2013

National Health Systems Resource Centre

[7TH COMMON REVIEW MISSION ODISHA]

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SECTION I

Executive Summary

The CRM visit to Odisha revealed numerous good practices and innovations adopted by State for health system strengthening as well as gaps that still exist and need to be plugged to achieve the goals of NRHM. The wide geographical disparity in the State is a major challenge and a cause of many areas that remain underserved. The State has however, taken appropriate steps in the direction to improve service delivery in these areas, primarily by classifying these hard to reach areas on the basis of grade of difficulty. State realizes the inappropriateness of the population norms for and has recruited more ASHAs against the population norms in these designated difficult areas. Mobile Health Units and utilization of NGO capacity in the underserved areas have been taken up and are promising interventions with their effectiveness yet to be established.

Shortage of subcenters and PHCs, many of which are running through rented facility in a dilapidated condition along-with limited package of services as against required of the respective level of health facility results in underutilization and lack of faith in services delivered and the entitlements amongst the community. There is an urgent need to facelift the existing subcenters and health facilities and brand them to ensure a complete package of services commensurate with their designated level to improve their utilization, to cater to large unmet need for health services and to induce faith of the community in public health system. Shortage of staff quarters is a major concern and a cause of grave dissatisfaction amongst the Healthcare providers, which affects the availability of the doctors, ANMs and other staff at health facilities including DH and SDH. This is needs to be addressed on an urgent basis.

A meager proportion of health facilities in State are delivery points with very few PHCs (11%) conducting deliveries. The non-functionality and underutilization of peripheral facilities leads to overcrowding at DH. There is a need to operationalize all the designated FRUs to ensure that majority of complicated pregnancies are managed round the clock at FRUs and not unnecessarily referred to DH.

ANMs at some Sub-centres were found to be allocated with too larger areas that it was daunting for them to manage field visits along with their routine Sub-centre activities. Time to care analysis should be done to calculate the actual ANM requirements considering the vast geographical areas.

State has introduced numerous IT initiatives for efficient administration and monitoring of Human resource, Infrastructure construction, service delivery and drug management in form of HRMIS, e-Swasthya Nirman, e-Blood bank, ODIMS respectively. These are very innovative steps to reduce the administrative hurdles and to ensure there is a clear and short line of communication between the health facilities and the SPMU. Still, there is a scope of better use for planning and improvement in the IT interventions being used in the State.

The community processes in the State are remarkably strong and efficient. ASHAs in the State are confident, motivated and respected in the community and have a symbiotic association with Anganwadi workers and ANMs. The inter-sectoral convergence at the ground level is commendable. The VHNDs and VHSNC meetings are held regularly and village health plans are formulated. Support structure for ASHA is good and they have been provided with cycle, uniforms, and benefits under Swalamban pension scheme and ASHA Ghar amongst other benefits. The disbursement of incentive to ASHA is directly into their bank accounts and no delays were reported by ASHAs except for delay in receiving payment for motivating for spacing in Jajpur. ASHA SATHIs are recruited to mentor and support ASHAs, the number of SATHIs needs to be increased so that one ASHA SATHI mentors not more than 20 ASHAs. The VHNDs are conducted separately from immunization days to ensure that VHNDs are merely not immunization days and other package of services is provided on the day.

The Drug and equipment availability in the State is good and no drug shortages were reported in any of the facilities visited. The introduction of the ODMIS that provides real time indenting of stock requirement and availability from Block CHC level is a good step to prevent stock outs, re-appropriation of drugs within facilities and districts to minimize wastage. The drug warehouses are present in all districts and a mechanism has been put in place for drug quality testing that is functional. The State Equipment Maintenance Unit was reported to respond to the requests for repair of equipment in the health facilities with a team of engineers. The HRMIS, which is basically instituted with the intent to serve as a tool to ease administration in respect of contractual staff may include the place of posting of the regular staff so as to guide policy decisions and bring about rational deployment which is warranted urgently.

The implementation of JSSK in the State is good at higher facilities with no out of pocket expenditure reported by postnatal women on drugs and diagnostics during pregnancy and stay in hospital. The provision of free diet however, needs attention as the mothers are being given one dry meal a day due to non-availability of kitchen in SDH and lower facilities. This can be a deterrent to 48 hours stay in facility after delivery. The JSY implementation in the State has been streamlined and Account payee cheques are issued to mothers after delivery, however, there has been reporting of inability of beneficiary to avail the incentive usually because of severe administrative hurdles in opening account with SBI bank. Awareness of free referral

transport for sick infants is low and the Janani Express in the State is underutilized despite the fact that the awareness of the 108 service is good in community in both the districts. District maternal death review team needs to be re-oriented on concept, protocols and processes of MDR as the review being conducted has not been able to tap the major causes and does not provide actionable information with a large proportion of maternal death still being attributed to 'others' in causes. Unnecessary referrals were also observed at some facilities equipped with adequate HR and infrastructure which may possibly be the reason for considerable share of maternal deaths occurring during the transit.

Further, AYUSH doctors do not have pharmacists. The AYUSH drugs may be included in DIMS and pharmacist may be entrusted the responsibility of dispensing AYUSH drugs as well.

All the delivery points have New born care corners, SNCU is functioning well at Koraput and have good bed occupancy. There is however no SNCU at Jajpur. There is a need to institute NBSUs at CHC level to act as referral center prior to SNCU. The staff in SNCU is trained and dedicated. There is very low uptake of PPIUCD in both the districts, despite availability of trained providers. Interval IUCD uptake is also poor with only MOs inserting IUCDs. ASHAs are involved in home delivery of contraceptives. There is no focus on NSV and there are very few trained providers for NSV. There is, however, a considerable network of YASHODAs who accompany women to institutions for delivery and also stay with women for the post-partum period but still counselling on Family Planning was not provided to the women at the facilities or at VHNDs. Monitoring of trained PPIUCD providers to track service delivery is important. Skill improvement of health care providers for few identified areas such as SBA, Hb estimation, AEFI reporting, Anaphylaxis management, F-IMNCI training for Pneumonia management, NSSK resuscitation protocol, IUCD training for ANM is essential.

Consistent decline in API for Malaria noted from year 2010 (9.3 to 6.2). The no. of total Malaria cases reduced from 4 lakhs to 2.5 lakhs per year. "MO-MOSHARI" initiative for pregnant women and tribal residential school for LLIN distribution is a good example of convergence. Cluster approach to LLIN, case treatment, strong BCC, ASHA involvement and ownership of the Health Dept. at all levels appears to be the success factor for the Malaria reduction. Under RNTCP, there are 93 vacant Lab Technician at Microscopic centres and less than 2% referral of chest symptomatic from health facilities leading to less detection. TB-HIV coordination is satisfactory. ASHA participation in case detection and as DOT provider with ANM involvement to ensure treatment compliance seen during the field visits. State Leprosy prevalence rate is 1.2 per 10,000 population against the target <1 even after Nationwide declaration of Leprosy elimination in 2005. 3 districts have more than 3 leprosy prevalence rate. 10 position of Epidemiologist of IDSP lying vacant at district level and these positions are crucial for State

prone to natural calamity for early detection and management of outbreaks. Need to recruit vacant position for Disease Control Program on a priority basis.

All the Districts in the State are reporting facility-wise data on HMIS portal. The registration of pregnant women and children on MCTS portal is around 74% and 64% respectively on pro-rata basis. Phone numbers of only 3% ASHAs have been validated on MCTS portal and personnel handling HMIS and MCTS have been entrusted other responsibilities which increase their workload.

There are large vacant positions under Financial Management that need to be filled up on a priority basis. There has been low utilization of RKS and Untied funds over past year. Physical progress reporting of various major activities is not being done.

The State is making satisfactory progress in health system strengthening and has adopted several promising strategies to exhibit the commitment to improve health service delivery and improve the health indicators. However, gaps continue to remain in other areas that need attention and have been elaborated upon in the report.

INTRODUCTION

The seventh Common Review Mission of National Health Mission in Odisha was organised from 8th to 15th of November 2013. The CRM team constituted of resource persons including Government Officials, Consultants, representatives of Development Partners and Civil Society.

The list of CRM team participants is as follows:

S. No	Name of Team Membe	Designation	Organization
KORAPUT			
1	Dr. Ajay Khera	Deputy Commissioner (Child Health and Immunization)	Ministry of Health and Family Welfare
2	Dr. G.S Sonal	NVBDCP	Ministry of Health and Family Welfare
3	Dr. Renuka Patnaik	Consultant(Family Planning)	Ministry of Health and Family Welfare
4	Dr. Dinesh Jagtap	Senior Programme Manager	Public Health Foundation India
5	Dr.Sai Shubhashree Raghavan	President	SAATHI
6	Dr. Indranil Ghosh Mondal	Assistant Adviser(Homoeopathy)	Department of AYUSH, GOI
7	Dr. Neha Kashyap	Consultant (NRHM-Policy and Planning)	Ministry of Health and Family Welfare
8	Dr. S. N Pati	Regional Director	Ministry of Health and Family Welfare
JAJPUR			
9	Mr. Alok Kumar Verma	Director (Statistics)	Ministry of Health and Family Welfare
10	Dr. P. K Patnayak	National Consultant (Central Leprosy Division)	Ministry of Health and Family Welfare
11	Dr. Sharad Kumar Singh	Consultant (Child Health)	Ministry of Health and Family Welfare
12	Mr. Sumanta Kar	Consultant (Finance)	Ministry of Health and Family Welfare
13	Dr. Anchita Patil	National Programme Officer	UNFPA
14	Mr. Nishant Sharma	Consultant	NHSRC
15	Ms. Deepika Karotia	Consultant	Planning Commission

OBJECTIVES OF CRM VII

The CRM VII was conducted with the prime objectives of:

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.

METHODOLOGY

Facility records and HMIS data were reviewed. Interviews with State Officials and District authorities were done to understand the challenges, issues and opportunities in implementation of various programmes. Interview and interactions with the Health care providers at the DH and health facilities including ANMs and ASHAs were done. Focus group discussions with ASHAs were done at the ASHA training sites and the VHNDs. Objective facility assessment was done with formats for facility inspection.

The broad components covered under the CRM were: Service delivery, Reproductive and child health, Disease control programmes, Human resources and training, Community processes and convergence, Information and knowledge, Health care financing, Medicine and technology, National Urban Health Mission, Governance and management
Visits were conducted in 2 districts viz. Jajpur (High Performing) and Koraput (Low performing).

List of Facilities visited in both the districts are as follows:

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

OBSERVATIONS

A. State Profile:

Odisha state has a population of 4,19,47,358 spread across 30 districts. It has 8 High Priority Districts (HPDs) harboring over 15 percent (65,26,632) of the total population. The state has 118 tribal blocks as a whole, and 59 tribal blocks in the HPDs. The state has categorized all its facilities into V1, V2, V3 and V4 based on the degree of difficulty-to-access, with V3 and V4 being the most difficult and inaccessible facilities. There are 749 identified V3 and V4 facilities in the state, of which 560 are in HPDs alone.

Table I. Number of facilities at various levels in the State and HPDs

Type of Facility	State	HPDs
District Hospital	32	8
Sub Divisional Hospitals	27	3
CHCs	377	79
PHCs (New)	1226	233
Other Hospitals	79	11
Sub Centers	6688	1459
Ayurvedic Dispensaries	619	111
Ayurvedic Hospitals	5	0
Homoeopathic Hospitals	4	0
Homoeopathic Dispensaries	561	90

There are 3 Govt Medical Colleges in the state with an annual intake of 450 MBBS seats and 160 PG seats. There are 2 more Govt. Medical Colleges in process and soon would be starting at Bhubaneshwar and Kalahandi. Besides, there are 3 Private Medical Colleges also with the total annual intake of 300 MBBS seats.

There are 22 Govt. ANM Training centres with the annual intake of 780 and 4 GNM colleges with annual intake capacity of 360. 1 Govt. BSc (Nursing) college and 1 govt. MSc (Nursing) college also exist with the annual intakes of 40 and 17 seats, respectively.

Demographic Profile			
Indicator	**Odisha**	**Jajpur**	**Koraput**
Total Population (In lakhs) (Census 2011)	*419.47*	*18.26*	*13.77*
Rural Population (In lakhs) (Census 2011)	349.51	16.91	11.52
Urban Population (In lakhs) (Census 2011)	69.96	1.35	2.25

Demographic Profile			
Indicator	**Odisha**	**Jajpur**	**Koraput**
No. of Sub Division/Talukas	58	1	2
No. of Blocks	314	10	14
No. of Villages (RHS 2012)	51313	1783	2042
Crude Birth Rate (AHS-2011-12)	19.80	18.30	25.10
Crude Death Rate (AHS-2011-12)	8.20	7.80	7.90
Natural Growth Rate (SRS 2011)	11.60	10.50	17.20
Sex Ratio (Census 2011)	978	972	1031
Child Sex Ratio (Census 2011)	934	921	970
Total Literacy Rate (%) (Census 2011)	73.45	80.44	49.87
Male Literacy Rate(%) (Census 2011)	82.40	87.36	61.29
Female Literacy Rate (%) (Census 2011)	64.36	73.37	38.92

B. Actions taken against the recommendations of 6th CRM

S. No	Major Challenges Pointed out by 6th CRM	Compliance –State Response
1	Strengthening of Facility based New Born care & linkages with community based interventions	• 93% of DPs have functional NBCC • 75 % of FRUs have SNCU/NBSU • DP Mentoring support programme initiated for concurrent skill upgradation • VHND strengthened through provision of essential logistics • Knowledge & Skill building of ANMs through mentoring support initiated
2	Strengthening of Infection control measures & Bio waste Management	• Outsourcing of Nonclinical service including BMW in major hospitals • Containment areas developed • Refresher trainings organized for staff • Signages displayed at strategic locations
3	Strengthening of Patient amenities & hygienic conditions in high case load institutions	• Outsourcing of Housekeeping & cleanliness services at 145 major health institutions • Basic Patient amenities have been provided by RKS
4	Reducing high out of pocket expenditure	• Free medicine distribution scheme for all diseases (Provisioned 200crs under in the State budget) • Odisha State Treatment fund & RSBY implemented across the State
5	Strengthening of Supportive supervision	• Comprehensive monitoring & supportive supervision framework developed • District Nodal Officers for each districts designated • Integrated Monitoring Team constituted at SPMU • Technical Consultants visit to districts as per Tor. • Structured checklists developed • Fixed day review meeting organised
6	Wide publicity of JSSK entitlements	• Multiple strategy adopted; Serials in TV (KANTHA KEHE KAHANI), Hoardings at health institutions, display board in Labour room, PNC ward , Publications in quarterly News letter 'SUNO BOHUNI", messages at Health Bulletin Boards at village level etc.
7	Strengthening of Referral facilities	• 108 implemented, Advertisement floated for 102.

C. Observations as per the TORs

I. SERVICE DELIVERY

Inadequacy of Health Facilities

The state has a total of 711 Delivery points at all levels of facilities. All the DHs in all districts are functional as delivery points whereas there are 4% SDH and 12% CHCs yet to be operationalized as Delivery points. The proportion of PHCs as active Delivery points is quite low in the state, i.e. only 11% PHCs (136) are functional as Delivery points out of the total number of PHCs. A meagre proportion of Sub-centres (2%) also acts Delivery Points in the state.

Table I. Total number of facilities and Delivery Points in the overall state and HPDs

Sl. No	Category o Institutions	Total in Nos.	Delivery Points *(State)*	Delivery Points *(HPDs)*
1	DHH	32	32	8
2	SDH	27	26	3
3	CHC	377	332	14
4	PHC	1228	136	40
5	Other Hospitals	79	28	7
6	SC	6688	157	24
Total		**8431**	**711**	**96**

Jajpur district has a population of 18,26,275 spread across 10 blocks and Koraput has a total population of 13,79,647 spread across 14 blocks.

Table II. Number of facilities (Functional vis-à-vis Required) in Jajpur and Koraput

S.No.	Type of facility	Jajpur		Koraput	
		Number functional	Required as per population norms	Number functional	Required as per population norms
1	District Hospital	1	1	1	1

2	Community Health Centres	12	18	16	13
3	Primary Health Centres	56	61	49	47
4	Sub-centres	260	365	307	460

There is shortage in the number of subcenters in both the districts. The existing subcenters visited by the team were found in a bad state of infrastructure. The subcenters need an urgent facelift to inspire confidence of the community for provision of basic healthcare.Since Koraput has *'Ektaguda'* system of habitation wherein 1-5 households constitute the hamlets, therefore the villages constitute of widely scattered hamlets spread across large areas. The large distances within and between the villages raises the requirement of enhancing the number of Sub-centres so as to improve the coverage. Considering the time to care criterion, the shortfall of health facilities would be higher in Koraput. Thus the State should consider relaxing the population norms for construction of health facilities especially so in the case of special districts with sparse population.

Subcentres are predominantly present in the Govt. buildings. In Odisha as a whole, only 3570 Subcentres of the total of 6688 Subcentres are in rented buildings. In Jajpur, out of the total 260 sub-centres, only 116 are located in the govt. building. In Jajpur, 4 buildings of sub-centres are in damaged condition and require repairs but no civil work has yet started. In Koraput, Status of electrification and water supply in health facilities shows that there are 101 SCs and 8 PHCs that have not got external electrification and water supply. The existing subcenters should be first given the basic amenities so as to ensure the ANM stays in the facilities and this is prerequisite to Subcenters providing services.

The Annual report of the State suggests that 556 sub-centers and 98 PHC (N) have been undertaken for new construction in the State, while there are 100 Sub-centers and 9 PHCs in Koraput operating without external electricity and water supply with no funds available[1]. *The*

State should focus on operationalizing these facilities and ensuring basic amenities in the existing sub-centers and PHCs prior to taking up new constructions of other health facilities.

Overloading of higher facilities:

In the State, only 2% of the subcenters are conducting deliveries. The subcenters in the two districts are not conducting deliveries.A meagre proportion of PHCs (11%) is delivery points. District Jajpur has a total of 17 identified and functional Delivery Points *(as DH, CHCs & PHCs),* of which 3 DPs are conducting C-sections and 2 DPs are functioning as FRUs with functional Blood Storage Units (BSUs). Jajpur has 3 hospitals categorised as 'Others' also (Chandikol AU, Gopalpur AH and Rama Devi Govt. hospital) that are working as Delivery Points also. Chandikol Out of the 5 designated FRUs in Koraput, only 2 FRUs are functional and are conducting C-Sections. In Koraput, a 106 bedded SDH Jeypore is also functional as a delivery point. The SDH too due to lack of round the clock anaesthetist services, refers complicated pregnancies to DH.

The Basic assessment of the health facilities in both districts and their functionality status against their designated level of MCH centre reinforces that District Hospital is catering to unusually high delivery load due to poor functionality and underutilization of the peripheral institutions. A probable reason could be absence of B/EmOC services at CHCs and PHCs.[2]


A PHC enroute to PHC Gobardhanpur

There is an urgent need to operationalize the peripheral health institutions for conducting deliveries and the designated L3 facilities to conduct C-sections so as to reduce the referral of high proportion of complicated pregnancies to DH.

Thus there is an urgent need to make the peripheral health institutions, atleast CHCs and PHCs to conduct deliveries so as to reduce the delivery load at the DH. The DH conducts more normal deliveries than C-sections and moreover the expected C-section rate from the district expected

pregnancies is much higher than that are catered at the DH and SDH together, which indicates that there is a high number of complicated pregnancies that are not getting C-Section despite indication and probably contributing to maternal mortality due to lack of indicated medical attention.

Inadequate bed strength:

22 *Maternity beds at the DH Jajpur are not adequate* enough to handle high delivery caseload of over 700 per month. The DH Koraput has reported over the past year a bed occupancy of 96% over the past year and had instituted floor beds for postnatal mothers. Thus, in view of the fact that both the hospitals are catering to a major proportion of the delivery load, the strengthening of the DH in terms of beds is the most crucial and appropriate to address the needs of the delivering mothers and also to ensure the post-delivery stay of 48 hours as entitled under JSSK. There is an urgent need to increase the number of beds. The MCH wing underway at DH Jajpur and Koraput has been granted sanction and construction is yet to start. These need to be expedited.

Operationalization of FRUs:

There is a mismatch between the designation and the functionality status in many facilities. So, where on one hand, in Koraput only 2 out of 5 designated FRUs are functional and conducting C-sections, on the other hand, in Jajpur, many CHCs apart from designated FRUs are catering to High caseloads: Jajpur has many other CHCs (Sukinda, Dharamasala, Mangalpur, Barchana) registering considerable number of deliveries, but there is a need to upgrade them as FRUs by making available requisite human resources and facilities therein. The status of the designated FRUs in the two districts shows that availability of blood storage facility is one constraint hindering the operationalization of these FRUs. The DH is catering to majority of delivery load of C-Sections in the district as SDH is selectively conducting C-sections due to Issues with provision of anesthesia. The other FRUs are non-functional due to non-availability of anesthetist ever since as reported by district officials. *The State should focus on operationalizing the FRUs by posting the*

requisite trio of specialists in the facilities which otherwise have a good infrastructure to support the provision of emergency Obstetric services.

Designated FRU name	C-section conducted	BSU/Blood bank operational (Y/N)	Whether FRU is functional as on the date of visit (Y/N)
JAJPUR			
DHH Jajpur	328	Y	Y
CHC Jajpur Road	97	Y	Y
Barchana CHC	0	N *(BSU licensed 2 day before; no stored blood available)*	N
Binjharpur CHC	0	N	N
Danagadi CHC	169	N *(BSU licensed 2 day before; no stored blood available)*	N
Dharamsala CHC	0	N	N
KORAPUT			
DHH Koraput	720	Y	Y
SDH Jeypore	240	Y	Y
CHC Nandapur	NIL	N	N
CHC Boipariguda	NIL	N	N
CHC Laxmipur	NIL	N	N

Lack of residential facilities for Medical and Nursing staff:

The DH Koraput has 27 doctors but only 13 Staff quarters, thus there are insufficient residential quarters, and however, they are all in a habitable condition and have been built by IAP funds. The Staff nurses have no staff quarters and have to reside in rented accommodation with meager salaries thus leading to dissatisfaction amongst the cadre. *The State could consider building a residential hostel for women and other staff to ensure round the clock availability of the staff as well as low attrition.*

Ambulance & Referral Services

In the state as a whole, 466 Janani Express have been engaged, existing Govt Ambulances mobilized, *'108'* services available in 15 districts.

'108' Ambulances are being managed through Public Private Partnerships with an agency namely, '*Jigitsa*' which operates a call centre at the state level to control and navigate all GPS and Mobile Date Terminal enabled '*108'*ambulances. Janani express program, on the other hand, is run through local NGO operated vehicles which are contracted for a period of one year. The contact number of the hospital, driver and doctor is displayed on the vehicle and also remains with the local ASHA. Now the state is planning to run all ambulances through a call centre centrally based at the state level.

Koraput has 27 BLS, 21 Janani express and 14 108 EMRI ambulances. State plans Operationalization of 102services by January-2014.

State funded '102' Ambulance

In Jajpur, there are 14 '*108'* Ambulances in the district, out of which 14 are for Basic life support and 4 are for Advanced Life support. Besides this, there are 12 Janani Express Ambulances exclusively for the care of pregnant women, women after delivery, sick neonates and infants below 1 year. All these 10 Ambulances have been positioned at the identified vehicle points with the objective of maximizing the coverage.

