits the ASHAs, AWC and frontline workers of the area would inform communities, PRI members and pregnant women about the timing of the van and the van would also use miking as a form of IEC in the area to inform the population in and around the area. The van

has a siren which would be sounded on arrival of the vehicle .The smaller vehicle is used to carry equipments and drugs and is also used to transport and drop back patients from interior parts of the village to where the van was stationed.

- Services were also provided by the Team in the inaccessible motorable area, barefoot.
- There is scope for improving service delivery, maintaining records, involvement in screening of NCD like cancer or diabetes etc.
- Also additional IEC can be planned by display of key messages in the van and counseling the Medical officer of the VAN.

2. Reproductive and Child Health

Plan for ensuring availability and to improve access in difficult tribal districts are in place and being monitored regularly by the state particularly for strengthening of delivery points, 24X7 PHC , SNCU , NRC and PPIUCD. Prioritization for upgradation of facilities on the basis of needs and coverage has been done.

Certain basic quality in terms of clean facility, clean stay, services of providing hot food are in place in most of the facilities upto the RH and DH level

However major issue is regarding observance of standard treatment protocols particularly in labour rooms, SNCU and in the Post Natal and Post Operative wards. Progress of labour is not being monitored as per the Partograph despite having digital Doppler available at most of the health facility even upto the subcentre level, Most of te places visited have shown records of one or two Foetal Heart rate recordings , uterine contractions are not monitored at all in any of the facilities. Progress of labour is being monitored primarily through PV examination and other parameters often getting neglected. In most of the places visited Ambu Bag was available but was placed in the labour room in such a major that Golden one minute will be wasted in just taking out the Ambu Bag.. Skills of ANMs in SC and PHCs were reasonably OK but the skills are not put to use.

SNCU is functioning in District Hospital Nandurbar and is providing services to almost 60 Newborns per month. Handwashing practices are being followed, though there is no elbow operated tap in the unit. There are onlu 5 Staff nurses provided to the unit and unit is also very small and also having all the unused equipment and stock of medicine within the unit. Though the another unit is under construction and is likely to address this issue. Antibiotics use rate is almost 100% in the unit. Seggregation and disposal of biomedical waste is not as per the protocols. Brooming is being done in the postnatal wards, which is likely to expose newborns to the infections.

State should on a priority start monitoring skilld and practices in being followed in the labour rooms, postnatal wards. Brooming in the hospital should be stopped and only mopping should be done. Bio Medical Waste management need special attention in the State.

Awareness amongst the beneficiaries regarding JSY was good in the state and ASHAs involvement in mobilizing the Pregnant women is very good. Most of the deliveries except for those from Gujarat and few more most of the pregnant women interviewed were accompanied by ASHA. Avaialblility of MCP card with the beneficiaries was reasonably good.

There was a delay observed in the District Hospital Nandurbar, but at other places visited Cheques were distributed on site.

There is scope for early tracking during ANC and facilitating the beneficiaries to open zero balance bank account, to ensure entitlements on time.

JSSK is being implemented effectively in the state, none of the clients interviewed has paid even a single rupee for availing delivery services from the institutions Home to Facility and Drop back facility is functioning well in the Nandurbar District. .

Transfer of Home to PHC is good to the tune of 80% in Nandurbar District, however transfer of pregnant women from home to SDH and DH is low, Although this has shown improvement as compared to last year .

Counseling in the postnatal wards for breastfeeding, prevention of hypothermia and family planning needs special attention. Audio Video can also be used in the PNC wards to improve.

Total number VHND planned are adequate in terms of number,a alternate vaccine delivery system is working very well in the state. Stock of vaccine was maintained, efforts are being made to mobilise children and pregnany mothers to VHNDs by ASHAs. Zipper bags were available at all the places for transportation of vaccines.

Due list is not being prepared and followed, cold chain needs special attention. Temperature monitoring is not followed stringently, ILR deep freezer attached without stabilizer and are some of the serious issues needs immediate attention. Stock management for vaccines is an area, which has scope for improvement. At some places

vaccine were available in abundance and at some places there were no stocks of vaccines. Conditioning of Ice packs is not being practices at any place.Open vial policy is not being followed. Open vaccine vials without date and time of opening were found the ILRs.