As per JSSK guidelines, women are provided drop-back transport services only if they stay for 48 hours. However, due to the higher caseloads most of the women are unable to stay at the facility for 48 hours and therefore get deprived of the transport facility

The awareness of the free referral transport and 108 toll free numbers is good amongst the inpatients and attendants. The calculations for the Ambulances available and those required was done and it was found that number of ambulances should be more to cater to the expected load of pregnant women and Sick neonates. Most of the women interviewed in the wards reported awareness about the transport facility available to the pregnant women to facility, however,

awareness on availability of free referral transport to sick neonates and drop back facility was low amongst the women and attendants. Despite good awareness levels, very few women reported arrival at the facility by government ambulance. The average number of trips made by the ambulance and the cost efficiency of these ambulances needs to be carried out extensively to optimize the use of the available ambulances and reduce the response time. A similar back of the envelope calculation in Koraput suggested that the ambulances number is low for the expected number of beneficiaries in terms of pregnant women and the sick newborns. The utilization of ambulances, however, showed that the number of trips made by ambulance per month is still far less than optimal number possible.

Therefore, considering the difficult terrain, the number of EMRI ambulances should be increased to provide referral to pregnant women, drop back and referral to sick newborn in context.

Waste Segregation

The State has made considerable progress in the biomedical waste management. Tenders are invited from the third party agencies on annual basis and L1 system is followed for the selection of the agency for biomedical waste management. The protocols of the infection control and BMW were adequately displayed in all the facilities. The waste is picked up by the outsourced agency on daily basis. Waste segregation is being done at the source and Biomedical waste pits and containment areas are well maintained at the higher facilities (CHCs and DH). The protocols for waste segregation were found adequately and well displayed in all the facilities visited.

The waste pits were found lacking in some PHCs and SCs whereas in some other facilities weren't adequately maintained. In Koraput, the considerable proportion of maternal deaths have been caused due to Sepsis as reported in the Maternal Death Review which raise questions over the quality of infection prevention measures undertaken in the district. In Jajpur,Guidelines on waste segregation were not being followed in some facilities. Even though dustbins of various colors were placed in most facilities, but they were not used for the required purpose. Often mixed waste, such as food with IV bottles and IV lines were seen in the same dustbin.

Support Services

The State has outsourced all the support services in District Hospitals like cleaning, security, diet and laundry to the third party agencies. The general cleanliness in the facilities was found satisfactory. Diet provision in District Koraput was outsourced to a women self-help group, Mission Shakti which provides Mission Shakti which provides high quality free diet to the pregnant women and inpatients. There is a need to outsource the dietary services and to ensure three meals to the delivering mothers in facilities below DH. The State may consider increasing the budget allowance for the amount per day for diet of mothers, providing locally appropriate dry food in case of non-availability of kitchen.

Even though State has instituted ASHA Gruhas for accommodation with basic amenities to ASHAs who accompany pregnant women, no accommodation facilities are available for patients' relatives at health facilities below DH. The patient's relatives accompanying from far off places to these facilities were staying outside in the premises.

IEC/BCC

At the state level, SIHFW acts as the nodal agency which plans and strategizes all sorts of IEC activities in the state. There is a whole dedicated team of professionals led by State Communication Manager and comprising Consultant IEC, Coordinator (Documentation Training and Research), Message Developer and a Programme Assistant, which looks after the IEC activities of the state. State government has also started a TV serial namely *'Kantha Kahe Kahani'* with the objective of providing health promotion related communication to the rural populace of the state. The programme airs on DD national channel and boasts of coverage of 30 districts and 47,000 villages of Odisha. NRHM, SIHFW, and other govt. departments are its partners.

Innovative IEC appropriate to the tribal community is used wherein the ***local troupe dancers convey IEC messages*** such as diarrhoea management, ANC Care and Family planning messages during VHND.

The IEC BCC Guidelines were found available at the district level. Wall paintings and posters regarding JSSK entitlements, Family Planning services, DOTS services were well displayed. Signages and citizen charter were displayed at higher facilities**.** The JSSK entitlements were displayed not in vicinity of labour room or maternity wards, where they should ideally be placed.The display of JSSK entitlement was pictorial, and hence appropriate to the largely illiterate community the health facilities cater to. However, placement

IEC display on JSSK entitlements within premises of District Hospital Jajpur

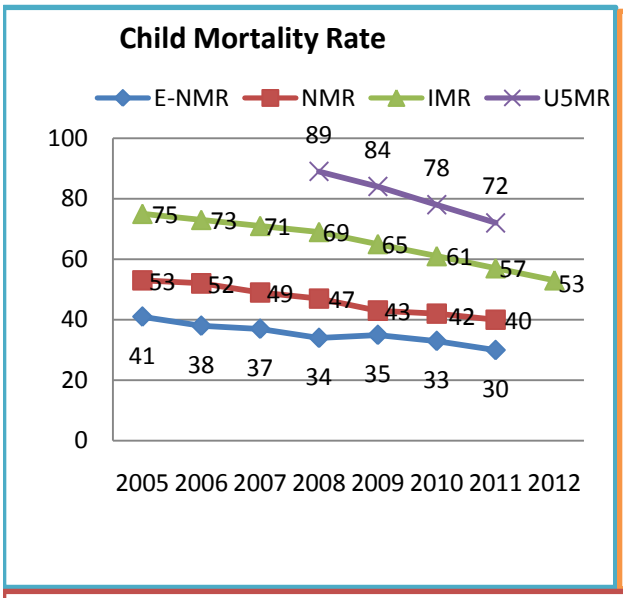
of some posters was not found appropriate. For example, a poster describing the role of VHSC was pasted outside the district hospital in Jajpur. The IEC material on family planning displayed at the facilities mentioned the 1-2 child norm. This is against the human-rights based principle of informed choice.

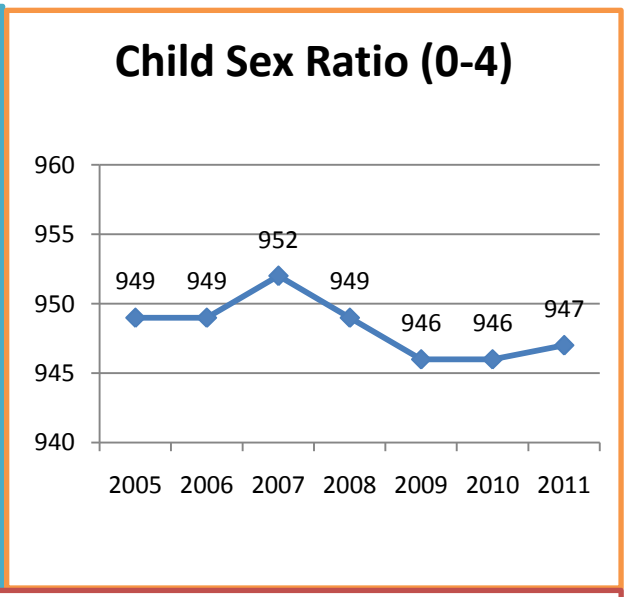
NGO participation:

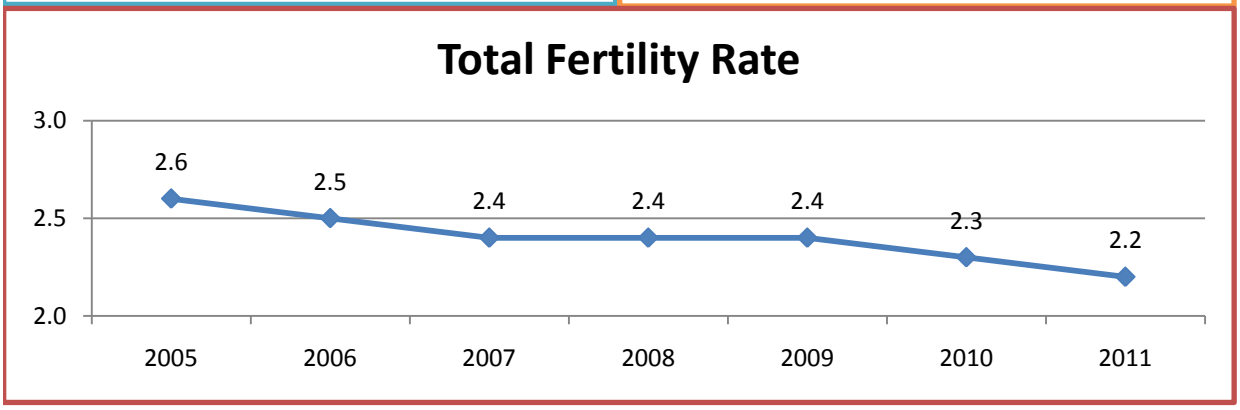
The State has roped in Field NGOs for the purpose of demand generation in the underserved V3 and V4 subcenters in the district. The demand thus generated through awareness and IEC is directed to the subcenter and services are rendered by the ANM. *The scheme is in the nascent stage, it is needed to be evaluated for its effectiveness in improving the service utilization in these V3 / V4 subcenters. There is a need to ensure that there is no duplication in the role of the ANM under FNGO and the ANM at the subcenter.*

II. REPRODUCTIVE AND CHILD HEALTH

A snapshot of RMNCH+A progress in Odisha







Data Source: SRS

	RMNCH+A Progress	Odisha	Jajpur	Koraput
Maternal Health-DLHS-3(2007-08)				
1	Mothers registered in the first trimester (%)	47.5	63.8	50.0
2	Mothers who had atleast 3ANC check ups(%)	54.6	67.7	53.1
3	Mothers who got atleast one TT injection (%)	82.4	99.6	97.3
4	Motherswhoreceivedpostnatalcarewithin48hrsofdelivery (%)	27.4	97.8	100.0
5	Institutional delivery (%)	44.3	61.5	19.0
Child Health-DLHS-3(2007-08)				
6	Full Immunization (%)	62.4	82.3	58.9
7	Childrenunder3yearsbreastfedwithin	63.2	66.1	66.2
8	Children(age6monthsabove) exclusively breastfed (%)	42.7	30.9	49.0
9	Children with Diarrhoea in the last two weeks who received OI	49.0	53.5	40.0
10	Children with Diarrhoea in the last two weeks who were give	60.4	54.5	38.8
11	Children with acute respiratory infection/fever in the last tw weeks who were given treatment (%)	66.8	73.7	51.8
Family planning (currentlymarriedwomen,age15-49)-DLHS-3				
12	Total Unmet Need	23.0	25.0	23.7
13	Using any modern method for family planning (%)	39.6	40.5	33.8
14	IUD insertion(%)	0.4	0.3	0.2
15	Female sterilisation to total sterilisation(%)	96.0	28.5	23.4
16	Percentageofbirthoforder3andabove	32.2	20.8	22.9
Adolescent Reproductive & Sexual Health - DLHS-3(2007-08)				
17	Percentageofbirthstowomenduringage15-19outoftotalbirths	5.5	3.8	16.1
18	Unmarriedwomenage15-24yearsheardofRTI/STI(%)	19.2	30.6	10.4
19	%ofUnmarriedwomenage15-24havingmenstruationrelatedproblemsduringlastthreemonths	15.7	18.6	10.3

Maternal Health

State of Odisha has shown remarkable progress in provision of Antenatal Care to pregnant women. Percentage of 3 or more ANC has increased from 54.6% (DLHS-3, 2007-08) to 77.0% (CES, 2009) and this is consistent at 76.0% in 2010-11 (AHS). The reported data (HMIS, 2012-13) shows that 92.6% pregnant women received 3 ANC checkups to total ANC registrations. Similar trend of ANC coverage has observed in two visited districts. In Koraput, 3 or more ANC coverage has increased from 53.1% (DLSH-3, 2007-08) to 72.6% (AHS, 2010-11) and further 80.7% (HMIS, 2012-13) women received 3 ANC checkups to total ANC registrations. Similarly; In Jajpur, 3 or more ANC coverage has increased from 66.7% (DLSH-3, 2007-08) to 74.3% (AHS, 2010-11) and further 100% (HMIS, 2012-13) women received 3 ANC checkups to total ANC registrations.

Institutional delivery in the State of Odisha has increased as high as national average with successful implementation of Janani Suraksha Yojana (JSY). Institutional delivery has increased from 44.3% (DLHS-3, 2007-08) to 75.5% (CES, 2009) in the State of Odisha. However, Annual Health Survey (2010-11) shows 71.3% deliveries are taking place in institution. Furthermore, HMIS (2012-13) reported data shows that 97.2% of the reported deliveries take place in health facilities. Similar progress of Institutional delivery has observed in Koraput and Jajpur districts. In Koraput, institutional delivery has increased from 19.1% (DLHS-3, 2007-08) to 44.1% (AHS, 2010-11) and HMIS (2012-13) shows that 60.5% reported deliveries are taking place in health facilities. Similarly; In Jajpur, institutional delivery has increased from 61.5% (DLHS-3, 2007-08) to 88.2% (AHS, 2010-11) and HMIS (2012-13) shows that 96.0% reported deliveries are taking place in health facilities.

Delivery Points (Status and Functionality)

	Total Delivery points	**FRU (DPs)**	**24x7 PHC (DPs)**	**No. of Janani Express**	**No. of Ambulance**	**No. of Blood Bank/ BSU**
Jajpur	17	02	06	11	12	02

	Total Delivery points	FRU (DPs)	24x7 PHC (DPs)	No. of Janani Express	No. of Ambulance	No. of Blood Bank/ BSU
Koraput	21	02	06	21	27	02
Odisha	**711**	**42**	**76**	**466**	**--**	**42**

Out of 8431, 711 (8%) public health facilities are functional delivery points in the State of Odisha. However, only 42 FRUs and 76 PHC (24x7) are functional delivery points providing 24x7 health care services. Both the visited districts have 2 FRUs and 6 PHC (24x7) providing 24x7 health care services.

In Jajpur, it was observed that 94 % of SBA trained manpower available in all delivery points. Only 5% delivery points are providing services at out reached areas. In Koraput, all functional DPs have SBA trained manpower(100%).

Ante-natal care

ANC was being provided at the VHNDs as well as in OPDs. While MCH cards were being issued to the women at VHNDs, the same was not being done at the facilities.

Integrated Lab services were available at DH, SDH and CHC. The Laboratories in the facilities visited were found to have adequate supplies of reagents and consumables. The laboratories are located within the facility premises. However, PHCs were not found to be providing any diagnostic facilities. PHCs therefore are highly underutilized. Subcenters are providing hemoglobin estimation, Urine test, pregnancy tests, Malaria, Diabetes testing and are functioning at the expected standards. In addition, these services were available at the VHND witnessed at Dumuriput village at Koraput.

Also, basic laboratory investigations for ANC like hemoglobin estimation, urine examination for protein and sugar were not being done at many facilities, due to absence of laboratory services, such as Gobardhanpur PHC. In this case, women were being referred to the nearby sub-centre

for these investigations (a case of “reverse referral”). At some places, these services were not being offered despite the presence of a Lab Technician. The LT was doing only disease control related investigations. The Barchanapur CHC was the only facility where ANC investigation like Hb, urine examination, blood grouping and RPR for syphilis was being done a regular basis.

The facilities including CHC and PHC (New) were highly underutilized in both districts. The PHC (new) is having an AYUSH MO and One NSSK trained MBBS MO is neither conducting Normal Deliveries nor immunization services. It is merely acting as a dispensary and giving treatment for minor ailments.

While some ANMs were conducting ANC investigations like Hb estimation and urine for protein and sugar at VHNDs, some others said that they did not have the kits (strips) for urine testing. One ANM was using the filter paper method for Hb estimation. VHND observations and records showed that not a single pregnant woman had been detected as being anemic, whereas they were found to be pale on examination. This is in total contradiction to survey reports (NFHS-3) wherein 59% pregnant women in India were found to be anemic. Also, 10% of maternal deaths in Jajpur and xx% at the state level are reported to be due to anemia. One ANM reported that she was unable to conduct urine analysis even though she had participated in the SBA training a few months back. She said that this part was not covered in the training.

Danger signs during pregnancy, delivery and in the postpartum period and essential newborn care is part of the MCH card however, there is no counselling of women on these issues, and women were not aware of the same. In fact most of them had never focused on/ read these pages on the MCH card. ANMs said that “birth plans” were being prepared for all pregnant women however they were not clear about the components to be covered under the birth-plan.

ANC was used for detecting “high risk cases”. ANMs said that women with a weight of more than 80kgs, short height, those with BP more than 140/90mmHg, severe anaemia, pedal edema, and urine blood albumin sugar were said to be high risk cases. These cases were referred to higher facilities. The others were continued to undergo management at the level of the ANM. The high risk approach is thus not in tandem with the global understanding that

"every pregnancy is at risk" as "most maternal complications cannot be predicted or prevented". The high risk criteria are not synchronized with the danger signs that signify complications or impending complications that need immediate attention and referral. Many so-called normal/ non high-risk pregnancies can go into sudden complications and may need attention, which the woman is then ill-prepared for. Thus there is a need to use ANC for early detection of complications and not for detecting high-risk cases.

HIV testing for pregnant women was also being done as a routine for all pregnant women at this facility. However, there was no counseling for the same. In case a woman was found to be HIV positive, she was referred to Cuttack medical college, often without even explaining the result.

Intra-partum care

Staff at all delivery points (nursing) are SBA trained. Many other SBA trained staff are present in the field, but are not conducting deliveries. All the labour rooms visited were clean, well-lighted and well ventilated in both the districts.

Toilets attached to the LR require attention. At places they were not clean, and did not have soap. At other facilities like Gobardhanpur PHC, there was no toilet linked to the LR. The one general toilet for patients was very dirty and did not have running water.

Flow-charts related to management of obstetric conditions, obstetric complications and newborn care were posted on the LR walls. However, the size of the same and the high placement often meant that staff was unable to read the content. Also, despite the placement of flowcharts, staff was not familiar with the defined protocol and was not following the same. Also, some of the charts placed there like for management of APH were not applicable to the labour room.

There was limited clarity about the use of uterotonics for prevention and management of PPH. Some are not giving oxytocin routinely after every delivery (e.g. PHC). At other places, the dose is less, or they are giving it IV. For PPH, they are unable to define the same, and often Oxytocin, with Misoprostol and Methergine is given together. However, the cases in which this is given,

PPH has not been recorded as an obstetric complication. At the DH, Methergine, is often used for prevention of PPH.

In some facilities, Oxytocin was being used to augment labour. In other cases, it was also used to "expedite" the second stage of labour for women who came to the facility when the delivery was imminent.

None of the facilities were maintaining the partograph correctly. At many places, it was being filled post-facto, which defeats the very purpose of filling a partograph (to diagnose prolonged labour). Some specific issues were:

- ✓ Not starting the partograph from the alert line.
- ✓ Starting the partograph in the latent phase
- ✓ Not using the simplified form of the partograph
- ✓ Conducting a P/v more frequently than every 4 hours
- ✓ Not marking the correct time
- ✓ Recording FHS even after delivery of the baby!!

No obstetric complication was recorded in any of the LR registers. On deeper probing, the LR staff revealed that the cases that they refer to higher facilities (such as eclampsia) were not recorded in the LR register, but only in the OPD records, even though the woman was admitted in the LR for some period of time and may have undergone treatment / interventions also.

In many facilities, bed-head tickets were not available and delivery case sheets were being maintained on plain paper.

Many harmful practices were being followed such as the excessive use of episiotomy. It was being done for all primigravidas and most of the second gravidas too. In fact, in a particular case where a woman delivered a 1900 gm baby, even there an episiotomy was given. The reason cited was the "risk of perineal tear". This also led to an almost universal use of antibiotics following delivery (see below under irrational use of antibiotics).

Another ill-recommended practice was the routine use of IV fluids for all women admitted to the LR. The explanation given was the “risk of PPH”, which would then require setting up of an IV line.

It was noticed that irrational use of antibiotics is prominent at all the health facilities. Antibiotics were given routinely to all women following delivery. Most commonly, these were cephalosporin group of drugs. In most facilities, the first dose was given IV. Information from the beneficiary revealed that antibiotics were also given to the woman on discharge. As most women were given episiotomy, antibiotic coverage for the episiotomy wound for cited as the most common reason for antibiotic use. However, even those women who had not been given an episiotomy were given antibiotics. Anti-spasmodics (oral or injectable) was also used routinely for all women following delivery. They were also prescribed at discharge.

All these additional drugs were being administered on the orders of the doctors placed at the health facilities. The doctors were either trained Ob-Gyn, or had undergone BEmOC training. Some of them were even SBA master-trainers

As per the records available at DH and SDH the still births are quiet high. As evident from their records, the causes of the still births are preventable.

	Deliveries	Still births percentage	Causes of Death
DH	350	4%	Fresh still birth and maceration.
SDH	172	20%	PET, ruptured uterus, prolonged labor, hand prolapse, cord prolapse, LBW babies and birth trauma.

Post Natal Care

Many women are unable to stay the complete 48 hours after delivery in the health facility due to facility overload or their own personal and family constraints. Nonetheless, facilities record an almost 100 % result for timely initiation of breastfeeding. However, this opportunity is not utilized for counseling the women for contraception.

Post natal visit by ANM and ASHA are being done in both the districts as per the schedule. ASHA used to make the home visit on 1st, 3rd, 7th, 14th, 21st, 28th, and 42nd after the delivery in the community.

JANANI SHISHU SURAKSHA KARYAKRAM

Free Referral:466 Janani Express ambulances have been engaged for the JSSK programme and various existing Govt. Ambulances have also been mobilized. 108. Ambulance services are also being deployed in 15 districts. 102 Ambulance services would be operationalized in January, 14.

Free Diet through Self-help groups: There are583 institutions providing diet to all JSSK beneficiaries. The State has made efforts to ensure free diet to mothers by outsourcing the services to a Self Help Group Mission Shakti which is providing good diet to mothers delivering in District Hospital.

Free Diagnostics: Strengthening ofexisting laboratory services is in process and the state has been able to make 463 facilities ready to undertake lab investigations. Multiskilling training of LTs have also been initiated. But the state still faces the dearth of LTs at many of the facilities. In some districts, the process of outsourcing of DHH labs has also been initiated.

Free Blood:75 institutions are equipped to provide Blood out of 94. Camps have been planned in collaboration with SBTC. Collection of Blood is done through Voluntary Blood Donation Camps.

Free Drugs: The State has increased the State budget from 30 crores to 200 crores and Essential Drug list has also been prepared. None of the facilities visited in Koraput and Jajpur was found having shortage of drugs. The ODIMS has been operationalized at the State and centralized

procurement is being done for all the districts. There have been instances reported of prescription of drugs from outside. The IEC for JSSK was seen at all facilities visited and was largely pictorial to ensure that the message gets delivered to the people irrespective of their literacy status. On the contrary, the suggestion box instituted in the District Hospital for addressing the grievances under the JSSK scheme had display in English, which seemed self – defeating and not serving the purpose intended.

ISSUES IN JSSK IMPLEMENTATION**:**

Low awareness on entitlement of referral services for infants. The utilization of the JSSK by referral transport shows that only 10 % of the beneficiaries of referral transport are infants, which indicates low level of awareness of the entitlement of sick newborns to get free referral transport. Some ASHAs, ANMs and beneficiaries were also found not aware of entitlement for free referral transport services that could be availed for the sick newborn up to 1 year of birth.*This awareness of the entitlement having been extended to the newborn upto 1 year of ageneeds to be emphasized through IEC activities.*

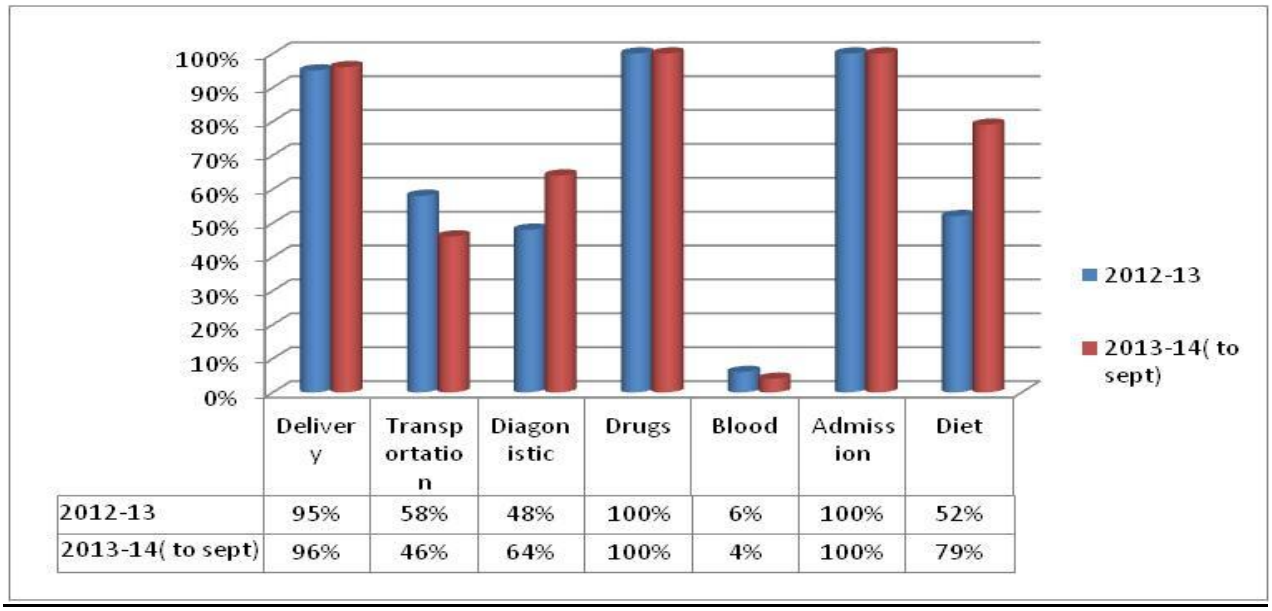
Quality of Diet needs improvement. SDH Jeypore provides the same Dry Diet to the pregnant mothers that it provides to all its IPD patients and the diet is given only once a day, with milk, biscuits and egg. The CHCs and PHCs also are providing the same diet. *The State should ensure three meals to the pregnant mother and increase the amount allocated for diet to more than*

Rs.50 per day to ensure good quality and adequate amount of food to mothers staying in health facilities during postnatal period.

JANANI SURAKSHA YOJANA*Year*	*No. of Beneficiary*		*Amount paid to Mother Beneficiary*	*Out of total beneficiary no. of beneficiary assisted by ASHA*
	Home	Institutional		
2010-11	0	29020	Rs.4,68,11,951.00	12856
2011-12	0	28450	Rs.5,16,77,000.00	27126
2012-13	0	24972	Rs.3,49,56,143.00	23634

In the state, JSY scheme benefits have been availed only for the Institutional Delivery cases, most of which having been assisted by ASHAs.

The following chart shows the trends in utilisation of services for the last 2 years in Jajpur:



	Delivery	Transportation	Diagonistic	Drugs	Blood	Admission	Diet
2012-13	95%	58%	48%	100%	6%	100%	52%
2013-14(to sept)	96%	46%	64%	100%	4%	100%	79%

As evident from the above chart, beneficiaries are getting drugs (100%), diagnostics (64%), Diet (79%) whereas referral facilities (64%) for pregnant women under the scheme.

Migrant ladies debarred of JSY benefits. Among the migrant population, women were not able to produce ID proof / address proof for getting enrolled into JSY and thus were unable to benefit from the scheme. They even faced difficulty in ANC registration as ANMs were not sure whether to include them in their “area”.

Since the ***Medical Colleges are not covered for providing JSSK benefits***, many referral cases from the DHs and CHCs end up paying Out of pocket expenditure for the services. One such case was observed which was referred to Cuttack Medical College from the DH Jajpur and the Beneficiary had to pay around Rs. 10,000/- for drugs and diagnostics in the Medical College which didn't get reimbursed from the facilities.

REFERRAL SYSTEMS

Excessive referrals to SCB Medical College were observed from the DH and CHCs in Jajpur district. Despite the DH being well-equipped with infrastructure and 3 Ob-Gyn, 2 paediatricians, 1 anaesthetist and 1 LSAS trained MO to conduct C-sections, a case of Hand prolapse was referred to the Cuttack Medical College which needed immediate C-section.

C-section rate lesser than normal trend. Based on the data shared, the C-section rate as a percentage of the total institutional deliveries conducted in DH and FRUs is only 2.66% in Jajpur, much lower than the minimum standards. According to international standards, the C-section rate should range from 5-15% of all deliveries. The reason for this could be attributed as the high referral to the Medical Colleges.

24x7 PHCs which should be offering BEmOC facilities were only conducting normal deliveries. Eclampsia cases were being referred from FRUs.

Some observations made in this regard are as follows:

- Only referral of newborn babies with complications was recorded in the LR register.
- The referral slip did not have a counter-foil that was maintained at the referring facility. Thus, details of the client (especially pregnant women / women in labour) referred to a higher facility were not easily available.
- Other than the DH, only 2 CHCs were conducting C-sections, and that is also a reason for the less than expected number of C-sections.

BLOOD BANK AND BLOOD STORAGE UNITS

There are a total of 66 BSUs in Odisha at the level of DHHs, SDHs and CHCs. 6 DHHs and 5 SDHs don't have any functional Blood Storage Unit, out of which 2 DHH and 4 SDH are not even conducting C-sections because of this reason. Among the CHCs, only 21 of 308 CHCs have the BSU facility.

In Jajpur, The blood bank at the DH was functioning well. However, it did not have some of the negative blood groups at the time of visit, but the blood-bank staff had contact details of negative blood group donors. The Blood bank at Jajpur CHC was also functional.

The Blood storage units at Dangadi CHC and Barchana CHC had been opened only 2-4 days prior to the visit. Thus, for all practical purposes, the FRU functionality status at the time of the visit was 1 FRU at the other level, other than the DH in Jajpur.

In Koraput, The 2 functional FRUs, the DH and SDH have blood banks. They both are functioning very well. Blood is collected through voluntary blood donation camps.

COMPREHENSIVE ABORTION CARE

The State has claimed operationalization of MTP services in 221 DPs and total 290 doctors have been trained in MTP services for these 221 DPs. On field visit, the MTP services of the PPC indicates that only 53 cases have been performed during the year 2012-13 and during the last two quarters of the current year, 33 cases of MTP have been performed. Doctors at PHCs did not report being trained in MTP.

A total of 9485 MTP cases conducted in the facilities with 525 MTP cases done in the second trimester of pregnancy and 8960 MTP cases done within the first trimester of pregnancy.

In Jajpur, CAC is available at 12 centres, of which 6 centres are offering second trimester abortions. However, second trimester services are available only in the DH. Dangadi CHC, Jajpur Road CHC and Barchana CHC offer only 1st trimester abortions. None of the PHCs are offering abortion related services.

The Ob-Gyn specialist at Dangadi shared that CAC guidelines had not been shared with him. He was averse to using medical methods of abortion as he felt that it led to incomplete abortions. He was conducting first trimester abortions using MVA for first trimester abortions. On the other hand, the Ob-Gyn at Jajpur road and Barchana CHCs were conducting medical methods as the preferred method for abortions. For pregnancies more than 6 weeks' duration, they were using suction evacuation. MVA was being used only for menstrual regulation.

In Jajpur, Drugs for medical abortion were not available at any of the facilities, and patients were asked to purchase the MMA kits from outside pharmacies.

Maternal Death Review

Maternal Death Review (MDR) has been well implemnted in the State of Odisha. A total of 398 total maternal deatha have been reported during the period April 2013-August, 2013 which shows significant coverage of MDR. State has taken cognizance of the recommendation of the previous CRM with this regard. 366 have been reported by the MDR Committee at district CDMOs and 266 by the District Magistrates in the State.

However, maximum deaths have been reported due to causes categorized as 'others'(153) haemorrhage(134) and the hypertension(54) apart from sepsis(36) and obstructed labour(20). Corrective steps need to be taken to analyse the causes under'others' as these could be attributed to social / familial causes, which perhaps could be related to the '3-Delays'.

The other causes related to hemorrhage etc. clearly again indicate the poor quality of training imparted which has poor impact on the service delivery despite the provisions of Tab misoprostol available as seen during the visit to the districts.

More than 25% deaths are reported to be occurring either in transit(60) or at home(42), indicating the need to analyse deaths due to the 3-delays and making provision for providing skilled care during birth at home.

It is extremely essential especially not only to take steps for effective outcomes in terms of training and care in High focus districts but also in the Non-high focus districts as well since majority of maternal deaths have been reported from non-high focus districts, like, Ganjam, Mayurbhanj, Puri.

The main high focus districts that need attention in this regard are Bolangir, Baragarh, Nawarangpur, Koraput, Keonjhar,Nuapada, Rayagada, Sundergarh and Malkangiri.

Only 33 deaths have been reported due to severe anaemia by 15 districts. However, the coverage is insignificant, which indicates the need to monitor the VHND sessions as well as linelisting of these women at facility during the antenatal period.

Only 88 women in the whole State have been covered for moderate anaemia whereas the maternal deaths reported is 121out of 398 reported deaths (accounting to more than 30% deaths due to anaemia)**.**

In Jajpur, estimated number of maternal deaths was 78 in 2012-13 whereas 37 cases were reported in the district. Thus, health system would able to capture only 47% of maternal deaths. The details of maternal deaths during last three years are given below:

Year	**2011-12**	**2012-13**	**2013-14 (up to Sept'13)**	**Total**
Maternal Deaths	43	37	11	**91**

	Causes of Maternal Deaths								
	PPH	APH	Heart Diseases	Prolonged Labor	Septicemia	Anemia	Eclampsia	Other	Total
No. of Maternal Deaths	25	5	9	3	4	9	4	32	**91**
%	27%	5%	10%	3%	4%	10%	4%	35%	

The major cause among the defined causes of maternal deaths is Post-Partum Hemorrhage contributing to 27% of the deaths. However, for considerable proportion of deaths (35%) cause is left undefined and categorized as *'Others'*.

DMO audits all the maternal death of the District and Collector & D.M. audited 88 maternal death out of 91. Certain decisions were taken to find out the gap analysis in the facilities.

Maternal death review has a number of issues and needs a lot of improvement. For example, based on the report shared it can be seen

- ✓ Not all deaths are being reviewed. **.** JSY payment records revealed of a maternal death occurred on the way on June 29,2013 while the patient was referred from Gobardhanpur PHC for a complication. This death, however, was not found in the list shared by the district team.
- ✓ The cause of death not listed according to standard norms. For example, one of the causes listed is "Heart stroke". It is not clear what this means.
- ✓ The person(s) reviewing the case are not taking triangulating data. For example, one of the deaths lists anaemia as the cause of death. However, the Hb mentioned is 12gm%, clearly indicating that the woman was not anaemic.
- ✓ No social or contributing causes (the 3 delays) were mentioned in the report. More than medical causes, these causes help in finding programmatic solutions. For example, women died in transit, but that has not been explored any further – what was the delay that was the reason behind the same. No solutions have been offered for the same at the review meeting.
- ✓ The review process at the district level is not in-depth, and does not really take into account the cause of death for finding solutions. For example, even though PPH and heart stroke and anaemia were identified as the causes of the three deaths in a review period, ensuring 4 ANC check-ups was suggested as a solution. As PPH cannot be predicted or managed during ANC, and same for heart stroke (though the cause itself is unclear), the solution does not address the problem. Even for anaemia, the number of ANC is not enough. Quality of ANC, including Hb estimation on each visit, followed by treatment of anaemia needs to be ensured.

In Koraput, It is appreciated that the Facility based Maternal Death Review is taking place, however, the quality of MDR needs to be improved as the district data on analysis reveals that the causes of death for many deaths are not mentioned clearly. The cause of each maternal death needs to be clearly identified. While a few cases related to the 'three delays,' the other reasons relate to inadequate or improper treatment, which are certainly preventable. 13 out of 19 cases of maternal deaths reveal severe anemia as the cause of deaths, which is a matter of grave concern.

These reasons of maternal deaths indicate that specific steps need to be taken for (a) intensifying regular monitoring of the antenatal care services being provided at the VHNDs by the members of DQAC (b) follow up of line-listed severely anemic pregnant women and their immediate referral to higher facility by ANMs and ASHAs; repeated follow up after treatment till delivery and ensuring actual consumption of IFA tablets (c) strengthening supportive supervision to improve the quality of antenatal care, including early detection of high risk cases and timely referral in the peripheral health institutions (d) enhancing the skills of the SBA trained staff nurses/ ANMs posted in the labour rooms at delivery points to prevent and manage certain common high risk situations during delivery (e) posting of EMoC and LSAS trained MOs at the CHCs (with appropriate facilities) for dealing with emergencies so that more number of the health facilities are not only available and accessible at the periphery but also strengthened to deal with obstetric emergencies such as PPH. The District has started experimenting with maternity homes in L3, L4 areas, which is being utilized and is a good strategy to refer high risk as well complicated pregnancies to these homes, located close to the functional delivery points or FRUs. The maternity waiting homes in addition should be well connected with the referral transport.

CHILD HEALTH

State of Odisha has shown remarkable progress in Infant mortality rate since inception of National Rural Health Mission. It has declined 22 points from 75 per 1000 live births in 2005 to 53 per 1000 live births in 2012. However, Neonatal Mortality Rate and Early Neonatal Mortality Rate have not shown the same pace of decline over the same period of time. Currently, about 70% of infants are dying within 28 days of life and 75% of these neonates are dying within 7 days of life in the State of Odisha. This signifies that quality of care to newborn during intra-partum and post-partum period at facilities should be ensured to prevent these deaths.

In Odisha, progress of facility based new born care is satisfactory and gradually has shown improvement.

Neo-natal care units	Targets 2013-14	Achievements	Remarks

SNCU	35	25	32 DH & 3 Medical college
NBSU	50	40	113 FRUs> 20 delivery/month
NBCC	793	634	711 delivery points

Out of 8 high priority districts, 6 HPDs have functional Special Newborn Care Unit (SNCU) in place. However, establishment of SNCU in Gajapati is under progress whereas Baudh district has proposed SNCU in PIP 2013-14. A total of 324 beds are available for care of sick new born in SNCUs. Most of the SNCUs have caseloads more than the bed strength. Average number of Medical officers and Staff Nurses available in SNCU are 2.8 and 9.2 respectively in comparison to GoI norms of 4 and 10 respectively.During F.Y. 2012-13, a total number of 27, 860sick new born admitted and of which 4, 061 died in the SNCUs.*The mortality rate (15%) in the SNCUs is higher than national average (11%).*

In Jajpur, a total of 17 New Born Care Corners are reported functional in delivery points. Reported 188 newborns have taken resuscitation at birth whereas 54 newborns have been referred to higher facility in 2013-14 till September'13. One 4 bedded New Born Stabilization Unit has been functional at Barchana CHC from dated 01.07.2013 under the supervision of one F-IMNCI trained Medical Officer and in view of the case load one mini NBSU has been made functional at DHH for inborn cases only. A total of 5 newborns have been managed in NBSU & death is NIL. One 24 bedded SNCU is proposed to be functional at District Head quarter Hospital and merged with MCH wing.

In Koraput, there are 2 SNCUs, 2 NBSUs and 24 NBCCs functional as on date whereas 1 NBSU and NBCC are under construction.

Facility Based New Born Care

NBCC was found in all the visited health facilities but cleanliness of Radiant Warmer and Ambu Bag was the cause of concern. Essential new born care was observed inadequate across the all visited facilities whereas health personnel were trained in NSSK. Radiant warmer were functional but Staff Nurses in labor room are not able to operate it properly. Skills of proper

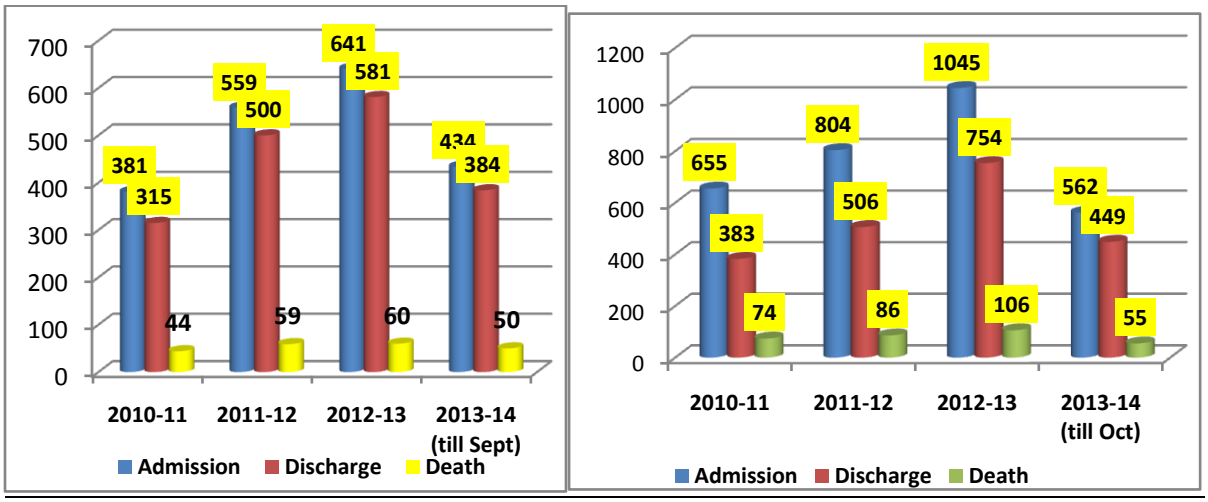
hand washing were missing in some SNs though they are well aware of other new born care skills such as cord cutting, wrapping of new born, KMC etc.

SNs are trained in NSSK but standard treatment protocol is not being practiced in labor room.**Vitamin K** is not given to all newborns at some CHC and all visited PHCs. Vitamin K is also not present in the essential drug list in the facilities.

Irrational use of antibiotics to new born has been observed across all the facilities visited in Jajpur district. All newborn children were routinely given a dose of IV Ampicillin. The rationale shared was “prevention of sepsis”. Even on discharge, antibiotics were advised for the child. In the case seen in the field, the child was prescribed oral cephalosporin on discharge. There was no indication for the same written in the discharge papers.

New Born Stabilization Unit (NBSU) at district hospital was not functional as per the GoI guidelines because there were 3 Phototherapy and 1 Radiant warmer available at the facility. On the other hand, NBSU at Barchana CHC was observed Underutilized as only 5 newborns had been admitted since August 2013 till date despite the fact thatfacility was catering to the delivery load of about 200 deliveries / month. The NBSUwas managed by the F-IMNCI trained medical officer. However, some treatment protocols were also found not being followed, for example, MO informed that Diazepam suppository was required for managing a child with convulsions whereas the guidelines mention the use of Phenobarb for this complication.

Utilization status of these two SNCUs is given below;



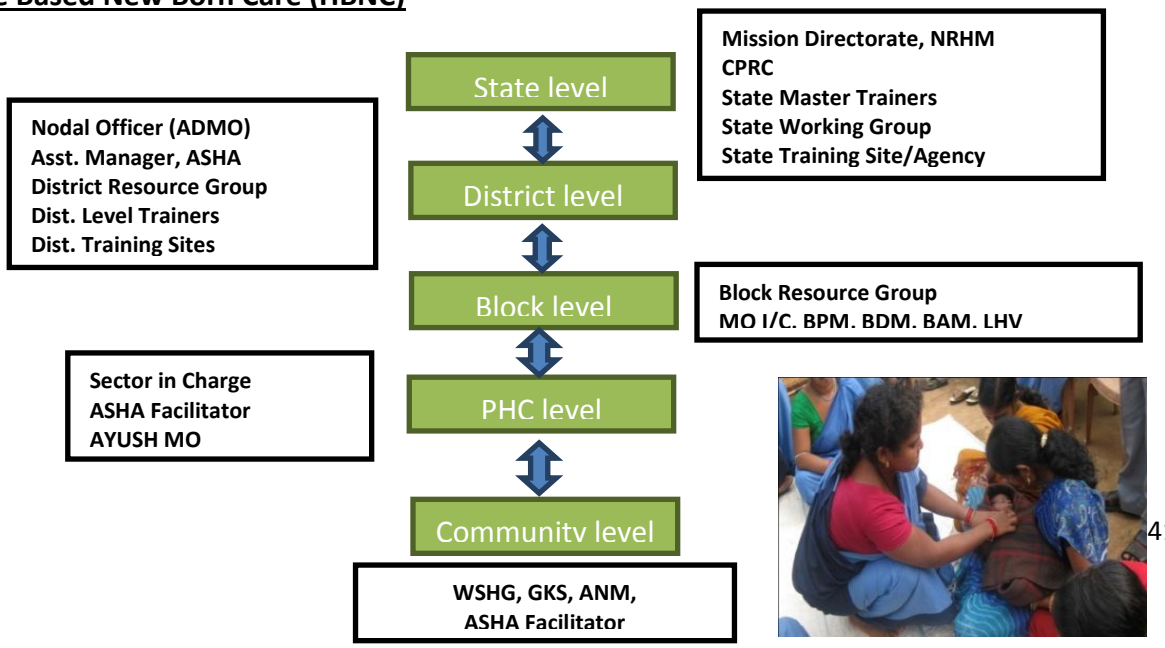
A total of 5081 Sick Newborn babies were admitted in these 2 SNCUs and 4547 sick new borns were treated and survive in SNCUs. This shows that 98.5% survival rate at SNCU in Koraput.

Management of LBW babies

A scrutiny of labour room registers reflected lesser than expected number of LBW cases. In some facilities, of the 50-100 last births recorded, the LBW (including VLBW) rate was 7-8% only. Often, the LBW cases less than 2000 grams were seen on records, but very few cases of 2000-2499 gms birth weight was seen. **In one PHC, a zero error of 200 grams on the mechanical baby weighing scale seemed to account for some errors.**

For management of LBW babies, there was very limited focus on Kangaroo Mother Care and counselling for breastfeeding.

Home Based New Born Care (HBNC)



Home Based New Born Care (HBNC) is being implemented in the State of Odisha. A total of 43, 272 ASHAs are in position as against the target of 43, 530 in State of Odisha. A total of 1856 and 1479 ASHAs are in position in Jajpur and Koraput districts respectively. Module 6 & 7 training of ASHAs are imparted in phased manner in the State. 18 high focus districts were selected in 1st phase of training and all 22843 ASHAs were trained in round 1 (HBNC). Another 12 non high focus districts have trained 16560 out of 20687 ASHAs. Thus, 90.5% of ASHAs are trained for the implementation of HBNC in the State. In Koraput, all ASHAs are trained in round 1 of module 6 & 7 training whereas in Jajpur 68% of ASHAs are trained in round 1 of module 6 & 7.