State has planned VHNDs every day which may hamper the monitoring and also creating mass awareness about these VHNDs. State may like to fix two days per week for VHNDs so that ANMs availability during other days can also be ensured.

3. Disease Control Programs

Integrated Disease Surveillance Program (IDSP) is being implemented in the state with the establishment of State (SSU) and District (DSU) Surveillance Unit for urban and rural areas. The weekly reporting system is in existence for data collection/consolidation/analysis/follow ups and with regular flow of information from SC, PHC, CHC to DSU and SSU.

In Nandurbar dist, the human resources like DSO, Epidemiologist, Data Manager and DEO are in place along with the Rapid Response Team. The IT infrastructure units are available in SSU/DSU but not functioning up to the mark because of erratic supply of electricity and poor communication networks. The toll free number is accessible through Vodafone and BSNL. Outbreak of ADD, Malaria, Cholera, Viral Hepatitis, Dengue was reported in 2012 which were controlled effectively by the state. There is proper coordination between various units under IDSP and data are being utilized for district planning for control of locally endemic and other communicable diseases.

There are three ophthalmic surgeons in the Government Hospitals. Three are two facilities equipped to perform IOL cataract operations; Civil Hospital, Nandurbar (with separate OT) and one NGO Hospital (Kanta Laxmi Eye Hospital). There are eye care facilities in Private Sector also. There are two Eye Donation centres in the District.

There has been gradual increase in number of cataract surgeries in the district from 7779 operations in 2008-09 to 13988 in 2012-13. Cataract Surgery Rate (CSR) was 874 per lakh population during 2012-13 which is satisfactory. However, main increase in catops is in NGO and private sector.

School Eye Screening programme is being implemented effectively with more than 70 thousand students being checked up annually. More than 2000 children were detected with refractive errors and provided corrective spectacles. Eye Donation is very low.

Only 32 eye balls were collected during 2012-13, mainly in voluntary sector (26). In the current year, 30 eye balls have been collected till October, 2013

NPCDCS is not being implemented in Nandurbar district. However, this district has been included in the PIP for 2013-14, approval of which is still awaited from GOI. The opportunity was used to identify feasibility of setting up NCD clinic, Cardiac Care Facility and District Cancer Care facility in Civil Hospital, Nandurbar. The District Authorities have already identified adequate space for these facilities in the campus. There is shortage of physicians (MD General Medicine) in the District and for implementation of NPCDCS, it would be necessary to recruit physicians.

The Civil Hospital has a Trauma/Casualty Centre with 5 ventilators. The hospital has facilities for sonography, CT scan, Dialysis (4 machines) and telemedicine facility (linked to KEM)

New Initiative for Palliative Care- Pilot in 2 Districts

While travelling to Nandurbar, the team visited RH, Igatpuri in Nashik District. The State has initiated Palliative Care centre with support from Tata Memorial Hospital, Mumbai. Terminally ill patients and other serious patients are being treated at this centre. The team observed one advanced case of cancer and one child with cerebral palsy admitted on the day of visit. Morphine tablets were available with the Centre and separate register was maintained for their use.

4. Human Resources and Training

Availability of specialists at DH/SDH/RH is critical and important. However it was found that specialists were not available as per IPHS standards.

Laboratory technicians are not available at PHC level. Lab tests are done from outside sources at PHC level.

AYUSH doctors need to be imparted with multi skill training for better integration of AYUSH with the health system.

The managerial training for effective planning, monitoring and supervision needs to be provided to all district and block level officials.

In 15 PHC in Nandurbar District has been upgraded and labeled as IPHS facilities. In all the PHC state has 2 medical officers in place. All the delivery point subcentres has 2 ANM in place.

5. Community Processes and Convergence

- **PRI system** is good compared to other states and is in place, COO are managing the RH, PHC and DH.
- ASHA resource centre is in place, 6th Module first phase is completed. Their **knowledge skills** are good
- HBNC visits are made, however scanty.
- Referring SAM/MAM to NRCs also doing post follow up at community.
- **Drug kits** are in place and regularly replenished.
- **VHSNC, RKS and DHS are registered** and optimally utilising funds as per norms. Registers are maintained, however meetings are irregular.
- **Community monitoring** very vibrant at Nandurbar and yet to be implemented in Ratnagiri .
- **Availability of ASHA ghar/homes** was not found in the facilities visited by the tea
- HBNC visits and follow up by ASHA needs to be strengthened.
- Required more thinking to increase the ASHA incentive, providing differential incentive packages in difficult and hard to reach areas.
- ASHA Block Facilitator roles needs to be redefined and support mechanism need to be strengthened.
- There is need for better understanding the concept of community mobilization in the context of NRHM.
- There is need to provide better training especially to those who are key actors for community mobilization in NRHM such as ASHA, ASHA Facilitators, District Community Mobilizer, DPM and MO-PHC to enhance this component

6. Information and Knowledge

- **SIHFW-** Training centre network is good. DTC are functional at both districts with good infrastructure facilities. Monitoring mechanism good. However insufficient number of faculty.
- **SHSRC-** facilitating guidelines, technical support to the state.

- **HMIS-** Multiple information systems still existent in state.
- **MCTS:** Functional with online data entry at block level.
  - Both systems need to be utilized for data analysis to review and prioritize the services.
  - Data validation needs to be strengthened.

Innovations under IT:

- 104 HACC, Mobile delivery kit, ASHA monitoring software, Telemedicine and CME through teleconferencing in place and functioning well.

Use of HMIS data for effective decision making is not found. The medical officers are not knowledgeable regarding the use of HMIS data. They need to be sensitized and trained in managing data for decision making to better utilize the resources provided under NRHM.

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

7. Health Care Financing

State is managing all the functions of NRHM with a dedicated Financial Management Group at State and District Level.

Improvements since last CRM:

In the last CRMs held following areas for improvement were highlighted:

- JSY incentives distribution needs to be improved.
- Rational utilization of Civil Works funds was need as per the guidelines.
- Strengthening of State Procurement Systems through formation of an autonomous body.
- Strengthening the capacity for utilization of untied funds.

During the current CRM while assessing the above areas it has been noticed that there is a good achievement in addressing the above areas. As regards the JSY incentives distribution state has adopted payments through Central Plan Scheme Monitoring System (CPSMS) and all payments are being done through CPSMS. As per the guidelines of Government of India funds for civil work should be kept within 25% of the total approved budget. As per the approval of PIP for the year 2013-14 the total amount sanctioned is within 10% of the total approved PIP. And to improve the procurement systems though no autonomous body has been formed but the procurement is being done through an independent cell created for procurement having specialized staff to handle the procurement system in the most transparent and effective manner. The status of utilization of untied funds is an issue which needs attention. During the current year 2013-14 the over all utilization till 2nd Quarter is 29% and the same for Sub Centre and VHSNC is 35% and 26% respectively.

State has taken good initiatives for the better management of funds by introducing e-file system by which the approvals of the higher authorities is obtained without no delay. Officials have been sanctioning the proposals on line irrespective of the location/ station. At state, district and block level all payments details of vendors.

For the maintenance of Books of Accounts, a tally accounting software is in use at each accounting centre (State, District and Blocks) along with the maintenance of a manual cash book. Cash Book was being maintained on regular basis. Whereas at other centers like PHC/ SC manual cash book is being maintained. Bank Reconciliation Statement was found to have been prepared.

8. Medicine and Technology

- Computerized drug inventory management system in place .
- Medicine were available upto sub centre level – both districts have high incidence of snake bites , scorpion bites and supply of ASV and ASS is also adequate.
- Quality of assurance for drug testing is in place
- Push mechanism was found at many facilities
- Inventory management of drugs: **Need based** drug indenting mechanism to be put in place.
- Drugs requiring cold chain be stored in ILR rather than the regular freezer and temperature monitoring be ensured (Nandurbar)
- Direct patient care through telemedicine connected to every district.
- 104 HACC is functional and being utilized

9. National Urban Health Mission

The state has prepared and submitted a NUHM PIP for Rs. 495 Crores and is awaiting approval. The PIP preparation started in May 2013 and the state has conducted a series of meetings with officers of Municipal Corporations, Municipal Councils, Cantonment Boards, Zila Parishads, and other relevant officers.

The PIPs from 95 cities with over 50,000 populations were received and collated to form the PIP for the state. The final PIP was finally submitted to MOHFW, after initial clarifications, on October 11, 2013, and is awaiting approval from MOHFW.