HBNC kit has been given to the ASHAs in the 18 high focus districts whereas 12 non high focus districts are in the process of distribution. HBNC formats from the 18 high focus districts were collated and compiled at State lavel. During April to September, 2013

Total no. of HBNC forms received	103215
No. of newborn visited on first day	77965
Six home visits conducted to no. of newborns	97338
No. of newborns diagnosed with danger signs	3705
No. of post natal mothers diagnosed with danger signs	1063
No. of newborns referred to hospital	1936
Incentive paid (in Rs.)	2.46 crores

ASHAs are well trained in HBNC and skills are being properly practiced. ASHAs are well aware that how to assess the danger sign in newborns, proper counselling of mother for breastfeeding and hand washing, cord cleanliness etc. In Koraput, ASHAs are reporting in HBNC formats whereas in Jajpur district printed reporting formats just reach to ASHA.

ASHA kits as well as HBNC kits are being regularly replenished by ANMs at Subcentres. Therefore, ANM supervise and mentor ASHAs for their home visits and ensure proper dispersion of drugs in the community during home visit. ANMs and ASHAs are working in close coordination in the community.

Management of Malnutrition

Pushtikar Diwas (Nutrition Day) celebrated on 15th of every month, where a Pediatrician or F-IMNCI trained MO attends the malnourished cases and other childhood illnesses as identified during the VHNDs. Here, the SAM children are referred to the NRCs. The ASHA receives Rs.100/- for referral, and the patient receives Rs. 200/- for drugs.

Two**Nutritional Rehabilitation Centres (NRCs)** were functional *(at DHH Koraput and CHC Rabanguda)*in Koraput and one was functional in Jajpur districtat Jajpur Road CHC. NRCs in Koraput have admitted a total of 291 cases so far. NRCs in both the districts were very well managed, and guidelines are being followed. Adequate man power was available in both the NRCs. In Jajpur district, there were one medical officer (part-time), 3 ANMs in rotation, 1 counsellor and 1 attendant-cum-cook in place. No cases needed re-admission at the NRC in the last 1 year of its functioning. The medical complications frequently observed in children admitted to the NRC include ARI, diarrhoea and dermatitis. A new MIS system is being developed to monitor the NRC cases. It is an innovation by the state. Pilot has been completed and it is now being expanded to multiple districts. NRC is functioning well and providing the care to SAM children.Records were properly maintained in NRC and reporting was streamlined through web based reporting.

Diarrhoea and ARI management

In Jajpur; ASHAs, ANMs and doctors were not aware of the role of Zn in management of diarrhoea in under-five children. While some facilities did not have Zn tablets available, at other places people considered it to be a mineral supplement. Some ANMs said that they give it to people more than 10 years of age along with IFA, but not to children. No one was aware about the dosage of Zn for management of diarrhoea.

Antibiotics like Norfloxacin and Metronidazole was routinely prescribed in all diarrhoea cases for children and adults. At some sub-centres, the ANMs had purchased antibiotics like Norfloxacin out of untied funds and were using the same for treatment of diarrhoea, even though ANMs are not authorised to prescribe/dispense antibiotics except in certain pre-

specified conditions.Even ASHAs were dispensing Metronidazole for management of diarrhoea cases in patients over 10 years of age.

For ARI, only 3 days of antibiotics was prescribed and dispensed. While the patient was called for follow-up after three days and most of them did not come. Such incomplete regime of antibiotics is one of the major causes of widespread antibiotic resistance.

Infant Death Review

The cause of death has not been fully explored. For e.g. LBW has been listed as a cause of death in many cases. However, the birth weight has not been mentioned anywhere in the analysis. Also, LBW is usually an underlying cause, and not a direct cause of death, especially when not associated with prematurity. Other places; symptoms such as "blood vomiting" have been mentioned as the cause of death. At another place, "malnutrition" has been listed as the cause of death of a 33-day old baby. This reflects that the review is not being done by a person with a medical background or who has an understanding of the cause of infant death.

No social causes have been listed in the review report.The review meeting only asks the team to further study the causes of death, but offers no solutions.

InKoraput, examination of the records at Labour room and SNCU revealed that during 2012-13, 20% stillbirths have been caused due to most preventable reasons during antenatal period as well as adequate monitoring of progress of labour, indicating therefore, the grave quality issues related to SBA training and poor quality of care during pregnancy and inability to diagnose the danger signs (by the service provider)either in pregnancy or during labour.

Table- Stillbirths (%) at DH &SDH, Koraput

Facility	Deliveries	Still births percentage	Causes of Death listed in labour room register
DH Koraput	350	4%	Fresh still birth and maceration.
SDH Koraput	172	20%	PET, ruptured uterus, prolonged labor, hand prolapse, cord prolapse, LBW babies and

			birth trauma.

SNCU records -The death records at SNCU, Jeypore at Koraput indicates that maximum deaths of newborns are caused due to birth asphyxia. Out of the 26 total deaths due to birth asphyxia,majority are inborn cases(18), indicating again the quality issues of care while the sick newborn is at the facility. Also,prematurity happens to be the second major cause of death.

RashtriyaBal Swasthya Karyakram (RBSK)

2 MMUs have been sanctioned per Block manned by a team comprising Medical Officer (AYUSH) (1-Male & 1-Female), one Pharmacist with proficiency of computer for data management & one Staff Nurse/ ANM which are to be deployed for the RBSK programme. The recruitment process has been going on & it will be completed by end of the month of November, 2013.RBSK has not yet taken off in the state. Teams are yet to be recruited.

Immunization

Immunization programme in the State of Odisha is considered to be implemented very well though the evaluated data shows that full immunization coverage has declined from 63.3% (DLHS-3, 2007-08) to 59.5% (CES, 2009) and further declined to 55.0% (AHS, 2010-11). On the other hand, Measles coverage has increased from 81.0% (DLHS-3, 2007-08) to 86.7% (AHS, 2010-11). In Koraput, full immunization coverage has declined from 58.9% (DLHS3, 2007-08) to 39% (AHS, 2010-11) and Measles coverage has declined from 81.8% (DLHS3, 2007-08) to 76.6% (AHS, 2010-11). Similarly; In Jajpur, full immunization coverage has declined from 82.3% (DLHS3, 2007-08) to 73.9% (AHS, 2010-11) and Measles coverage has slightly declined from 86.6% (DLHS3, 2007-08) to 85.7% (AHS, 2010-11).

OBSERVATIONS

In Jajpur, district officials and program officers presented the HMIS reported immunization data which was not matching the data reported to the National portal of HMIS. District presented data is shown below:

Antigen	Achievement 2011-12	Coverage in % 2011-12	Achievement 2012-13	Coverage in % 2012-13	Achievement 2013-14(up to sept.13)	Coverage in % 2013-14
TT (PW)	35339	95.32	32246	87.88	16322	97.78
BCG	35239	104.55	32262	96.71	16575	98.30
DPT1	33643	99.81	32479	97.36	14262	84.59
DPT3	32383	96.07	33222	99.59	13967	82.84
OPV3	30814	91.42	32239	96.65	13965	82.82
Hep-B3	11765	34.90	32189	96.50	14082	83.52
Measles 1	31085	92.22	33559	100.60	15709	93.17
Full Immunization	21325	68.87	32246	96.67	15682	93.01
DPT Booster	26632	86.02	29049	94.66	14513	93.56
DPT5	20076	66.65	26528	88.36	10937	72.08

The data on Immunization reflected a discrepancy between the antigen-wise data and the full-immunization rates. It also reflects that this data is not used for planning and improvement at the district level.

The State has begun with alternate vaccine delivery system which is operationalized for the children of difficult and tribal dominated pockets to enhance immunization coverage. TIKA express transports the vaccines to the vaccination sites by health worker and carries back the used vaccines. The TIKA express though not seen during the field visits, the logistics for immunization day were found to be adequate.

The immunization points were well-maintained.ANMs at these points were aware of the storage and administration of vaccines. There was no stock-out of vaccines.

An “innovation” in the form of a pass-book for indenting and stock of vaccines has been developed with support from UNICEF. This helps with indenting the required amount of

vaccines based on the micro plans. The due list for immunization was generated automatically using MCTS. Only due dates for booster doses of vaccines were added manually to the lists.

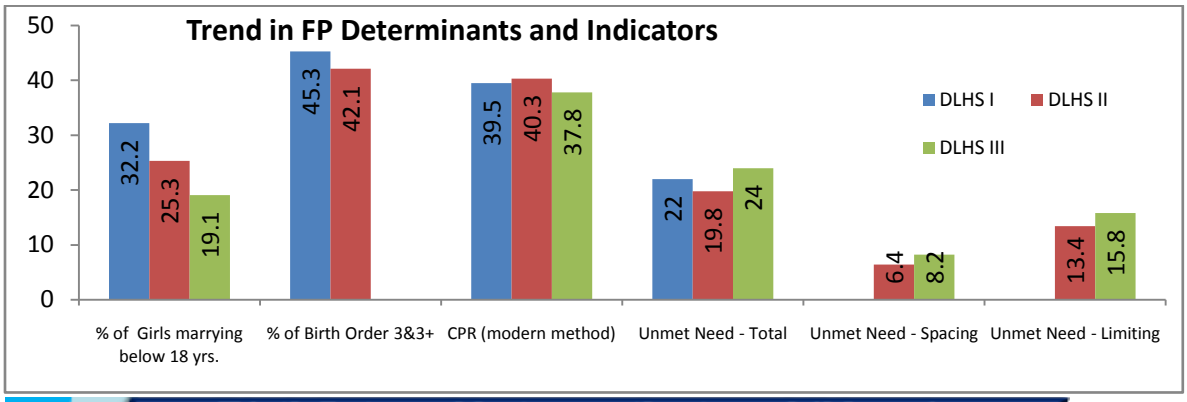
Immunization days are held in the field on every Wednesday.As observed at VHNDs, children were fully immunized according to age.The staff was given refresher training on RI 3 years back.On 31st of October, the Measles intensification campaign has been started in Jajpur.

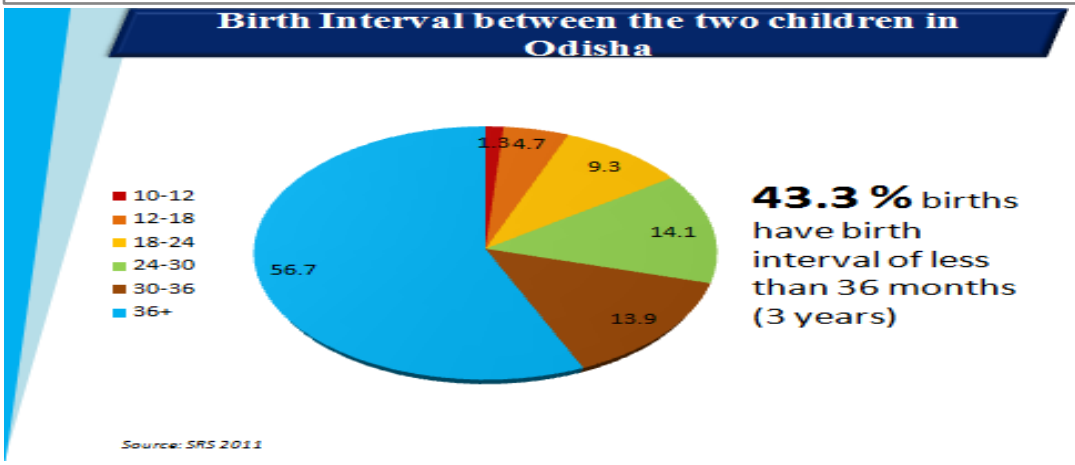
FAMILY PLANNING

TFR of the state has reduced to 2.2 (SRS 2011) and CPR for any modern methods has declined in DLHS-3 from DLHS-2 (from 40.3% to 37.8%).Total Unmet need of the state still remains very high.

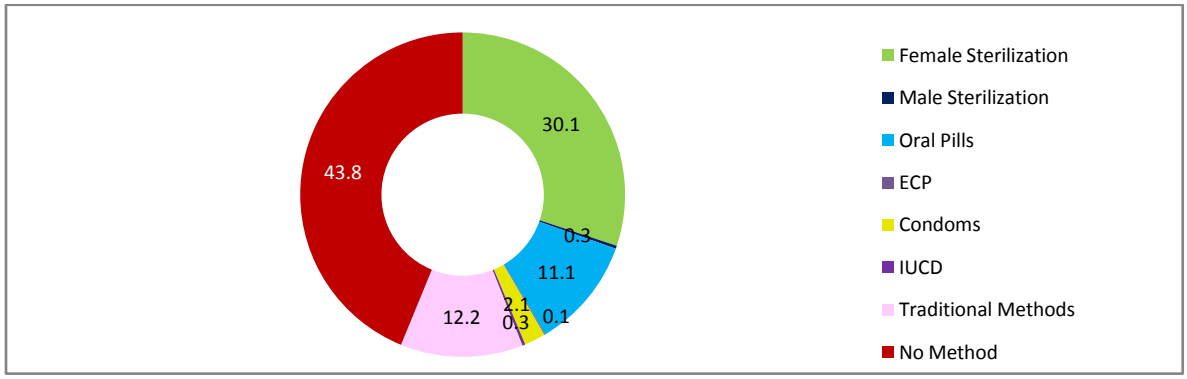
Family Planning Programme is progressing well in the State of Odisha. Sterilization performance has shown constant improvement in the state (from 1, 17,955 in 2009-10 to 1, 37,366 in 2010-11 and further to 1, 43,599 in 2011-12).IUCD insertion has been more or less constant since last 5 years (from 1, 34,401 in 2008-09 to 1, 32,135 in 2012-13).PPIUCD: As per the report provided by the state, total 123 doctors and 127 nurses are already trained on PPIUCD and only 25 of them are performing (10%). It is planned to train 60 MOs and 60 Nurses in the year 13-14.

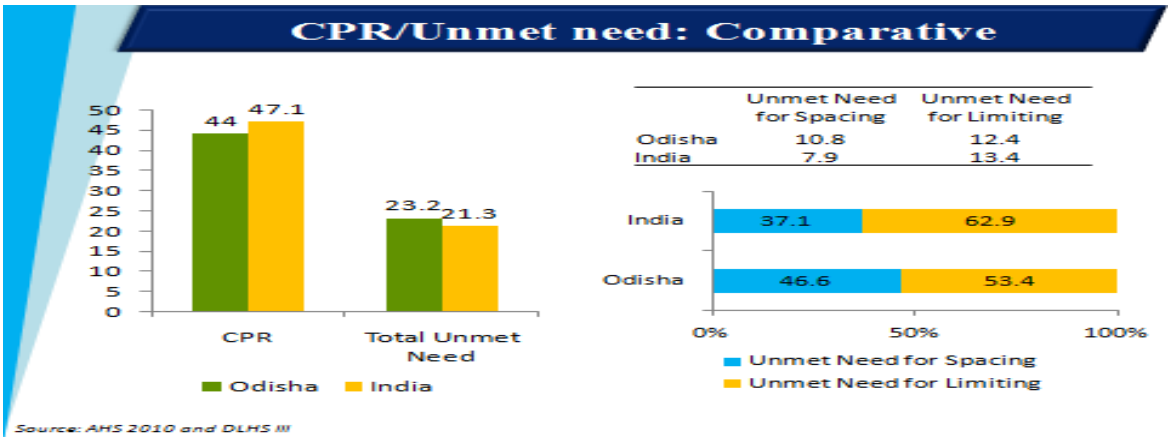
Trend in Family Planning determinants and indicators- DLHS I-III





Current use of FP services in Odisha





It is evident; the unmet need for spacing is very high in Odisha(AHS2010 &DLHS-III). Approximately, 43.6% births in Odisha have birth intervals of less than 36 months. The unmet need of Koraput is still higher at 34.8 %, while Jajpur it is 15.7%. This indicates the dire need to provide contraception to the younger age group to unwanted pregnancies and births. Hence, the Scheme for ensuring spacing of Births by ASHAs (through provision of incentives) needs to be extensively monitored for implementation especially after birth of the 1st child and delay of the first child.

Sterilisation services

In both districts fixed day services for sterilisation are available only at higher level health facilities. The fixed day services are not available for IUCD services. *The services are not displayed at the citizens' charter as well at the sub- centres.*

For all sterilisation cases, a case card is filled, including basic investigations such as urine pregnancy tests, Hb estimation and HIV testing. However, there is *no counselling prior to HIV testing*, and HIV +vecases were not operated upon (based on feedback from nursing staff). If the woman was found to be pregnant, an MTP was conducted followed by sterilisation.

Discussion with few pregnant women in Jajpur who had come for sterilisation revealed that often other FP options were not offered to the woman if she was deemed to be an "appropriate" client for sterilisation; other methods were not offered, even for the interim period. For example, one woman who had an 18 month old baby and shared that she had

thought about using the pill but was told that it was “not good”, and that she should go for sterilisation. A discussion with the ASHAs who were accompanying the women also showed a clear provider bias against reversible methods for women with two or more children.

In Koraput, the PPC at DH Koraput is highly underutilized in terms of service delivery. The ANMs posted at the PPC are underutilized as they only conduct immunization services.

IUCD and PPIUCD services

The PPIUCD services in the state as a whole has improved in the last two quarters of the current year, however, the performance by trained providers in PPIUCD insertions in Jajpur as well as Koraput is NIL. The performance of other family planning services with regard to sterilization and spacing has increased in Koraput, but NSV services have not taken place in current year.

In Jajpur, very limited staff has been trained in PPIUCD. For example, of the 5 staff nurses in the LR in the DH, only two had been trained in PPIUCD insertion. None of the ANMs / SNs in the other facilities was trained in PPIUCD insertion. Even the ones trained in the DH had not inserted any PPIUCDs as they did not have the needed equipment (Long Kelly’s forceps) for the same. They also mentioned that it was very difficult to convince the women for PPIUCD.

At the DH, a PPIUCD register was maintained that showed that a) very few numbers had been achieved, and b) PPIUCD was being inserted by the Ob-Gyn only and c) it was being done as an intra-caesarean procedure only and not following normal delivery. Similarly, at Jajpur Road CHC too, only the Ob-Gyn was inserting PPIUCDs. He admitted that he had inserted only 4 PPIUCDs till now. But here all of them were done following a normal delivery and not intra-caesarean. No PPIUCD insertions had taken place at Dangadi CHC, which was an FRU and had a gynaecologist on board.

As the discussion with ASHA facilitators also showed very limited uptake of PPIUCD, and most of which was intra-caesarean. They said that acceptance by women of this method was very low.

None of the ANMs in the urban areas were trained in IUCD insertion. They shared that the same was being done by the MO only. This was also validated by the Ob-Gyn at the facility.

In Koraput, the ANMs posted at PPC, DH do not insert IUCD, which is one of their prime jobs as majority are not trained. As the LHV is also untrained, the IUCDs are inserted by the Gynaecologist. The present practice is to only motivate couples for IUCD/ sterilization services, which is in fact redundant over the services provided by ASHAs under the Scheme of Home Delivery of Contraceptives at doorstep of beneficiaries.

In view of the high unmet need for family planning in the State as a whole (23%) and Koraput(23.7%), despite 88% sterilization services, it has earlier also been emphasized that spacing services need to be strengthened in the district in particular and the State as a whole.

The ANMs posted at the PPC should be trained to provide IUCD services and the LHV should be strengthened with the skills of supportive supervision in this regard. Follow up of trained providers needs to be done for PPIUCD services as there are two trained MOs already posted in the labour room but not rendering the required services.

Distribution of Condoms, OCPs and ECPs

In Jajpur,Contraceptive supplies such as condoms and OCPs were available at the ARSH clinics. At one CHC, a special area had been designated for FP counselling. However, the absence of seating space for clients, and the complete lack of audio and visual privacy did not render it amenable to FP counselling. There was no stock of FP products at the PHCs.Condoms and OCPs are available at VHNDs also. However, no counselling for FP takes place at VHNDs.

Doorstep delivery of contraceptives by ASHAs: ASHAs have adequate supplies of OCPs and condoms for their village. They are not taking any payment from the clients for the same.One reason is that ASHAs feel that there is not enough money to be made from FP, and also, the clients are used to of receiving free contraceptives.

On checking their records, it was observed that while they are giving OCPs and condoms, some of them are unable to ensure regular use of these products by clients. However, some ASHAs

have devised their own innovative systems such as maintaining a calendar for users of OCPs and ensuring that refill supplies of the same reach the women on time for the next cycle to prevent discontinuation and chances of contraceptive failure.ASHAs do not have EC Pills as there is no supply from the state perhaps at Jajpur

Birth spacing by ASHAs: As this scheme was launched in Nov 2011, and requires at least 2 years of lag time, no incentives have been given till date for delaying first birth for at least 2 years after marriage and spacing of at least 3 years between children as some officials are under the perception that the "clock" for the 2 or 3 year time frame starts from the day the scheme was launched.

On talking to ANMs, they shared that clients still approach them for contraceptive supplies. However, they refer them to ASHAs. While theoretically they admit that it would be preferable that they too keep a supply of FP products, however they felt that given their excessive work-load, they do not want the responsibility of stocking and distributing contraceptives again.

The ANMs working in urban areas shared that many women in urban slums are using injectable contraceptives. They buy the same from the pharmacies, and the ANMs inject the same for the women. They are also more likely to use OCPs than women in rural areas. Most women in urban slums have small families.

Family planning schemes of Home delivery of contraceptives by ASHAs at doorstep of beneficiaries and ensuring spacing of births are being implemented extremely well in Koraput and Jajpur. ASHAs interviewed at Subcentres as well at the training site informed that they are able to sell contraceptives. Few ASHAs reported that they have earned incentives to the tune of Rs.10-15000/- as per Guidelines of the Scheme of ensuring spacing of births.However, these reports are not been received at GOI yet.

The supply of contraceptives, including EC Pills and pregnancy test kits are sufficiently available at the subcenters and in ASHAs kit. The operationalization of the software RHCLMIS for indent and distribution of contraceptive stock was witnessed at the District Hospital, Koraput as well as at CHC Ramanuguda. The system has been made operational till district level in all districts.

However, the indenting system from the sub-centre level is operational only in few districts. ASHAs were also well aware about HDC & ESB schemes in both districts and records of payments are maintained at block level for ESB Scheme.

The warehouse at DH Koraput had buffer stock of Pregnancy testing Kits, andIt is also suggested that the MOs (PHC) need to be trained to provide Minilap services. The ANMs at the sub-centre need to be equipped with the requisite skills to insert IUCD(interval) and through fixed day services. These services need to be promoted through IEC and counseling. RMNCH+A counselor posted at the DH needs to ensure that PPIUCD is promoted and it is ensured that each woman/ couple has been sent home with appropriate contraceptive method of their choice

It was observed that although RCH services are being provided at the higher facilities including DH, SDH and CHC, the Family planning services such as PPIUCD and Family planning counselling are not being provided despite availability of trained providers and RMNCH counsellor in DH. The PHCs are not providing Minilap services. Also, IUCD services are not being provided by ANMs at SCs. The interviews with the clients indicated that the YASHODAs present in the postnatal ward did not counsel the patients about family planning.

Pregnancy testing kits are available with ASHAs and they are confident about using the same.The supply of these kits was seen at the warehouse in the districts as buffer stock. The distribution of these kits and other contraceptives further could be seen in the ODCLMIS. . The supply was available at the Subcentres at Koraput, while not at Jajpur.The ANMs shared the need for re-inclusion of the same in the ANM kits and many clients approach them for testing. They shared that timely confirmation of pregnancy would also help with timely referral for MTP if required.

Adolescent Health

Weekly Iron Folic Supplementation (WIFS) – IFA for the adolescents are distributed by the AWW every Monday.There is no supply of Free Days Sanitary napkins in the district. They are available only on 3-4 districts in the state.

Adolescent health clinics (Shraddha clinics) were observed in two CHCs (they were not present in any PHC. The presence of a clinic could not be observed at the DH as the OPDs had closed by the time the team reached for observation). They were run by AYUSH doctors. While it was active in one facility, the initiative was very new in another facility. In both places, the clinic was run on Mondays and Saturdays. About 3-4 patients were attended by the clinic on any given day. The common reasons were anemia, menstrual problems, RTI, sexual issues and misconceptions like nightfall in young boys etc. As this clinic was run along with the AYUSH OPD, this reduced the changes of "stigma" for the adolescents who attended this clinic. FP supplies were available at these clinics, though utilisation was not significant.

KishoriMelas have been conducted in the AWCs, once in quarter to Promote Adolescent Health Programme at Block Level to promote health sanitation of Adolescent girls & to control Adolescent Anemia Programme.

To reduce the prevalence and severity of nutritional anemia in adolescent population (10-19 years), Kishori Swasthya Melasare being conducted in both rural & urban areas with focus on school going adolescent girls and boys in government/gov.aided/municipal schools from 6th to 12th class (10-19Years) & Adolescent girls who out of school/Married/pregnant and lactating adolescent girls through anganwadicenter.

5676000 Nos. of IFA (Large) has already been distributed in Jajpur district.

Year	**Quarterly Kishori Swasthya Mela Conducted**	**No. of Adolescent Girls Attended**	**No. of Girls administered under HB Test**	**No. of Girls with HB<7.0 g/dl.**
2012-13	5009	118753	23603	344
2013-14 (Upto Sep-13)	2461	55372	14379	25

III. DISEASE CONTROL PROGRAMMES

Part A: Communicable Diseases

A.1: Integrated Disease Surveillance Programme (IDSP)

Integrated Disease Surveillance Project implemented in the state in June, 2005-06. State Surveillance Unit, 30 District Surveillance Units and 3 Govt. Medical College surveillance units have been made fully operational by the month of November 2006-07 and all reporting units (Form P- 1745, Form S – 6688 & Form L-381) started reporting by the year 2008. IDSP portal launched by NCDC in 2009 however software was shared with the State during later part of the year. All the districts have been provided with IT equipments (Data Centre / Training Centre i.e., Video Camera, LCD Projector, Microphone etc), however the video conferencing was made over broadband connection and it was controlled by NCDC.

All the 30 district surveillance units are reporting on time & weekly basis and consistency of reporting ranges from 90% - 95% against the 80% target set by Central Surveillance Unit (CSU). The completeness of 'P' forms reporting from health facilities ranges from around 70- 100%. The generated data is used for mapping of vulnerable districts/blocks for ADD, Measles, Dengue and other outbreaks and taking preventive and containment measures. Regular review meetings are being conducted at all levels with all the stakeholders for sensitization & sharing of information.

The strength of IDSP in the state is that it has 314 dedicated Block Rapid Response teams (RRTs) apart from 30 District RRTs & one state RRT. Common User Groups (CUGs); SMS/Telephonic/e-mail transmission of reports by DSUs for early warning signal is being used. All programme personnel are in positioned are trained.

IDSP has established linkage with Medical Colleges and ICMR laboratories. They are used as Reference laboratories for lab confirmation of outbreak prone diseases. Inter-sectoral convergence meetings are held with PRI, RD, H&UD, School & ME, WCD, ARD, Forest, Works deptt etc.

Team has observedthat in both the districts, IDSP is functional. Reports are being received from all reporting units in time. In Koraput district Public health Lab has been established and

integrated with Dengue Sentinel site. Network has been established with RMRC laboratory and State Public Health Laboratory, Cuttack. All equipment and facilities are in place except, bio-safety cabinet, 20 degree freezer, Autoclave (bigger one), water bath cum shaker, Hot Air Oven. The posts of epidemiologist and Data Entry Operator are vacant. In Jajpur no separate Public Health Lab. has been established and District lab. Is carrying out function of public Health Lab and SCB Medical College is designated as referral lab for the district.

It is suggested that the vacant posts of 4 Data Managers, 6 DEOs, 10 Epidemiologists and 2 Microbiologists may be filled up. Epidemiologists should be qualified on public Health as State is prone to natural calamities like Flood, Cyclone, Heat Wave and epidemics etc. State Surveillance Unit and District Surveillance Units have to play critical role for Health emergences. Innovative methods need to be adopted to get timely and complete reports from 5-6 left wing extremist problem districts as well as inaccessible and hard to reach SCs/PHCs. Many districts have been provided with broad band based Video Conferencing facility under IDSP are not suitable and Facility provided under NIC is functioning which should be listed and reported. Bio-safety Cabinet, Auto Clave, Hot Air Oven, -20^0 Deep Freezer etc. should be procured for optimizing the function of all Public Health Lab activities. Adequate Funds and mobility support should be provisioned for intensive monitoring of outbreak prone diseases, adequate response to outbreaks and disasters (Check list wise details may be seen in the folder Final TOR- TOR_A1)

A.2 National Vector Borne Disease Control Programme (NVBDCP)

A.2.1.Malaria:

In the state of Odisha, Malaria and Filariasis are prevalent while Chikungunya and Dengue have emerged recently and reported since 2005. Malaria poses major public health problem in the state and Odisha, contributes around 25.45% of reported malaria cases and 16.42 % of reported deaths to the country's total in 2012. Odisha continues to contribute around 24% of malaria cases to the country's reported total cases but the contribution of reported deaths due to malaria by the state to the country's total has declined i.e. from 24.2% in 2010 to 16.4% in 2012. The Incidence has been brought down from 3.96 lakh in 2005 to 2.62 lakh in 2012. Reported deaths due to malaria have also reduced from 255 to 79 during the same period. The Annual Parasite

Incidence (API) which is key impact indicator has declined from 10.1 in 2005 to 6.1 in 2012. However country targets to bring down API at all level <1 by 2017 so as to achieve pre-elimination status and state of Odisha needs to intensify control activities extensively and Districts like Koraput, Malkanagiri, Keonjhar, Mayurbhanj, Kalahandi, Kandhamal, Nuapada, Angul, Sundargarh etc. reports very high malaria cases and concerted efforts are required to bring down incidence in these high burden districts.

Rapid Diagnostic tests (RDT) both Monovalent and Bivalent and new drug for treatment of falciparum malaria i.e. Artemisinin Combination Therapy (ACT) have been provided upto the village level and are being optimally used by trained ASHAs. Capacity building of more than 38000 ASHAs, 500 Forest Animators, 787 AYUSH doctors, 5061health workers and 3500 tribal school teachers to provide basic diagnostic and treatment services on malaria has been done. The Block Public Health Extension Officers (BPHEO) have been given training on the reporting, surveillance, drug administration on malaria and other vector borne diseases. The community is now aware that malaria causes fever and the patient should immediately report to ASHA or nearest health facility. Total 71 Sentinel Site Malaria Laboratories have been established and are functioning at hospital and CHC clinic level: Dist. HQs Hospital, Sub Divisional Hospital and CHCs where falciparum malaria case load is very high for diagnosis and tracking the severe malaria cases as to reduce mortality due to malaria.

Integrated Vector Control Measures (IVM) are being used for prevention of malaria. A total of 41.65 lakh Long Lasting Insecticidal Nets (LLINs) have been distributed in the districts which protect around 89 lakh of population. Further 55 lakh population is being covered under Indoor Residual Spray (IRS). Thus around 144 lakh populationis covered under IVM. The timely release of spray wages is critical which should be ensured for successful and effective rounds of scheduled rounds of IRS.

Team has observed the state's initiatives like "MO- Mashari" scheme *(my mosquito net)* for pregnant women and students and inmates in tribal residential schools and NidhiRath campaign for creation of community awareness about benefits of using mosquito nets has given positive impact on the malaria control programme. Unique ownership of programme, right from Health

Secretary at state level, distract collector at district level and Medical Officer at PHC/ CHC level have geared up the implementation of programme. During field visit in the districts of Koraput and Jajpur, it was observed that involvement of Female Health worker and ASHA has enhanced the outreach services for diagnosis and treatment of malaria cases at community level.

Community interaction revealed that they were aware about ASHA facility and avail the services. ASHA is getting incentives. Tribal residential schools were also provided Nets. *Malaria Samadhan Sibir* is being organized in high endemic blocks. The household visits by the teams in Koraput and Jajpur district validated the usage of nets among vulnerable populations.

Microscopic Labs were well maintained. Stock of Rapid Diagnostics and Antimalarial are adequate at all level. However, ANMs at some CHCs were found skill deficit in preparation of blood smear,and TB technicians doing microscopy also needed reorientation training. Further it was noticed that Bivalent RDTs have been distributed recently, a quick Reorientation on the interpretation of RDT result will build up confidence of ASHA and peripheral health workers.

It was also observed that Male Multi-Purpose Workers were not available in all Sub-centres which need serious consideration for smooth function of malaria programme and other disease control programmes. Convergence of programme is found to be good as free flow of funds from NRHM to NVBDCP is ensured timely and programme also involves ASHAs and ANMs effectively.

RECOMMENDATIONS

Posts of male MPW may be created and filled up at all the Subcentres.

District Malaria officer (DMO) should be redesigned as District Vector Borne Diseases Control officer (DVBDCO). Six posts of DVBDCO, 9 Posts of Malaria Technical Supervisor (MTS), 10 Posts of Laboratory technicians which are key posts for Vector Borne Diseases should be filled up.

Reorientation training of ASHA and Health workers on the use of bivalent RDT, reorientation of New Lab technician and TB technician on microscopy should be conducted under skill building. The ownership needs to be sustained.

Simple source reduction for elimination of breeding sources of vectors can be done within the activities of VHSC (GKS). Under NREGA, the minor engineering activities for source reduction can be carried out. Supply of diagnostic, drugs and Nets should be sustained.

A.2.2. Lymphatic Filariasis

Filaria is chronic and endemic in most of the coastal districts of Odisha. 20 endemic districts are covered under annual Mass Drug Administration (MDA) since 2004.

The coverage of MDA has been around 90% but compliance to drug consumption has been ranging from 39% in earlier years to 80% since 2010.

Microfilaria Rate (Mf Rate) which is key indicator for filaria elimination targeted by 2015 has been showing consistent decline from 2.5 in 2004 to 0.4 in 2011. Except districts like Deogarh and Ganjam other districts have brought Mf rate to 1% and five districts Malkangiri, Nawarangpur, Gajapati and Koraput have achieved Mf rate zero and Khurda has reduced Mf rate to 0.18 in 20012. These districts are ready for Transmission Assessment Survey (TAS) as the reported Mf rate has been brought <1%. During 2013, the MDA has been deferred due to problem in procurement of DEC, followed by PHAILIN and is to be rescheduled.

There are huge numbers of hydrocele cases and operation of these cases needs to be done on expeditious manner.

During district visits, it was **observed** that many hydrocele cases are being operated in private hospitals but those cases are not reported under operated list. Developing mechanism for capturing such cases and reporting will reveal real burden of hydrocele cases and help in planning. Timely MDA with good coverage of drug delivery and compliance will also bring down Mf rate in other districts which is the need of the programme for achieving elimination of Filariasis in the state by 2015.

It is **suggested** that in view of target for elimination of Filariasis by 2015, MDA coverage should be ensured >85% in terms of coverage and compliance. The hydrocele cases getting operated in

private sectors or tertiary hospitals should also be reported and plan for clearing remaining cases should be developed.

A.2.2. Dengue and Chikungunya

Dengue has emerged in the state in 2010 when 29 cases and 5 deaths due to Dengue were reported. State experienced a massive spell of dengue in 2012 with reporting of 2051 cases in contrast to 1846 cases in 2011. Most of the cases were linked to travel and migration. However, with prior readiness and efficient case management, the total number of deaths due to Dengue could be restricted to 6 which was a significant decline (80%) to that of the 2011 data .During 2013 till mid Oct 5726 cases and 5 deaths of dengue have already been reported.

Chikungunya has emerged in 2009 when 2306 suspected cases were reported. Since then, it is declining consistently and in 2012, 129 suspected cases were reported out of which 17 were confirmed and in 2013 up to mid Oct 21 confirmed cases have been reported.

Key indicators of dengue are Positive cases and deaths. The cases of dengue is consistently rising and spreading in many districts which is a cause of concern. Case fatality rate has been contained which indicated that case management has been appropriate. Key indicator for Chikungunya is positive case and it shows declining phase. Total 10 Sentinel site laboratories for Dengue and Chikungunya are functional in the State with provision of NS1 &IgM ELISA based test kits.

For control of Dengue, following important strategies have been undertaken by the state:

- Regular Muliti-sectoral meetings both at state and district level involving all related deptts. and sectors (H&FW, PRI, RD, S&ME, Industries, SC&ST, Agriculture, Environment& Forest), Corporate houses, Municipalities/Corporations &Urban local Bodies in all 30 districts.
- Appointing Sub Collectors and BDOs as Nodal Officers at Sub-divisional and Block level respectively for intersectoral activities.
- Training of Master trainers (5) from each of the 20 Dengue vulnerable districts

- Involvement of Dengue volunteers for conducting community level awareness by house to house visit, active surveillance and help in eliminating breeding sources have been undertaken.
- Massive awareness campaign called “Malaria Dengue Diarrhoea” is conducted since 2012 using all sorts of media during 1st August to 15th August which is an unique initiative and all these efforts should be sustained

Dengue is emerging as a major public health problem in the country and it is spreading. It becomes a potential threat to rural areas also. It was evident from the field visit that district Koraput had few cases during 2012 and one imported case in 2013. In district of Jajpur also 845 dengue cases have been reported in 2013. Sentinel site laboratory in Koraput is functioning in integration with Public Health Laboratory at District HQs. Hospital and for Jajpur, the Microbiology Dept. Lab of SCB Medical College, Cuttack has been identified as Sentinel site lab and the SCB Medical College Hospital is Sentinel site hospital for management of complicated dengue cases.

The state Govt. has declared dengue cases diagnosis and treatment at sentinel site hospitals is free. As dengue is more of socioeconomic problem apart from health, the initiatives taken by state are appreciated.

Intersectoral coordination and community participation is key issue. The steps taken in this regard by the state is the need of the programme and should be sustained. Trend assessment of cases and death due malaria and dengue and Microfilaria rate showsthat there has been a 84% decline in Mf rate in 2011from2004.

A.3. Revised National TB Control Program - ODISHA

DOTS (Directly Observed Treatment Short Course Chemotherapy) strategy implemented in the State in the year 1997 with the objective to detect 70% of infectious sputum positive TB cases and cure at least 85% of them under the Revised National TB Control Programme (RNTCP).The program was implemented in a phased manner from 1997 with the State wide coverage achieved in 2004. Quality sputum microscopy, uninterrupted supply of quality assured drugs and Directly Observed Treatment are key to successful implementation of the Programme.

The programme is implemented through 31 implementing District TB Centre units, 109 TB Units and 549 Designated Microscopy Centers. In addition there are 42673 DOT Centers identified under the programme.

The Anti TB Demonstration & Training Centre (ATD&TC) Cuttack is functioning as a training center of RNTCP. This center conducts External Quality Assessment (EQA).

The accredited Intermediate Reference Laboratory (IRL) has been established at ATD&TC, Cuttack for Culture & Drug Susceptibility Test (DST) to diagnose Drug Resistant TB Patients (DR-TB) under the Programmatic Management of Drug Resistant TB (PMDT). Currently it is using both solid culture as well as Line Probe Assay (LPA) to diagnose Drug Resistant TB (DR TB) Cases.

Three Drug Resistant TB (DR TB) Centers have been established and functional at SCB Medical College, Cuttack, MKCG Medical College Berhampur and VSS Medical College, Burla to provide pretreatment evaluation and initiation of treatment to the diagnosed DR-TB patients.

The annual new sputum positive case detection rate of Orissa in 2012 was 61% against the norm of 70% and the treatment success rate was 86%, against the norm of 85%. The reported death rate during 2012 is 4.9% against the Norm of >5%. Pediatric cases are ranging from 4 to 5%.

Sate has developed partnership with Lepra-India, Catholic Bishop Conference of India and Indian Medical Association (IMA) for supporting RNTCP activities in different districts of the state

Programmatic Management of Drug Resistant TB Cases (PMDT) was implemented in all 31 districts of the State. The **Line Probe Assay (LPA)** was installed at Anti TB Demonstration & Training Centre,

Cuttack and accredited by the National TB Institute and Central TB Division. This has cut down the time taken for diagnosis of MDR TB from 2-3 months to 2-3 days. The Liquid Culture laboratory has also been established at ATD&TC, Cuttack for diagnostic and follow up culture of sputum of Drug Resistance TB (DR TB) patients. Cartridge Based Nucleic Acid Amplification Test (CBNAAT) facility has been installed since August 2012 at Koraput TB Unit with the support from FIND (Foundation for Innovative New Diagnostics) for rapid diagnosis of TB patients as well as DR TB patients. Three DR TB Centres are functioning at SCB MC Cuttack, MKCG MC Berhampur and VSS MC Burla. Creation of a 4th DR TB Centre at DHH Koraput has been approved.

NIKSHAY: To further improve TB surveillance in both private and public sector in India, the Central TB Division has developed a web based ICT application called *NIKSHAY*. This application is being utilized for digitizing patient data and subsequently it will be extended to enter private sector data on TB Notification. All Data Entry Operators and MIS Coordinators have been trained and are entering data on TB patients in NIKSHAY platform.

The state of Odisha has also issued an order to implement the TB Notification andCDMOs have been designated as TB notification authority. All Private Practitioners / Labs / Hospitals are in the process of being sensitized.

For TB and HIV Coordination, TB HIV Intensive Package is implemented in all the districts since 2010 in collaboration with the OSACS. HIV test in TB cases has increased to 54% in 2nd quarter of 2013 as compared to 11% in 2nd quarter of 2011.

Serological kit has been banned in the state under the programme, notification has been issued in the month of October, 2012 and awareness campaigns have been undertaken to stop use of kits in pharmacy or local market. Sensitization programme in this regard has been undertaken by districts regarding the same.

All vacant posts need to be filled up specially, 21 posts of STLS, 93 posts of DMCLT, 16 posts of TBHBS etc.

During District visits in Koraput and Jajpur, it was **observed** that TB units are functional in the districts. In Koraput district CBNAAT is functioning but resistant test is done for Rifampicin only. In both districts

there is coordination in TB and HIV and patients are being sent for HIV test in the district hospital and from PHCs and CHCs cases are being sent for HIV test after registration.

Co-infection (TB &HIV): 3 cases in Koraput and 9 cases in Jajpur were reported in 2013. In the field visits, it was observed that ASHA and ANMs are well conversant with the symptoms for suspecting TB cases. They are involved in case detection, DOT, treatment compliance and defaulter action. TB laboratory in CHCs are functional and records are properly maintained. 1st line and 2nd line drugs are available at District and CHC levels. It is **suggested** that all vacant posts should be filled up. Dedicated DTO should be posted. TB notification should be implemented specially to involve Private sectors. Ban of serology test in private sectors should be ensured.

Achievements against Key Indicators are given below:

<table>
<tr><th>S.No</th><th>Indicators</th><th>2013-14</th><th></th></tr>
<tr><td></td><td></td><td>Targets</td><td>Achievements</td></tr>
<tr><td>1</td><td>Case detection rate</td><td>70%</td><td>60%</td></tr>
<tr><td>2</td><td>Treatment success rate</td><td>85%</td><td>87%</td></tr>
<tr><td>3</td><td>MDR TB treatment success rate</td><td>50-60%</td><td>60%</td></tr>
<tr><td>4</td><td>Treatment success rate among new TB patients tribal districts and Poor and Backward districts</td><td>88%</td><td>87&</td></tr>
<tr><td>5</td><td>Number of cases to be put on treatment</td><td>Increasing trend</td><td>In increasing trend details attached below
<table>
<tr><th>Year</th><th>Total TB Cases registered for treatment</th></tr>
<tr><td>2005</td><td>44613</td></tr>
<tr><td>2006</td><td>44792</td></tr>
<tr><td>2007</td><td>49285</td></tr>
<tr><td>2008</td><td>51031</td></tr>
<tr><td>2009</td><td>52145</td></tr>
<tr><td>2010</td><td>49869</td></tr>
<tr><td>2011</td><td>48970</td></tr>
<tr><td>2012</td><td>49192</td></tr>
<tr><td>2013</td><td>23902</td></tr>
</table></td></tr>
</table>

S.No	Indicators	2013-14	
			(up to 2Q13)
6	Default rate among new TB cases	<5%	6%
7	Proportion of estimated incident TB cases notified	60%	61%
8	Proportion of TB patients with known HIV status.	90%	60%
10	Proportion of districts TU aligned at block level with health systems	25%	51%
11	Proportion of Key RNTCP staff in place as per approved ROP	90%	87%
13	Proportion of TB patients treated under RNTCP by a community DOT provider	50%	78%
14	Proportion of pediatric cases diagnosed out of new cases	8%	5%

A.4 National Leprosy Elimination Program (NLEP), ODISHA

Odisha achieved elimination of Leprosy during the year 2006-07. The prevalence rate was 0.65/ 10, 000 population. As on March'13, the prevalence rate was 0.98/10,000 population. Currently, the state Prevalence Rate (PR) of State as on September, 2013 is 1.25/10, 000 population. 19 districts are still reporting >1 PR. Three district; Bolangir, Boudh and Nuapada are reporting PR >3. The child proportion among the new cases remaining below 10 since last 5 years. Annual new case detection rate (ANCDR) as on March, 2013 was 19.07/ 100, 000 population. After 2006-07, the ANCDR showing a rising trend due to involvement of ASHAs in suspect referral mechanism, involvement of General Health Care system in NLEP & intensive case detection drives in 247 high endemic blocks. The disability proportion among new cases is remaining more than 3 since last five years.

In order to achieve elimination of Leprosy in the state, all health care providers & ASHAs have been trained on early detection of Leprosy cases. The suspect referral mechanism & case validation is strengthened to detect cases early and put them under treatment.

Multi Drug Therapy (MDT) & other logistics are being supplied upto district & block level on regular basis for providing quality service. Deformity Prevention and Medical Rehabilitation (DPMR) services are provided at the block & district level every week. Trained AYUSH MOs, Paramedical staffs are providing DPMR services like ulcer care, self care practice, supply of MCR Foot wear, management of Leprosy reaction etc. Skin smear examination facility is available at Dist Head Quarter level for confirmation of difficult to diagnose cases. District level Apex Committee is functional for management of critical Leprosy cases. District Nucleus is functional in all 30 districts. All the staffs of Dist. Nucleus have been trained during the 2012-13.

Reconstructive Surgery (RCS) is conducted in 08 Govt. institutions (MKCG Medical College, Berhampur, Leprosy Home & Hospital, Cuttack, DHH, Koraput, Bolangir, Sonepur, Bargarh, Dhenkanal, Mayurbhanj). 17 Doctors (Orthopedics/Surgery Spl.) have been trained on RCS and are conducting regular RCS. MCR Foot wears are being procured every year and supplied to the districts as per their need.

325 post of PMW, 21 posts DLO are vacant. 184 post of PMW, 22 post of PT and 1 post of SMO at state level and 22 SMO sanctioned by GoI have not been filled up.