The key health issues in Maharashtra Urban areas are inadequate health facilities and manpower, Social health problems, and rapid urbanization leading to overstretched facilities.

The total population to be covered under NUHM is 43593731 and total sum population to be covered is 20123467 covering 26 corporations, 63 councils, and 5 Cantonment boards. The proposal of the state is to set up 828 UPHCs with construction of new 157 UPHCs , and establish 90 UCHCs. The state would need extensive additional human resources such as 1784 additional ANMs, 302 full time medical officers, 1486 staff nurses, 807 pharmacists, 828 accounts clerks, and 828 public health managers. This will put a huge burden on the state to recruit several thousand new employees over a definite period of time. The state also plans to set up 8020 Mahila Arogya Samities and select 5844 ASHAs.

The salient features of the PIP are:

1. Hiring of an agency for mapping and conducting the survey.
2. Establishment of one SPMU and 95 CPMUs which will be responsible for monitoring the activities under NUHM.
3. Training of functionaries. The recruitment of ASHAs and MAS will be done in a phased manner.
4. Community processes through MAS groups.
5. Innovative activities > Examples are : Mobile Medical Units in Mumbai to be operated by NGOs, Nutritional Rehab Centres, women check up camps, PPP activities, specific action on commercial sex workers, MDR TB unit in Mumbai.

The state is committed and geared to implement a robust Urban Health Program and is ready to roll out, once it gets approval from the ministry.

The state has developed a comprehensive plan with inputs from important stakeholders, through a participatory process. It has also included several ideas of innovative activities.

The state has appropriately planned and prioritised activities for implementation of NUHM.

Given that the state of Maharashtra has submitted the final PIP, the discussion should happen soonest to discuss and approve the PIP. At a minimum, early approval of initial activities should be given a go ahead to set the ball rolling to allow the state to start activities such as recruitment. The municipal corporations and municipal councils of the state are anxious to get a go ahead.

The plan for submission of a three year PIP is worth revisiting as the team feels that the NUHM implementation is new and developing a three year plan at one go may be a long shot. It may be considered to give some time for the state to get initial experience.

Given the extensive nature of the program and the need for coordination with tens of municipal corporations and municipal councils, the state may consider, depending on the need, engaging additional staff at the state level for efficient roll-out of the program. The state may consider setting up a solid base for the NUHM program before embarking on additional innovative activities.

Given Mumbai's population and complexities, it may need additional focussed attention from the state NRHM leadership.

10. Governance and Management

- **SPMU , DPMU and BPMU** is in place in most of the districts.
- **Good coordination and integration** of panchayat raj institutions with directorate of health services in planning, monitoring of programme activities.
- **Supportive supervision** visit are taking place. However there was no structured visit plan.
- **Inadequate Integration** of the **PMU** established under NRHM with the departments at all level.
- Procurement, distribution logistics management was **not responsive** to the need specifically for Primary Health care.
- **Inadequate performance monitoring** of the staff and facilities, even though HMIS and staff performance monitoring software is in place.
- **Poor retention and motivation** of the contractual staff recruited under NRHM.
- **Community based monitoring project** is functioning well in the piloted districts in the State.
- **Grievance redressal cell established** at the state and district is not functional and also has multiple numbers at different districts.
- HR policy for the programme management staff should include periodic capacity building, career progression strategies.
- Capacity building programmes should have more focus on technical and managerial aspects of programmes - SOPs, problem solving and district planning skills.
- Need for better procurement and logistics systems - to ensure responsive management system in primary health care.
- Supervision plan calendar should be generated at district level with regular random checks

Supervision and monitoring activities are planned, and are taking place. Around 60% of the scheduled visits are taking place. However there is need for systematic monitoring and supervisory visits with subsequent visits planned to document the progress as per the timeline. For this the Supportive Supervision format designed by GOI can be used and also improved upon depending on the need. Refresher training for the district programme officers on the operational aspects of the programme should be given. All the reports of the visit along with the action taken, timeline for action and action taking authority needs to be uploaded and shared.

Need to establish an integrated grievance redressal system having a Common Toll Free number for managers, providers and beneficiaries to ensure better accountability and transparency in the districts