During District visits, teams found that DLO is functional. In Jajpur DLO was also looking after RNTCP. In Koraput there was no dedicated DLO and the DMO is looking after DLO. The Physiotherapist is in position in Koraput and all the equipment for Physiotherapy were available. In Jajpur the physiotherapist post is vacant. It was observed that the ASHA/AWW/HWs are involved in Intensive Case Detection Drive (ICDD) and ASHAs are lso involved in treatment of cases. It is suggested that all vacant posts including the post sanctioned by GoI may be filled up on priority basis. In the high endemic blocks of leprosy, ICDD may be done frequently.

B: Non Communicable Disease Control Programme

B.1. NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

NPCB is being implemented in all districts of the state. During 2011-12 to 2013-14 upto Q-2 the no of Cataract cases were operated against the target given below

Year	Target	Achievement
2011-12	130000	107975
2012-13	130000	116595
2013-14 (upto Qtr.2)	130000	42450

There are 61 Eye surgeons against sanctioned post of 91. Under NPCB screening for refractive errors for correction is being carried out. The target and Achievements since 2011-12 to Q-2 of 2-13-14 is given below

Year	No. of school children screened		Free spectacles provided to students	
	Target	Achievement	Target	Achievement
2011-12	450000	388703	10000	11787
2012-13	450000	467368	10000	17586
2013-14(upto Qtr.2)	450000	123500	20000	5125

The programme has been linked with School Health Programme. Exclusive School Health programme are been carried out withthe assistance of our PMOAs along with other field-workers. Those poor children who are detected with refractive error are being supplied with spectacles free of cost by the District Health Society (NPCB). Achievement of screening against the target is >80%. No OPD complex like room for OPD patients, waiting room, dark room, and room for minor surgery is available in all the 30 districts. There are shortages of manpower as 7 post of Paramedical Ophthalmic Assistant (PMOA) regular and 21 posts of contractual PMOAs are lying vacant. The exiting infrastructures for NPCB in the states are as follows:

20 bedded eye hospital	30
10 bedded eye hospital in SDH (except Chhatrapur, Rairakhole Biramaharajpur)	23
Vision Centre	75
Eye Donation Centre (3 in Govt./3 in NGO/Pvt.)	6

Eye Bank (3 in Govt./3 in NGO/Pvt.)	6
EYE BEDS	
D.H.H.	600
S.D.H.+ Capital Hospital + RGH	250
SCB M.C.	91
MKCG M.C. Berhampur	100
VSS M.C. Burla	90
Total Beds	**1131**

Observation during district visit: in Koraput district, NPCB is functioning and Senior Eye specialist is heading. Separate Eye Operation theatre and ward have been established and well maintained. Annual cataract operation ranges from 684 to 2599.

There is big gap between numbers of Cataract cases and operation done as during2013-14 only 539 operations were done against the target of 7243. IOL are being procured in the district level itself. Eye screening of school children is being carried out. Refractive errors are being corrected but glasses are given to children who belong to BPL families. In Jajpur the post of Eye Specialist is lying vacant but the CDMO is looking after the programme. It is observed the NGO is conducted about 60% of the target Operations.

It is **suggested** that in all the OPD complexes, waiting room for OPD patients and dark room for refraction may be provided. 31 Eye Surgeon posts are vacant and should be filled up.

B.2.National Programme for prevention and control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

NCD Clinics at DHH in l 5 districts (Nuapada, Koraput, Nawarangpur, Malkangiri and Balangir) and at CHCs in Nuapada district are functional in an integrated manner. NCD Clinics at DHH will run under NCD Complex after completion of the building. Physiotherapy Equipments are procured and installed in the Physiotherapy Units at DHHs. Construction of NCD complex in all districts is at the final stage of completion. In Malkangiri district, civil works have already been completed.

The screening for Diabetes and Hypertension in 5 districts shows that the prevalence of diabetes is 5.41% and Hypertension is 2.8%. It was observed that in Koraput all population >30 yr age are being screened. There is need to rationalize target population for screening.

By the end of September 2013, a total of 131 persons have been detected for Cancer out of which 110 patients are referred to AHRCC, Cuttack for higher treatment. Patient Card and Referral Cards have been developed and available at DHH and CHC level for referral of patients from CHC level to DHH and Tertiary Care Centre for higher treatment.

Cardiac Care Units are being established and will become functional at 5 DHHs from January 2014. The construction of NCD Complex in Nuapada, Koraput, Balangir&Nawarangapur districts are in progress. NCD complex also include "Day Care Chemotherapy Unit"

All the drugs for NCD as per ELD are available at CHCs and DHH level. Steps have been taken to include more drugs including chemotherapy drugs in EDL of State.

During district visit in Koraput, it was **observed** that the construction of NCD complex is in progress. Most of the equipments have arrived. The Geriatric Clinics is being run and is integrated with Medicine OPD. Reporting system has been established. Physiotherapy is fully functional. In CHCs, rehabilitation worker has been posted in 7 blocks out of 9 sanctioned posts. The equipments for rehabilitation for elderly patients have been supplied in all 14 CHCs.

Suggestions: NCD Complexes in the identified districts are in the advance stage of construction and equipments have also arrived in the districts. Hence the requirement and training plan has to be initiated so that the NCD Complex gets functional right after completion. Adequate budget should be provisioned for smooth implementation of NCD programme.

B.3. National Tobacco Control Program (NTCP):

A dedicated Tobacco Control Cell for implementation of NTCP at State Level is functioning at Directorate of Public Health, Odisha. Director of Public Health, Odisha has been declared as the focal point for tobacco control and Joint Director, Public Health is the Nodal Officer for implementation of

NTCP at the State level. NTCP is functioning in two Districts of Odisha namely Cuttack and Khurda and is centrally sponsored by Govt. of India.

The State Tobacco Control Cell is supported by Staffs viz. State Consultant (WHO) and the District Tobacco Control Cell is supported by staff of 2 viz. a Psychologist and a Social Worker (Supported by MOHFW). State Level Co-ordination Committee has been constituted and notified. State Level steering committee and Monitoring Committee has been constituted and actively functioning in the state. The Inspector of Police/ Drugs Inspectors/ Food Safety Officers have been notified as enforcement authority to implement the Cigarette and Other Tobacco Product Act (COTPA). 2003. District Level Monitoring Committee has been formed.

Integration of Tobacco control programme with State Aids Control Society (OSACS)/Non Communicable Disease Programme/Mental Health Programme/RNTCP(Revised National Tuberculosis Control Programme) for involvement of the Counselors was done. District Tuberculosis Officers under RNTCP Programme were trained on Tobacco control Programme to take care of preventive aspects.

The National Tobacco Control Programme is functioning in two Districts viz. Cuttack &Khurda and the District Tobacco Control Cell is functioning in both the NTCP districts. MOH&FW has supported two staffs viz. a Psychologist and a Social Worker at both the NTCP districts.

OBSERVATIONS

Currently, the post of psychologist is lying vacant in Khurda district since the Psychologist has resigned.

Different IEC Materials viz. posters pamphlets, banners on ill effects of tobacco have been developed and disseminated at grass root levels in both the NTCP districts. Hoardings on ill effects of Tobacco and COTPA -03 Rules have been installed in crowded public places in NTCP Districts.

The Counselors(ICTC/NCD/Mental Health/ Tobacco) and Clinical Psychologist of Mental Health Programme were trained on Tobacco Cessation Activities and providing tobacco cessation counseling services at their centers and referring the clients to DTOs and ADMO (PH) for treatment therapy.

It is suggested that IEC campaign against Tobacco consumption may be carried out at all levels. Adequate funds may be allocated for effective implementation of NTCP.

B.4.1.National Iodine Deficiency Disorders Control Programme for the year 2013-14

NIDDCP was implemented in Odisha in December, 1989. The State Iodine Cell functions under the Director of Public Health. Deputy Director (Iodine and Fluorosis) is the Nodal Officer who monitors and supervises the Programme. There is IDD Cell at state level manned by Dy. Director IDD, and one Statistical assistant.

IDD day celebration is done at state and district level so as to promote awareness. IDD survey in 3 districts has been planned (Nayagarh, Sonepur, Mayurbhanj) and is going on.

B.4.2.National Programme for Prevention and control of Fluorosis (NPPCF)

NPPCF was implemented in Odisha in 1st Phase in Nayagarh district in 2008-2009 and 2nd phase was implemented in -2010-2011 in Nuapada&Angul. At district level, ADMO (PH) and Consultant-Fluorosis (2), LT (2), Field Investigators (9) are in position.

District wise blocks and villages affected are as follows.

District	No of Blocks affected	No of affected villages
Angul	8	99
Nuapada	8	105
Nayagarh	5	76
Total	21	280

Activities Conducted in the Year- 2012-13

District	Fluorosis case detected	Training of MOs/Paramedical
Nayagarh	831	Planned in Dec
Nuapada	1308	Planned in Dec
Angul	2278	Conducted for MOs

Suggestions:

The salt testing kits are to be provided and adequate funds should be provisioned.

House to House survey for early case detection should be conducted. Extensive IEC & BCC activity need to be carried out, and Training of MOs & Paramedical Workers regarding signs and symptoms of fluorosis is needed in Nayagarh and Nuapadafor the success of the programme.

IV. HUMAN RESOURCES FOR HEALTH

Against the regular sanctioned posts, there are substantial vacancies in all categories of healthcare workforce in the state. However, for most of the categories state has tried to fill up the gaps through adding in NRHM staff.

REGULAR WORKFORCE		
	Sanctioned	***Vacant***
Doctors	4362	1610
Staff Nurses	1950	359
Pharmacists	1873	276
Radiographers	138	70
MPW (M)	4284	2868
ANM	7353	470

The availability of total health workforce *(Regulars and Contractual staff)* in the state is as follows:

S. No	**District**	**Doctors ***	**Staff Nurse**	**Pharmacist**	**Lab Technician**	**Radiographers**	**ANM**	**Health Worker(M)**
1	Angul	70	104	53	40	2	186	118
2	Balasore	149	144	99	40	7	352	101
3	Baragarh	100	54	62	31	2	266	139
4	Bhadrak	84	99	66	29	4	206	123
5	Bolangir	132	79	81	48	4	298	175
6	Boudh	31	15	17	8	1	72	23
7	Cuttack	206	107	93	48	8	417	180
8	Deogarh	24	34	16	11	1	53	42
9	Dhenkanal	82	86	65	28	4	221	92
10	Gajapati	66	32	42	27	2	161	94
11	Ganjam	200	119	122	64	5	526	76
12	Jagatsinpur	73	44	47	24	4	243	108
13	Jajpur	98	84	71	33	3	326	153
14	Jharsuguda	40	49	25	20	3	101	59
15	Kalahandi	118	87	93	51	6	327	186
16	Kandhamal	96	76	74	32	6	220	138
17	Kendrapara	62	99	55	29	4	272	115
18	Keonjhar	142	157	100	56	3	472	241
19	Khurda	245	258	100	48	5	301	174
20	Koraput	114	113	103	33	5	454	148
21	Malkangiri	48	58	70	16	5	203	83

22	Mayurbhanj	229	265	183	80	6	679	54
23	NawaraPur	56	33	62	21	2	374	122
24	Nayagarh	74	110	60	26	8	206	74
25	Nuapada	45	37	32	19	4	135	126
26	Puri	112	135	79	37	3	271	152
27	Rayagada	75	46	68	37	2	300	89
28	Sambalpur	126	115	57	41	6	231	105
29	Sonepur	71	35	39	15	2	128	82
30	Sundargarh	168	241	127	81	7	501	214
	Total	**3136**	**2915**	**2161**	**1073**	**124**	**8502**	**3613**

Generation of Human Resources

The details of ANM & Nursing schools are as follows:

Institutes	**Government**		**Private**	
	Number	**Annual Intake**	**Number**	**Annual Intake**
ANM schools	22	780	80	2370
GNM Nursing colleges	4	360	34	1970
BSc Nursing Colleges	1	40	27	570
MSc Nursing Colleges	1	17	9	65

There are 4 Govt. Medical colleges and 4 Private Medical Colleges in the state. The details are listed hereunder:

Govt. Medical Colleges						
S.no.	**Name of the Institute**	**Location**	**Intake**			
			MBBS	**BDS**	**PG**	**DM/M.Ch. Courses**
1	S.C.B. Medical College & Hospital	Cuttack	150		78	17
2	M.K.C.G. Medical College & Hospital	Berhampur, Ganjam	150		41	
3	V.S.S. Medical College & Hospital	Burla, Sambalpur	150		41	

4	SCB Dental College,	Cuttack		50	6	
Private Medical Colleges						
S.no.	**Name of the Institute**	**Location**	**Intake**			
			MBBS	**BDS**	**PG**	**DM/M.Ch. Courses**
1	Hitech Medical College	Pandra, Bhubaneswar	100	100	6	
2	Institute of Medical Science & SUM Hospital	Kalinganagar, Ghatikia, Bhubaneswar	100	100		
3	KalingaInstitue of Medical Science	Patia, Bhubaneswar	100	100		
4	Gandhi Dental College	BadaRaghunathpur, BBSR		50		

Considering the burgeoning requirements, the state plans to revise the intake capacity of Medical Colleges from 150 to 250. In addition, proposal for establishment of 4 more Medical Colleges (2 in KBK+ districts) has been sent to GOI.

Recruitment, Sanctioned posts & vacancies

Medical Officers & Specialists: There are three mechanisms for the Medical Officers & Specialists to get entry into services in the state, i.e. 1) Regular appointment through Odisha Public Service Commission (OPSC), 2) Adhoc appointments under the state govt, 3) Contracting-in of specialists/trained MOs at SNCUs through NRHM. Direct regular recruitment is done through an entrance test followed by interview conducted by OPSC. There is also a provision of regularising Adhoc appointees after they complete 2 years of their service.

Table- District-wise Sanctioned against vacant positions across the state[3]

Sl. No	District	Sanc.	Vacant
1	Angul	133	71
2	Balasore	184	58
3	Baragarh	135	51
4	Bhadrak	116	51
5	Bolangir	161	30
6	Boudh	56	28
7	Cuttack	224	39

[3] *Odisha Public Health workforce study, NHSRC*

8	Deogarh	51	30
9	Dhenkanal	140	73
10	Gajapati	83	31
11	Ganjam	269	102
12	Jagatsinghpur	110	54
13	Jajpur	142	60
14	Jharsuguda	67	33
15	Kalahandi	175	72
16	Kandhamal	145	66
17	Kendrapara	118	71
18	Keonjhar	198	65
19	Khurda	283	70
20	Koraput	165	55
21	Malkangiri	88	42
22	Mayurbhanj	271	64
23	NawarangPur	116	67
24	Nayagarh	126	68
25	Nuapada	70	30
26	Puri	166	71
27	Rayagada	121	50
28	Sambalpur	146	30
29	Sonepur	76	14
30	Sundargarh	227	64
	Total	**4362**	**1610**

Kendrapara has the highest proportion of vacancies *(60%)* across the state. **Deogarh***(59%)*, **Nawrangpur***(58%),***Naygarh***(54%),***Angul***(53%)* are the other districts having more than half of sanctioned posts lying vacant.

ISSUES-

- Huge shortfall of staff exists in the categories of MPW (M), Staff Nurses, Radiographers and Specialists with respect to the population based IPHS norms. State needs to revise the sanctioned strengths for all these categories in order to keep up with the rising requirements.

- There is no specialist cadre in the state. MOs and Specialists join services at the same level, i.e. Asst. Surgeon and sometimes don't get posted at a facility where their skills are more required.
- Monthly remuneration of Rs 28,000 is quite less to attract specialists to work in SNCUs. Salary needs to be revised under NRHM head, if the state wants to ensure availability of Paediatrician at all its SNCUs.

Nursing & paramedical staff: All Staff Nurses are recruited on Adhoc basis under the state contractual term initially and get regularised after continuing for 6 years into the service. State also hires SNs through NRHM who get the remuneration same as Adhoc SNs. Adhoc recruitment of the contractual staff accrues at the state level and merit based selection procedure is followed for selection. Nursing and paramedical staff under NRHM is recruited at the district level where Chief District Medical Officer acts as the recruiting authority.

S.no	District	Staff Nurse		Pharmacist		Radiographer		MPW(M)		ANM	
		S	V	S	V	S	V	S	V	S	V
1	Angul	70	14	52	18	6	6	115	92	202	32
2	Balasore	89	5	95	1	7	0	208	136	352	21
3	Baragarh	41	12	62	25	4	3	145	128	247	23
4	Bhadrak	54	2	65	15	1	0	134	112	178	-23
5	Bolangir	80	12	72	2	5	1	166	4	271	17
6	Boudh	25	16	16	3	1	0	44	28	76	13
7	Cuttack	121	27	101	9	6	0	259	79	395	35
8	Deogarh	22	5	13	4	1	0	35	28	50	1
9	Dhenkanal	87	25	64	23	6	4	126	110	206	27
10	Gajapati	38	18	33	3	2	1	120	100	158	21
11	Ganjam	138	44	130	8	10	9	343	279	535	55
12	Jagatsinpur	20	13	50	14	3	3	92	74	189	-19
13	Jajpur	43	3	74	4	4	1	179	26	322	50
14	Jharsuguda	29	4	23	1	3	3	52	47	81	1
15	Kalahandi	99	13	78	4	7	1	178	8	282	7
16	Kandhamal	59	10	65	9	7	4	142	126	187	14
17	Kendrapara	55	10	57	15	3	1	121	108	273	32
18	Keonjhar	78	10	89	2	6	4	221	125	376	0
19	Khurda	138	24	96	18	10	5	188	166	289	15
20	Koraput	95	34	83	3	6	5	190	178	360	8
21	Malkangiri	40	5	57	6	5	3	83	83	175	11

S.no	District	Staff Nurse		Pharmacist		Radiographer		MPW(M)		ANM	
		S	V	S	V	S	V	S	V	S	V
22	Mayurbhanj	130	4	133	31	6	4	264	210	666	9
23	NawaraPur	30	1	57	4	2	0	142	35	315	12
24	Nayagarh	90	14	54	23	5	3	145	126	187	10
25	Nuapada	31	5	31	0	4	0	75	0	113	2
26	Puri	110	28	82	12	7	4	188	164	288	63
27	Rayagada	35	7	56	5	2	2	140	129	270	13
28	Sambalpur	81	12	56	10	7	2	120	109	208	20
29	Sonepur	22	8	29	4	2	1	69	58	102	0
30	Sundargarh	131	15	97	12	9	5	241	199	467	24
	Total	**1950**	**359**	**1873**	**276**	**138**	**70**	**4284**	**2868**	**7353**	**470**

Boudh*(64%)* and **Jagatsinghpur***(65%)* are the districts with highest proportion of vacancies of Staff Nurses.

Rayagada, **Jharsuguda**, **Jagatsinghpur** and **Angul** are the districts with no Radiographer working on regular term.

Huge dearth of MPWs is seen across the state with almost all districts having over three-fourth of the vacancies.

ISSUES:

- ***Delay in regularisation:*** Adhoc SNs at some facilities (CHC Barchana and DHH Jajpur) were found to have already completed the required tenure of 6 years in service but had not yet got approvals for getting regularised owing to the limited vacancies. In view of this, the state has however planned to increase 2,934 SN posts in a phased manner.
- Experience of SNs working under NRHM is not counted for getting regularised, and they are required to enter again into Adhoc services and work for 6 years to get eligible for getting regularised irrespective of their past experience.
- There are only 3 Govt. LT training colleges in the state with annual intake of 150 seats which is quite less in view of the high requirements. However, there are a few Private institutes also offering the diploma but none is recognised by AICTE and thus the candidates (LTs)

passing out remain ineligible to apply for the Govt. posts. There is a need to scale up the production of LTs by opening up of more institutes and by accrediting the currently operational private institutes.

Training

State Institute of Health and Family Welfare (SIHFW) looks after the coordination and monitoring of RCH training in the state.

'ITEMS'Software: State has also developed a web-based software namely *'ITEMS'* to develop and maintain real-time training database of all trained personnel and track the training quality. Data is uploaded by Dy. MRCH on quarterly basis. Quality parameters used in the software comprise of Pre and Post training test, usage of training manual, logistics arrangements, and utilisation of funds.

District Jajpur has already achieved annual targets FY 2013-14 for SBA, NSSK, IUCD and ARSH training.

Table- Training achievement against targets FY 2013-14

Name of the Training	Physical target FY 2013-14	Achievement FY 2013-14	Percentage achievement
MATERNAL HEALTH			
SAB	1000	545	55%
LSAS	30	4	13%
BEmOC	400	75	19%
BSU	20	38	190%
RTI/STI	405	80	20%
CHILD HEALTH			
IMNCI of BHWs	3120	1152	37%
FBNC	120	24	20%
FIMNCI	384	224	58%
NRC	225	75	33%

NSSK	1504	608	40%
Minilap	96	24	25%
MTP	30	10	33%
Laparoscopic Sterilisation	42	15	36%
NSV	55	5	9%
IUCD (MO&SN, ANM&LHV)	1370	618	45%
PPIUCD	120	80	66%
ADOLESCENT HEALTH			
ARSH	19355	9590	50%

State has already achieved the saturation in training achievement for LSAS, BSU and NSSK training as against the targets. Cumulative achievement for all training up to March-13 is shown hereunder.

Table. Cumulative achievement of training under Maternal and Child Health

Name of the Training	**State Load**	**Cumulative achievement *(Upto Mar'13)***	**Percentage achievement**
MATERNAL HEALTH			
SAB	16042	9982	62
LSAS	123	127	103
EmOC	57	38	67
BEmOC	1800	838	47
BSU	271	293	108
RTI/STI	18200	12325	68
CHILD HEALTH			
IMNCI	55524	37818	68
FBNC	752	548	73

FIMNCI	2208	360	15
NRC	264	229	87
NSSK	5984	6192	103
Minilap	772	361	46
MTP	772	297	38
Lap. Sterilization	477	102	21
NSV	772	187	24
IUCD/PPIUCD	5110	3322	65

Gaps at FRUs

There are 8 FRUs not functioning due to non-availability of O & G /EmOC specialists. 15 FRUs not functioning due to unavailability of Pediatricians. 21 FRUs lacking with Anesthetists/LSAS trained MOs. There are 19 FRUs not functioning due to non-availability of BB/BSU.

Irrational deployment of skilled health workforce

- Only 20 out of 79 LSAS trained MOs have administered spinal anaesthesia after getting trained in LSAS. Unavailability of requisite facilities and absence of the complementing team members were reported to be among the prime reasons attributing to non-utilisation of their taught skills.
- 2 EmOC trained MOs are placed at the PHCs which are not the Delivery Points and have not conducted any delivery post training.
- Rational use of LTs not there- e.g. the one at PHC is conducting only sputum microscopy (about 40 / month) and PS for malarial parasite (about 65 / month), but is not doing any ANC related tests. The work-load requires him to take on this additional responsibility. In another CHC, while one LT was conducting all ANC related tests, routine urine and blood tests and HIV testing, the other LT was doing on PS for malarial parasite (about 200 samples per month) reflecting a great discrepancy in work-load distribution.

Remuneration

Large disparity in salary exists between Regular and Contractual staff in the state. While a Regular Staff Nurse gets a monthly remuneration of Rs 22,000 her contractual counterpart only gets Rs 8,200.

Delayed salary: ANMs complained that they were not receiving their salaries on a regular basis, but after a gap of 3-4 months. For example, one ANM received the salary for April to July 2013 in the month of August. She has not received any salary (for August September, October) since then.

Staff benefits and retention issues

Lacking residential accommodation: Residential accommodation is not provided for doctors in some CHCs (CHCs Bari, Binjhapur, Jajpur road) in Jajpur. At DHH Jajpur as well, the quarters are quite lesser than required. It must be seen that Bari CHC and Binjhapur CHC are also facing crunch of specialists with none having any Surgeon or Paediatrician.

Due to absence of government buildings for Sub-centres, ANMs often have to do their own residential arrangements outside the rented Sub-centre buildings which usually consist of only one room. Often basic facilities like toilets were also not there, making working a difficult proposition.

Overloaded ANMs with no support staff (MPW): ANMs placed at sub—centres are entrusted with large population spread across vast geographical areas. Recently (in the past 6 months), male workers have been recruited to support them.

INCENTIVES

Monetary incentives in KBK+ districts: MOs working in peripheral areas get Rs 8,000 per month and MOs in District Hospitals get Rs 4,000 per month extra to their monthly salary.

Specialist allowance of Rs 3,000 has recently been introduced for the MOs with PG qualifications working at the capacity of specialists.

Post Mortem allowance (Rs 500 per case) is also introduced to compensate for the unwillingness of the MOs towards attending Post-mortem cases.

5% retainer-ship allowances are givento the contractual clinical staff per term of 11 months as a special incentive. This is often given in the form of arrears at the end of a year.

Hardship allowances of Rs 1,000 for Paramedics serving in difficult areas (V3 and V4) under NRHM.

HUMAN RESOURCE MANAGEMENT INFORMATION SYSTEM

State has developed web-based software with the objective of creating an information base of all contractual employees working under NRHM. This software, however, aims at helping the HRD cell at State Programme Management Unit (SPMU) in managing the contract terms and pay processes of the contractual employees. But it hasn't found proper use in the HR planning and deployment so far. There are issues reported of not getting timely updated.

User IDs and Passwords have been given to Block Data Manager at block, District Accounts Manager at district and HR cell at the state level. Updates on vacancies, transfers and new additions are done on monthly basis after getting validated and certified at the district and state level.

However, it is yet to find its application in HR planning and Training need assessment. There is a need for HRMIS to also include the data of regular staff, and integrate it with GOs involving transfers, postings and promotions thereby enabling better assessment of HR gaps facility-wise within the state on real time basis.

Establishment of skill labs to plug in skill gaps

There are 4 sites identified for setting up of skill labs as under*: i) SIHFW; ii) GNMTC; iii) ANMTC Bolangir; iv) Nursing college Berhampur.* Working group has already finalized the layout and consultation with the faculty members and respective CDMOs and district NRHM staff.

Deployment of AYUSH MOs

There are 14 PHCs that are independently being managed by the AYUSH MOs in Jajpur.

Training for AYUSH MOs: AYUSH MOs have been trained for SBA and ARSH training in the state, and NSSK training has also been proposed for the upcoming rounds. 626 MOs who have already been trained in SBA but still there is a considerable pool left out who could be trained and utilised for conducting deliveries.

Role of AYUSH MOs: Apart from doing their routine tasks of handling AYUSH OPDs, AYUSH MOs were also found providing counselling services and prescribing medicines at Adolescent clinics (as was observed in Danagadi CHC). AYUSH MOs have also been involved in National Health Programmes wherein they pay field visits on weekly basis for monitoring & supervision of Immunisation, VHNDs, School Health Programme, Disease Control Programme.

The overall utilization of funds for AYUSH is very poor in Koraput. No funds have been received by the State after 2011-12 for Mainstreaming of AYUSH due to pending UCs.

Sanctioned and Vacant Posts for AYUSH Doctors in Odisha, Koraput and Jajpur

Total sanctioned posts for AYUSH doctors	**Filled up posts**	**Vacant posts**
Odisha		
1476	*1273*	*203*
Koraput		
60 posts Out of which 31 posts for Ayurveda and 29 posts are for Homoeopathy.	*36 filled up posts* Out of which 16 posts are for Ayurveda and 20 posts are for Homoeopathy.	*24 posts are vacant*

Total sanctioned posts for AYUSH doctors	Filled up posts	Vacant posts
Jajpur		
64 posts Out of which 35 posts are for Ayurveda and 29 posts are for Homoeopathy.	*62 posts filled up* Out of which 34 posts for Ayurveda and 28 posts are for Homeopathy.	*2 pots are vacant*

Initiatives to fill up all the sanctioned posts may be taken in Districts including Koraput, Malkangiri, Nabarangapur, Rayagada, Sundargarh and Ganjam where vacant posts are quite high.

There are a total 25.51 lakhs patients treated with AYUSH doctors in different Districts.

The remuneration they are receiving is Rs 12,000 basic and Rs. 4,000 extra for KBK District and as performance incentives they are receiving Rs 3000.

V. COMMUNITY PROCESSES AND CONVERGENCE

Community processes are working very well and many of them serve as promising practices for other states.

The ASHAs in the State are present as per norms. In Jajpur, 1854 of 1861 ASHAs required are in position and in Koraput 1479 out of 1488 ASHAs are in position. The State has also recruited 578 Additional ASHAs for difficult and most difficult terrain facilities as V3 and V4 Subcenters. This is a good practice as the norm of 1 ASHA per 1000 population is clearly inadequate in these areas of sparse population which entails travelling long distances for ASHA to reach to the community.

Roles and responsibilities:

ASHAs spend about 5-6 hours a day on this work. They are doing very good work in mobilizing women for institutional deliveries, immunization, HBNC and supply contraceptives. ASHAs are also facilitating TB patients for DOTS treatment. At community level, ASHAs are involved in: Village Health and Nutrition Day meetings (called as *GaoKalyanSamiti* in the state)& and perform various activities for several programs as under:

- IEC activities forANC, NNC, CHC, RNTCP, NVBDCP, Family Planning etc.
- Case detection activities for Leprosy, Malaria, NPCB
- They have shouldered the responsibilities of Updating of Swasthya Kantha& Referral of Malnourished children to Nutritional Rehabilitation Centers.

Training:

All ASHAs in Jajpur district are trained till 5th module and for some training on 6th and 7th module has also been completed. With regard to module 6 and 7, training is almost complete for ASHA in High Focus districts (18) and is under way in non-high focus districts (12). Majority of the ASHAs interviewed were also trained on Malaria, TB, Leprosy and Dengue.But no proper mechanism to evaluate the quality of trainings being provided to the ASHAs is established in the district.

They need support in the form of HBNC kits, and need to improve their counselling skills for promoting reversible methods of contraception and for motivating young couples to delay first birth.

Considering high Infant and Neonatal mortality in the state, additional resources and efforts to be extended to complete the training of Asha in module 6 and 7 even in the non-high focus states.CSR or other funding resources to be leveraged for training of community members as potential future ASHAs can be explored.

Mentoring and Support:

ASHA facilitators, SATHIs have been selected in the State and are recruited from ASHAs with good performance over the past three years. The incentive earned over the past three years is used as proxy indicator for performance. They are responsible for mentoring of ASHAs and GKS and for grievance redressal for ASHAs. The provision of ASHA facilitator is a good way of providing handholding to ASHAs by experienced ASHAs. However, there is 1 ASHA facilitator per sector (for about 25-35 ASHAs, and sometimes even for 50 ASHAs, while ideally 1 ASHA SATHI should be responsible for mentoring about 20 ASHAs. Therefore, there is a need to ensure provision of 1 ASHA per 20 ASHAs so that SATHI is able to provide quality mentoring and support to ASHAs.

Outcomes of home-based care should be analyzed and linked to trends in infant and maternal mortality and Outcomes of supportive supervision system to be analyzed and further strengthened.

ASHA Drug Kit and HBNC kit:

HBNC kits are being provided to ASHAs. They were shipped from the state to the district and then to the CHCs. From the CHCs, the ASHAs collect the kits. This ensures that ASHAs can check the kits and return if defects are found. At the sector meetings, the ASHAs report on their contraceptive stocks. The meeting is held under the leadership of the Block PHC MO I/c and the BPM. They are held on the third Saturday of every month.

Services:

ASHAs are able to deliver both RMNCH+A and NCD services well in the community. Majority of the ASHA interviewed had adequate knowledge and skills in diagnosis, referral, treatment and follow-up of TB, Malaria, Leprosy, and Dengue cases. They have started using rapid tests for Malaria diagnosis.

With regard to Home based care, 97338 babies were provided with six home based care visits, 3705 babies and 1063 mothers were identified with danger signs and 1963 babies were referred to the hospital. The state has paid 2.4 crores in incentives to ASHA towards home based care visit.

ASHA is delivering contraceptives at home. ASHA kit carries Pregnancy test kits. ASHA is involved in scheme of home delivery of contraceptives and all the necessary logistics were available in ASHA kit including NISHCHAY kits.

Performance monitoring:

Performance monitoring of ASHA is in place and blocks are graded as follows based on the performance of ASHA. 101 Type A Block (>75% of ASHAs are functional); 108Type B Blocks (50-75% of ASHAs are functional) (108), 64 Type C block (25-50% of ASHAsare functional), 41 Type D Block (< 25% of ASHAs are functional).

1123 Best performing ASHAs were selected as **ASHA SAATHI** to help improve the performance of poorly performing blocks. The Best performing ASHAs are being promoted as ASHA SAATHI, and given preference in admission into ANM and GNM courses.Performance review of ASHAs is done through structured questionnaire on the following 10 points:

1) Home visits done within 24 hours after birth
2) Following HBNC guidelines - six PNC visits in case of institutional delivery (on 3rd,7th, 14th,21st, 28th, and 42nd day) - Seven PNC visits in case of Home Delivery.
3) Following guidelines of JSY, Accompanying pregnant mother to the institution.
4) Mobilizing villagers to attend VHNDs
5) Mobilizing of eligible cases to session site for vaccination and ensuring completion immunization of child.
6) Acts as DOTS provider
7) Motivation for Family Planning measures like sterilization and spacing
8) Organizing Gram KalyanSamiti
9) Collecting blood sample collection, report & treatment

10) Management of pneumonia and diarrhea.

Payment to ASHAs:

ASHAs are receiving payment on 10th of every month through e-transfer to their bank accounts. Average monthlyincentive of an ASHA has gone up from Rs 1600to 1900 during the year 2012-13 and certain ASHAs interviewed were making an incentive of 8,000 to 15,000 per month, mostly due to incentive for motivating for sterilization. Online payment through CPSMS completed in 4 districts including Jajpur and Koraput. The average monthly incentives being taken by ASHAs are ranging from INR 350 to INR 1000.However, issues regarding delay in transfer of incentives related to immunization activities were reported by some ASHAs.

Inter alia, awards on the basis of performance of ASHAs are being given at block and district level. At block level, INR 5000 is distributed as INR 2500, INR 1500 and INR 1000 to I, II and III rank holder respectively. At district level, INR 5000 is being given to each of the 6 best performing ASHAs of the district.

ASHA Support System:

The Database on ASHAs in maintained at the State level and annual tracking of their attrition is done.The attrition rate has been low at 0.65% during 2012-13. The low attrition could be attributed to theexcellent support structures created in the State with mentoring and support from ASHA SATHIs, timely disbursement of incentives to ASHAs directly into their bank accounts. Provision of career progression bypromoting good performing ASHAs as ASHA SATHIs is a good practice. AHSAs havebeen provided with uniforms and cycles in the form of mobility support to help them cover largework areas.

The inclusion of ASHAs in Swalamban pension scheme is also a considerate step taken by State in welfare for ASHAs on whom the success of the programme heavily relies on. Rs.1 lakhcompensation is provided to ASHA in case ofdeath while at work from Chief Minister Relief Fund (CMRF).

ASHAGruhas are constructed at 143 Deliverypoints with attached bathroom and toilet facility for

ASHAs accompanying pregnant women to instituteon for delivery.

The grievance redressal mechanism for ASHAs seen in the State may be appreciated as a postcard addressed directly to the Chief District Medical Officer is provided to each ASHA, so that she candirectly send her complaint to CDMO, District Hospital. Inter alia, they can submit their complaints to theMO (PHC), BPM and BAM.

The ASHA scheme is a success in the State and is a model that should be emulated by other states.

VILLAGE HEALTH NUTRITION DAY

The State has separated the immunization day from the VHND thus ensuring that a VHND is not merely an immunization day. Even now, the RI sessions are held on Wednesday. During RI sessions, the ANM does not have the time for any other activity. Thus this segregation ensures that adequate focus is given on the VHNDs to ANC, growth monitoring, take-home ration, group counseling, and individual counseling on FP, including distribution of supplies. Alternate vaccine delivery system through NGOs is found to be satisfactory.

Kishori Swasthya Melas are organized in the VHND sessions to provide essential and comprehensive Health & Nutrition services to pregnant women, lactating mothers, children (0-3yrs), and Health care services to the adolescent girls along with counseling. The number of sessions held against those planned in the State has been 97 % and 96 % in the last and this year respectively. VHNDS are held on Tuesdays. For those who cannot be covered on Tuesdays, Friday is kept as an additional day. Equipments such as weighing scales, curtains for privacy for ANC etc. have been provided by GKS.

Immunization sessions are exclusively held on Wednesdays and kept separate from the VHNDs. Every quarter, aKishoriMelais organized as part of the VHND in which, sessions are held on Sanitation, Menstrual Hygiene, and Nutrition etc. TT10 and TT16 vaccines are also given. Often a competition is also held to engage the adolescent girls' interest.

The team observedthat all three workers (ANM, AWW and ASHA), along with the HW(M) were present at the VHNDs.

Growth monitoring was being done. Some mothers shared that they did not have growth monitoring cards, however the same was marked in the MCH cards. While the mothers were told weight of the child, they were not explained categorization of the weight based on the WHO growth charts. While SAM children were advised for referral, there was hardly any counselling given on nutrition for the normal children. Women were aware of the period for exclusive breastfeeding. However, there was no support for women who were unable to follow IYCF guidelines such as for women with "not enough milk".

Take home ration was not given during the VHNDs. Second Thursday of each month was fixed for the same. Thus most of the out-reach activities were still split across various days, and VHND was not an integrated session for all outreach services.

GaonKalyanSamiti (GKS)

45407 GKS formed at Revenue village level, Comprising of Ward Member as President, AWW as Convener, and ASHA as Facilitator, Best performing GKS is provided with awards entitled as SusthaGaon Award. GKS is well integrated with PR system at various levels. There is a good convergence between ASHA and AnganWadi workers at the village level. The GKS meetings are held regularly and village action plans are being formulated. However, the utilization of VHSNC/ GKS funds in the State is poor.

Composition: Ward member is the *Chairperson*, the AWW is the *Convenor*, ASHA is the *Facilitator*. 3-4 SHG leaders are also members, along with representatives from hamlets. A VHSC has 10-12 members in total.

To strengthen GKS, CDPOs (2-days), Mukhya Sevikas (1-day) and AWWs (as part of sector meetings) were trained on role of and record keeping of GKS. Following the training, the GKS meetings are happening regularly, on the last Thursday of every month.

Earlier SOEs of the GKS had to be submitted on a quarterly basis. However, that was not happening. Now, they have been instructed to share the same on a monthly basis. While only about 40% of the GKSs share the reports on a monthly basis, but the frequency has been improved following the new guidelines.

On an average, the GSK spends 75% of the annual funds allocated to them. The common activities include *Jaldan*(setting up drinking water points) during summers, cleaning of the village, healthy baby shows, and bangle ceremonies for pregnant women.

For every GSK meeting,Rs. 150/- is paid to the ASHA, Rs. 50/- to the ward member, and Rs. 100/- to the AWW for record keeping. Thus a total of Rs. 300/- is spent per meeting, making it a total of Rs. 3600/- spent per year on the GSK meetings also.Remarkably good and efficient coordination between ASHA, AWW and ANMs demonstrated at the GKS meetings.

VI. INFORMATION, KNOWLEDGE AND MANAGEMENT

Health Management Information System (HMIS)

Status of Facility wise reporting:

As per information provided by the State in their briefing session on all the Districts of the State have shifted to facility based reporting since October, 2012. Data available on HMIS portal as on 13th November, 2013 shows that all the 30 Districts of Odisha have been reporting facility-wise data on HMIS portal during 2013-2014.

While all the Districts in the State are reporting facility-wise data on HMIS portal, this data is not being entered directly in HMIS portal. The data is first entered in DHIS-2 and then posted to HMIS. However, this posting is not done by Block or District level officials but at the State level so as to save the Block and District level officials time and effort in this exercise. The data of nearly all facilities is being regularly entered in the HMIS portal except for a few remote blocks in Koraput and a CHC in Jajpur district.

Flow of HMIS and MCTS Data:

ANMS from 4-5 subcenters under the jurisdiction of a PHC report the performance of the subcenters at PHC (New) level in the sector level meeting taken by the supervisor on every Saturday of the month where ANM deposits the MCTS reports and the drug requirement, if any for the subcenters. The data thus received from ANMs is taken by the supervisor to the CHC level on every Monday. The block level consolidation of data is done here. These are entered in the MCTS portal and the microplans thus generated are given to the supervisor, who distributes them to ANMs in the next sector level meeting.

Use of Data:

Immense amount of efforts going into overall data management but it is weakly analyzed and at times it not scientific. Information is being used to prepare plan related to immunization activities but not in all outreach activities District level dashboard indicators are developed which are being

reviewed at district and state level. On the basis of these dashboard indicators Koraput stands at 26th out of 32 districts in the state. State plans are substantially based on HMIS.

HMIS data is being used to review the programme performance by facility level reports are generated from DHIS-2. At district level, a Committee headed by Asstt District Medical Officer (FW & I) has been constituted to review the HMIS data. At the Block level HMIS committee under the chairmanship of BMO, BDM, BPO, BPHEO has been constituted where facility wise report is presented on 1st of every month to committee. The State has grouped PHCs in Sectors. HMIS data is being used in Sector review meetings and Block review meetings to review the performance of the facilities. The ANMs of the facilities with poor performing indicators are contacted and notice is given to them in case of consistent poor performance. In effect, Analysis of data was done and used during regular monthly visits at district level but not at block and below level. The supply of vaccines to ANMs for immunisation is based on HMIS data.

Challenges:

Personnel handling HMIS and MCTS have been entrusted other responsibilities which increase the workload at a time when facility based reporting in HMIS portal and increased focus on MCTS data has already increased the workload for personnel handling HMIS and MCTS. These factors limit the utilisation of HMIS data at different levels. For better results, separate manpower may be hired for handling the data of other programmes. Secondly, the internet connectivity available at District, CHC and PHC in Jajpur District is slow. Poor performing blocks in the Koraput district due to poor connectivity are namely Narayanpatna, Bandhugaon where generally data entry is not possible. Better internet connectivity at the District, CHC and PHC levels may help in real time updation and better utilisation of HMIS and MCTS data.

Quality of data:

Data entry portal has in-built functionality to validate data; however limited checks on quality of data in the HMIS Monitoring is confined to validation of data and alignment of data in respect to previous reports. LHV is majorly engaged in ensuring correct and timely reporting but not able to scrutinize each service delivered during outreach activities. There was some discrepancy found in quality of ANC services provided. There are some instances found where without performing Hb

estimation data are entered in the registers. High risk mothers are not attended with due priority where tracking is important to reduce the maternal mortality and morbidity.

Mother and Child Tracking System (MCTS)

Status of Registration:

As per information provided by the State in their briefing session on 9th November, 2013, the registration of pregnant women and children on MCTS portal upto September, 2013 was 84% and 72% respectively. As per data available on MCTS portal as on 12th November, 2013, the registration of pregnant women and children was 73.7% and 63.7% respectively on pro-rata basis. The follow up of services shows gaps. For example, as per information provided by the State in the briefing, deliveries were reported for 69% of pregnant women registered with LMP in September, 2012 and measles vaccination was reported for 65% of children with date of birth in September, 2012. For both the district also the situation is similar. This is clearly an area of concern.

The ANM at the subcenter is maintaining the MCTS register and has work plans available.

Use of MCTS Data:

MCTS data is being used to review the programme performance. At District level, a Committee headed by Asst. District Medical Officer (FW & I) has been constituted to review the MCTS data at District level. MCTS data is being used in Sector review meetings and Block review meetings. The supply of vaccines to ASHAs for immunisation is based on MCTS data. Work-plans are being used by ASHAs and ANMs for MCH services. The work plans were found with the ANMs at the VHND thus showing their utilization. However, the quality of reports is significantly poor in some of the aspects like anaemia detection and diagnosis of PIH, gestational diabetes. To some extent, high risk mothers are identified but not adequately tracked for care in some of the visited sub-center like Kundar and Kellar.

CHALLENGES

As mentioned earlier, the internet connectivity and increased workload of the personnel handling HMIS and MCTS are two major challenges that limit the updation and utilisation of HMIS data at different levels. For better results, separate manpower may be hired for handling the data of other programmes. Details of address and husband's/father's name of ASHAs are necessary for making MCTS the single source of information for making ASHA disbursements. However, this data is lacking. Call-center facility may be utilized to validate the phone numbers of ANMs, ASHAs and getting other details of ASHAs.

State Health Systems Resource Centre (SHSRC)

State Health System Resource Center, Odisha (OSHSRC) has been established as a technical support unit for the Department of Health & Family Welfare, Government of Odisha under the Odisha State Health & Family Welfare Society. It is the sate version of National Health Systems Resource Centre established under Government of India. In essence by acting as a Knowledge Management Centre, OSHSRC serves as the think-tank and mentor working within NRHM, Odisha. The OSHSRC has a multidisciplinary team with skills in the area of Community Processes, Quality Improvement, Public Health Planning, Training management, Data management & use, Procurement & Supply Chain management. It is providing technical support in preparation of PIP, operational guidelines for different activities, strengthening of procurement process, community process activities and quality assurance.

The SHSRC works in collaboration with the following institutes:

- **Development Partners** like UNICEF, DFID, NIPI, UNFPA and JHPIEGO are providing technical assistance in the areas of RMNCH+A services.
- **Medical colleges** are providing assistance for technical areas like preparation of Standard Treatment Protocols; training modules for ICUs, SNCUs, NRCs; preparation of EDL. Some trainings like LSAS, EmOC and BEmOC are being conducted by the medical colleges.

- **NGOs** like Human Development Foundation, OVHA, My Heart, PHFI, PFI etc are providing support for community processes, ASHA training, GKS training, implementation of RCH activities at Sub Centre level, urban health.

Activities performed:

1. Health Planning through preparation of PIP both for NRHM & NUHM
    a. In partnership with Development partners took steps in building capacity of the district team for preparation of District plan
    b. Capacity building and hand-holding practices for special district based planning for HPDs (dedicated personnel from development partners being trained by OSHSRC)
    c. Support to different divisions including NCD for preparation of PIP
    d. Supported districts & state in planning, providing them adequate GIS based information with regards to institution, HR mapping.
2. Policy Initiatives & Inputs:
    a. Initiation & being part of the establishment of dedicated Public Health and Nursing Directorate in partnership with TMST, Jhepigo and SHRMU.
    b. After both the directorates are being in place, preparing SoPs& guidelines for detailed road-map for bulic health cadre & nursing cadre in the state.
    c. Being part of the core group in the state helped in establishment of Nursing Directorate and strengthening the nursing education (SNC at College of Nursing, Berhampur, ANMTCs & GNMTCs)
    d. With deptt. of W&CD concept, policy input finally roll out of MAMTA (a multi tranche cash incentive scheme from registration of pregnancy till one year of the child), special nutrition activity for PVTG blocks and a comprehensive 1000 day approach service delivery in health & nutrition from pregnancy till 2nd year of the child.
3. Partnership with Development partners, Academic institutions etc.:
    a. Planning for QIP for 6 DHH with the help of TMST and following up its implementation with the implementing agency (AIPH).

b. Gap analyses of SNCUs & NBSUs were done with the help of UNICEF, NNF and Medical Colleges along with feedback provided to the Child Health section.
c. Similar exercise was done for VHND with the help of UNICEF & IIPH, Bhubaneswar and feedback was provided to the Maternal Health section.
d. Piloting CMAM in Kandhamal in partnership with TMST & DW&CD.
e. Training & follow up of IUCD with HLFPPT
f. Partnership with IIPH & AIPH for different capacity building activities e.g. DPH course, mid-level management training in the field of RCH
g. Preparation of SoP& implementation of for Swasthya Samikhya at different levels through NGO. CPRC is following up.

4. PIP implementation & Supportive Supervision:
   a. Delivery Point mentoring support planning & preparation of its SoP, Checklist etc. This focuses on skill& knowledge of the service providers along with ensuring availability of all essential, mandated equipments and logistics
   b. Sub-Center mentoring support planning & preparation of its SoP, Checklist etc. with the help of TMST, Odisha.
   c. Monitoring supporting the activity of the districts, IMTs are formed and providing feedback to appropriate level after analyzing the same.
   5. Worked for rationalization of existing Human Resource and their retention policy in collaboration with SHRMU
6. Repository:
   a. Publication of Annual Report
   b. All the activities & follow-up of IMT is documented & uploaded in web-site
   c. GIS based documentation of requirement of different facilities including PHCs & HSCs.
   d. Similar documentation is done for facility based man power availability & road-map for rationalization (GIS based)
7. OSHRC is the key functionary in implementation of newly focused programmes & schemes like RMNCH+A, RBSK, Iron plus etc. (Mainly involved in preparation of SoPs, guidelines, monitoring tools etc.)

8. OSHRC is involved in a number of cross-cutting areas with other departments e.g. DW&CD planned programme like MAMTA, piloting of CMAM in Kandhamal, special nutrition activity for PVTG blocks.

Proposed activities:

1. Midterm evaluation of activities of NRHM specially GKS activity & DPMU.
2. Gap analysis of existing Healthcare Service Delivery System with focus on out-put of the service delivery points.
3. Health Management Information System –its status (effectiveness study)
4. Incorporating essential reporting by the Private Institutions and preparing appropriate rules & regulations in Clinical establishment Act.
5. Evaluation of quality improvement systems implemented in district level institutions
6. Programmes for integrating AYUSH activities to improve Health Service Delivery to the public
7. Evaluation of ASHA activities for women and child care in Odisha and working towards their career progression which is now just conceived.
8. Evaluation study on utility of infrastructure development done under NRHM in Odisha
9. Strengthening SPMU with rational use of Human Resource.
10. Preparation of Multi Year Prospective Plan along with Annual PIP.
11. Preparation of framework and road map the QIP all over the state.
12. Essential road map for piloting & scale-up use of Iron-Sucrose in management & follow-up of severely anaemic pregnant women.

State Institute of Health & Family Welfare (SIHFW) and Regional Health & Family Welfare Training Centres (RHFWTCs)

SIHFW is the apex training institute of the state to train the in-service doctors, paramedics and health managers starting from Sub Centre to State HQ. Regional Health & Family welfare Training Centres at Jagatsinghpur, Cuttack &Sambalpur function under the administrative control of SIHFW and all the communication officers from block level to the state level are also functioning under the control of SIHFW. Most of the positions in SIHFW are filled. It functions to to provide technical assistance and capacity building measures to Dist. health Institutions, provide support to State for planning in health initiations, Quality improvement, coordination with State Human Resource Management Unit (SHRMU) to prepare a viable Human Resource Planning (HRP) for all health institutions, to act as data warehouse and gather national, international and local evidence to strengthen health services

Composition:

ASHA and VHSC (GaonKalyanSamiti) are very important community level link with General Health care system. **State ASHA Reource Center (SARC)** is devised to play a pivotal role towards strengthening the ASHA in the state of Odisha. SARC is to strengthen the ASHA in the state. SARC is to open channels for dialogues between ASHA and the other stakeholders placed within the hierarchy of NRHM. SARC and OSHSRC will work in conjunction within OSHSRC there is the senior consultant on Community Process. It's impact that she/he would lead all activity of SARC.

The **State Child Health Resource Center** is working in coalition with OSHSRC in the up scaling the child health interventions in the state of Odisha under NRHM. OSHSRC is creating avenue through critical gap analysis and midterm correctional measures to bridge the critical gap (through research and innovations) and; technical support for the quality improvement of child health programme; thus, creating a road maps for the CHRC especially setting up special care units like SNCUs. This is being implemented with inbuilt partnership with NIPI.

INNOVATIONS

There is no District specific innovation. However, the State has devised a system of communicating MCTS workplans to ANMs through Alternate Vaccine Delivery System (AVDS). The filled in work-

plans are collected by Sector supervisor in Sector meeting which is conducted on every Saturday. These filled-in work-plans are submitted by Sector supervisors for data entry on Monday. Thus, the MCTS workplans are communicated quickly and the data entry in MCTS is expedited.

During Phailin cyclone, the pregnant women having EDD from 12th to 17th October, 2013 were identified from MCTS data. Telephonic messages to these women were sent through ANM / ASHA / BDM to attend any public institution for delivery. Use of MCTS data in a situation of natural disaster is an innovative step.

The State has taken many other initiatives. A web-enabled software application called NRC Tracker is being implemented for tracking the status of children coming to NRCs. It is envisaged that NRC Tracker will be integrated with MCTS. Similarly, a software application called SNCU Tracker is being implemented for maintaining the database of children admitted to SNCU and their follow-up after their discharge from SNCU.

The facility of determining availability of blood of a particular blood group through SMS is a people-friendly initiative for blood bank management.

The State has developed a web enabled software application called e-Swasthya Nirman to track and trace the physical and financial progress of all construction activities undertaken by respective Zila Swasthya Samiti under NRHM and State budget.

Technical assistance is provided from NIHFW (1 Medical, 1 Finance &1 Research Consultant) are working in training wing for Training coordination and monitoring. One programme coordinator from UNICEF is working in communication wing. TMST, BBC and UNICEF are providing support particularly in the field of communication and its related training.

VII. HEALTH CARE FINANCING

State Health Society-Odisha

Human Resource: The Financial Management Status at various level of the State Health Society is as below and there is only Vacant position is at DPMU & DHH Accountants, SDH Accountants and CHC/PHC Accountants that is 9,4 and 54 respectively for which the state may please take the necessary steps for the fill-up of the same position.

HR position for Finance & Accounts	Sanctioned	Positioned	Vacant
Director (finance & Accounts)/Deputy Director/Finance Controller	1	1	0
State Finance Manager	1	1	0
State Accounts Manager	1	1	0
District Account Manager	30	30	0
DPMU & DHH Accountants	77	68	9
SDH Accountants	26	22	4
Block Accountant	0	0	0

CHC/PHC Accountant	434	380	54

Maintenance of the Financial Books of Accounts: The State is maintaining the books of Accounts on Tally-7.2 but the opening balances are not incorporated in the books of accounts and the expenditure of the district level are also not incorporated in the books of Accounts only the fund received, releases and expenditure of the state level are taken into account.

Bank Reconciliation: The State health Society has reconciled all the bank Accounts under NRHM up to 30th Sept, 2013 but there is some entries which are pending for more than three months needs to be reversed are transfer to still cheque/liability account as the cheques are not presented for more than three month and if the same is claim by the claimant then the payment will made after revalidation of the cheque.

Advances under RCH Flexible Pool : The State has given advances for various training programme during the Financial Year 2013-14 which pending for reconciliation that is amounting to Rs.14.10 Lakhs as on 30th Sept, 2013. It is recommended that if the old advance is settled than the further advance will not be released or a time line for the settlement of the advances may be given.

Advances under Mission Flexible pool: The State has given advances for various review meeting work shop during the Financial Year 2013-14 which pending for reconciliation that is amounting to Rs.16.24 Lakhs as on 30th Sept, 2013. It is recommended that if the old advance is settled than the further advance will not be released or a time line for the settlement of the advances may be given.

Expenditure against Committed Liabilities: The State has reporting expenditure against the committed liabilities for the previous year but the committed liabilities from the district level are not submitted by the district even though the State Finance department has circulated the format to all the district but field visit to Jajpur District revealed that the district has made Expenditure under Training, Infrastructure and ASHA Incentive for which there is no committed liabilities declared by that district.

Tally ERP-9 Implementation (Customized version): The customised version of the Tally is not implemented by the State Health Society Odisha but the state has developed one software on

Financial Accounting & Management System and which is on the pilot run basis and the persons designated to work on it is required trend from the software agency.

CPSMS :The registration status of the Accounts under NRHM is very good and state has already started the DBT at 4 district and another 11 district will be started on Nov-2013 and the balance 15 district will be started on January-2013 and the registration status at various level are as below:

Various level	Target of Registration	Target Achieved	% of achievement
Dist level (DHS, RKS-DHH & PPC)	90	100	111%
CHC level (CHC, RKS-CHC, SDH & RKS-SDH)	806	807	100%
PHC level (PHC, RKS-PHC, OH & RKS-OH)	2614	1870	72%
Sub Centres	6688	6513	97%
GKSs	45204	43313	96%
TOTAL-	**55402**	**52603**	**95%**

Statutory Audit Report (2012-13): The state has not submitted the Audit report for the Financial Year 2012-13. Due date for submission was 31.7.2013. The state may please follow up the same to submit the Audit report at earliest with all the DCPs so that the ministry can release further funder under NRHM.

Concurrent Audit: The concurrent audit system is implemented in the State and District Level but there is some observations;

I. **State Level 2012-13:** The State health Society has not submitted the executive summery which is required on quarterly basis to the Govt. of India and the State has not submit the ATR Action Taken Report on the observation of the concurrent Auditor of 31st March, 2013.

II. **State Level 2013-14:** The appointment of the Auditor for the FY 2013-14 has been appointed and the auditor has submitted the report up to Sept-2013 but the executive summary report for the two quarter is pending to send to the Govt. of India.

III. **District Level 2012-13:** The Auditor for the financial year 2012-13 has been appointed at all the district but the following district have not been Submitted the status is as Table (A)

IV. The Auditors have been appointed in all the 30 districts but Audit report has been submitted by 20 of the Districts. Of the districts visited, Koraput has submitted its audit report while that from Jajpur is awaited.

V. **District Level 2013-14:** The concurrent Auditor for the Financial 2013-14 for the all district has been appointed for all the 30 districts but the report for the June and Sept-20103 has not been submitted for 17 districts for upto June 2013 and 28 districts upto Sept 2013. The two districts visited have both submitted reports upto June 2013. The State internal Audit team may please monitor the status and take the necessary steps for the follow up of same.

State share Status: There is no Pendency under State share till date.

Utilisation Certificates: Provisional UCs for the F.Y.2012-13 have been received from the State, however Audited UCs are yet to receive which is one of the conditionality for the release of funds.

Status of Allocation Release and Expenditure:

Sl. No.	Programme	2013-14		
		Allocation (In Crore)	Release (In Crore)	% of Release on Allocation
1	RCH-II	180.6	135.45	75%
2	MFP	204.17	153.13	75%
3	RI	9.06	1.92	21%
4	P.P.I.	6.37	4.78	75%
5	IM (Dir & Adm)	157.34	118.01	75%
6	Disease Control Programmes			
A	I.D.S.P.	1.52	0.93	61%
B	N.I.D.D.C.P.	0.26	0.02	8%
C	N.L.E.P.*	3.21	2.07	64%
E	N.V.B.D.C.P.*	46.03	9.32	20%
F	R.N.T.C.P.*	21.42	9.02	42%
Grand Total		**629.98**	**434.65**	

Major Financial Issues:

(i) **Misappropriation of fund under NRHM:** A misappropriation of fund of Rs 11.48 lacs has been reported during the year 2010-11 at Angul district. Legal action has been initiated and the matter is still pending with the court.

(ii) **Internal Audit Cell:** Internal Audit cell under NRHM has been approved during 2012-13 however, the effectiveness of the cell needs to be evaluated due to high unspent balance.

(iii) **As per the FMR reported in Sept-2013, the State has achieved only 30% Utilisation against their Budgetary Targets under RCH & MFP.**

(Rs. in Crore)

Budgetary Target (Committed Liability + PIP Approvals)	**Total Expenditure** Reported up to Sept-2013	**% of Expenditure** against Financial Target
945.83	279.23	30%

[Only RCH & MFP considered.]

(iv) **As on 31.9.2013, Unspent balances under RCH and Mission Flexible pools are as under:**

***High unspent under MFP:**

Pools	**Approved BE(2013-14)**	**Unspent Balance as per SFP Sept-13**	**% of Unspent Over Current Yr. Allocation**
RCH Flexi pool	180.60	102.08	57%
Mission Flexi Pool	204.17	296.92	145%*

Status of Utilization of Funds up to Second Quarter of Sept-2013:

(i) **Utilization under two Major pool:** The reported expenditure against their Budgetary Targets in Second quarter is 34% and 26% in RCH Flexible Pool & Mission Flexible Pool respectively.

(ii) **RCH Flexible Pool:** Component wise Utilization of upto second quarter shows very poor utilization under the PNDT and the training budget heads, and poor utilization under Child Health, ARSH and HR head. The utilization is as per approved PIP of 2013-14 and committed liabilities.

(iii) **Mission Flexible Pool:**Component wise Utilization up to 2nd Qtr. against approved SPIP figures show that utilization has been particularly poor under the AMG, Hospital Strengthening , New Constructions , PRI and procurement budget head being lower than 20% .

Discrepancies under Financial & physical reporting:

Physical Target against the actual not provided by the State under Major Activities i.e. Caesarean Section, Program me Management and all the heads under Mission Flexible Pool except ASHA. Mismatch in reporting of Financial and physical progress is as in table below:

Pool	**Physical Progress**	**Financial Progress**
Compensation for Female Sterilisation Camp	11%	92%
Compensation for Male Sterilisation	4%	11%
NSV Training	6%	3%

Major Statutory Audit issues F.Y. 2011-12:

(i) **Pending Reconciliation of Accounts:** A majority of the districts and block level bank accounts have not been reconciled. As a result the impact of any adjustment arising from such reconciliation on the financial statements could not be ascertained by the Auditor.

(ii) **Diversion of funds:** Frequent diversion funds under current liabilities from one pool to another in the nomenclature of loans. Few of which remained un-adjusted as on 31st March, 2012.

(iii) **Ineffective Concurrent Audit Mechanism:** Reports were not being submitted timely and more stress of compilation of financial statement rather on finding the weakness in internal control, deficiencies on compliance with financial guidelines.

(iv) **Non-Monitoring of Advances:** No age wise analysis of advances and no steps for monitoring or early settlement of advances have been initiated.

(v) **Non-compliance to the Income tax Act:** Non-compliance of many Income Tax issues in some of the districts.

District Health Society Jajpur

Human Resource:

At District Health Society and Block Health Society level, there is no vacant position under Financial and Management i.e. DPM, DAM & DDM at district level and BPM, BAM, BDM at block level.

Maintenance of Records/Books of Accounts & reporting:

a) The district health society is maintaining the books of Accounts in Tally ERP-9 which is not customised version of books of Accounts i.e. Cash Book, Ledger Accounts but the ledger Accounts are not available for our verification for any financial year.

b) The print out of the ledger accounts for the Financial Year 2011-12, 2012-13 & 2013-14 are not kept in record for the verification of the expenditure even the Statutory audit for the FY-2011-12 & 2012-13 is completed

c) The Journal Vouchers for the indirect expenditure are not prepared with the supporting documents for the booking of the indirect expenditure.

d) There is a difference in the opening balance as on 01-04-2013 of Rs.12.50 Lakhs under RCH, MFP, RI & IPPI between the Statutory Audit report of 2013-14 and the DHS Books of Accounts

e) All the DCP's i.e. RNTCP, IDSP, NLEP, NPCB & NVBDCP are maintaining the Cash Book and ledger are in manual and the expenditure are tallied with their books of Accounts.

f) There is good integration between the RCH-II and the DCP's and the reporting to the PMU in 25th of the month.

g) Bank reconciliation are up to Oct-13 of all the accounts under NRHM including DCP's.

h) NVBDCP: There is a difference of Rs.0.67 Lakhs of expenditure reported by the NVBDCP and the Expenditure booked by the DHS in the FMR of District.

i) The District programme Management unit is the custodian of the DHS books of Accounts of RCH-II, MFP, RI & IPPI and DCP, s are kept by their respective accountant or programme staff.

j) NVBDCP: The Bank reconciliation prepared by the Accounts personal is not showing the details of the cheque pending for clear to whom cheque is drawn and for what purpose.

Reporting/Monitoring and utilisation Trending:

a) **Financial Monitoring Report:** The district health society is capturing the physical achievements as well as the financial data in the FMR.[source-FMR-sept-13]

b) **Statement of Fund Position :** The District health society is only reporting the RCH, MFP, RI & IPPI in the Statement of Fund Position and DCP's fund position is not reported by in the Statement of Fund Position though the DCP's SOE having the fund position but the DAM is not compiling the same completely. [source SFP-sept-2013]

c) **Expenditure Reported in FMR are tallied with Books of Accounts:** The expenditure reported by the district in FMR are tallied with their books of Accounts.

Observations in the Financial and the Physical achievements in the FMR-sept-2013:

(i) Physical target is not given for any activity under NRHM in the FMR Sept-2013 in District Jajpur.

(ii) Discrepancies/anomalies between the physical achievements &Financial expenditure are as shown below:

Budget Head	Physical Achievement in %	Financial Achievement in %
JSY Rural	42%	55%
JSY urban	5%	6%
Asha Incentive Rural Area	18%	40%
VHNC People participation	12%	26%
Incentive for Investigator	-	12%
Support cost to family	-	13%

Budget Head	Physical Achievement in %	Financial Achievement in %
member		
JSSK Drugs for normal deliveries	-	15%
JSSK drugs for C-section	-	6%
Diagnostic under JSSK	1%	33%
Free referral transport JSSK	-	54%
Free Diet under JSSK	-	32%
Transportation cost of parents to attending prustikar divas	61%	90%
Female sterilisation Camps	-	61%
Compensation for female sterilisation	16%	27%
Accreditation of PPP IUD insertion Services	-	145%
Training of Staff Nurses in SBA21 days	-	90%
Training of ANMs/LHVs in SBA 21 days	-	637%
Training of Medical officer Safe abortion	-	75%
NSSK Training for SNs	-	79%
Other family planning Training	-	44%
ARSH training for ANM/LHVs	-	70%
ARSH training for AWWs	-	85%
RBSK Training	-	6%
DPMU Mobility support and Filed Visit	-	80%
BPMU/Block Visit	-	271%
Completion of round 2& 3 field training of ASHA	-	21%
ASHA monthly sector meeting	39%	47%
Incentive for mobilization of targeted beneficiaries to VHND	18%	34%
ASHA incentive for mobilising eligible couples opt for permanent	40%	124%

The district may clarify the reason for the expenditure without having any physical achievements.

CPSMS Status: The District has achieved 1854 registration of Bank account against the target of 1910 which is 97 % of the accounts under NRHM at all the level District Level, Block/Taluka level, panchyat Level, between panchyat and village level which is excellent achievement of the District.

Monitoring and supervision of the DPMU units: The monitoring and supervision by the District Accounts Manager and the District Programme Manger are made but the report for the same is not made available to the team for verification nor there is any ATR by the CDMO on the same visit report but the payment under this head is made up to 80% of the budget available.

Utilization Trending:

a) **Utilisation under two Major Pool:** The Utilisation up to Sept-2013 under two major pool RCH & Mission Flexible pool is 39% and 31 % of the Budget approved as Committed liabilities previous year are not included in the approved budget if included then the % of Expenditure will be reduced.
b) **DCP's utilisation:** The utilisation under DCP's is good except NLEP 8% of the approved budget allocation which is very low this needs to improve in the utilisation pace.
c) **Release of funds without deducting the unspent balance as on 1st April from District to CHC PHC:** The district health society has releasing funds to the CHC PHC without deducting the opening balance with the CHC PHC or the other units/agency.
d) **Expenditure under Strengthening of Training Institution without approval and without having any committed liabilities:** The district has made expenditure of Rs.1.30 Lakhs under the Strengthening of Training Institution for which there is no budget approval for this financial year 13-14 and there no committed liabilities reported by the district or State Health Society to Govt of India. So that the expenditure under this head is made without any approval and same may be recovered from the responsible persons.
e) **Negligible utilisation under District Hospital RKS funds :** The district hospital has received the funds under RKS of Rs.5.00 Lakhs on 22-7-2013 out of which the District Hospital has made expenditure only Rs.51,799.00 up to Sept-2013 for repair maintenance of Instrument and refilling of Fire extinguisher and which is only 10% of the approved budget.

f) **Committed Expenditure reported under Hospital Strengthening:** The district has made expenditure of Rs.94.00 Lakhs under this head for which there is no approval in the FY-2012-13 and the district health society has also not reported any committed liabilities under this head for revalidation.

g) **Negligible expenditure under Panchayati Raj Initiative:** The district has reported negligible expenditure of Rs.1.67 lakhs which is 0nly 11 % of the approved PIP

h) **Nil expenditure under PNDT Activities:** The district has reported nil expenditure under PNDT activities against the approved budget for the FY-2013-14.

i) **C-Section Expenditure:** The District has not reported any C-section deliveries under JSY but the JSSK medicine of Rs.9628.00 has been purchased under C-section deliveries.

j) **Female Sterilisation Camp Expenditure:** The district has made expenditure under this head of Rs.24260.00 for which there is no budget up to Second quarter-sept-2013 as per District PIP of 2013-14.

k) **SBA Training of Staff Nurses:** Training of staff nurses in SBA for 21days of 15 staff nurses in four quarter i.e. 2, 2, 8 & 3 respectively @ Rs.12000/ per staff nurses total of Rs.1.80 lakhs budget approved in PIP 2013-14 but the district has booked expenditure of Rs.1.61 lakhs up to 2nd quarter as per PIP maximum expenditure can be booked Rs.48000.00 (4*12000) excess expenditure of Rs. .13 lakhs of the approved budget and there is no physical training information available for verification.

l) **Training of ANMs/LHVs in SBA:** Training of ANMs/LHVs in SBA for 21 days of 4 staff nurses in second quarter @ Rs.12000.00 per staff nurses total of Rs.48000.00 budget approved in PIP but the district has booked expenditure of Rs.3.06 Lakhs in second quarter which is Rs.2.57 Lakhs excess expenditure to the approved budget and there is no physical training information available for verification.

m) **Strengthening of existing Training institutions (SIHFW, ANMTCs) :** The district has make an Expenditure under Strengthening of existing Training institutions (SIHFW, ANMTCs etc) of Rs.1.03 Lakhs against which there is no budget approved in the PIP 2013-14.

n) **ARSH Training for ANMs/LHVs:** The District has booked expenditure of Rs.1.12 Lakhs and the budget is Rs.1.60 lakhs i.e. for 4 batch 2 batch up to Sept & 2 batch in Dec because per 35 ANM

will be trend and work of the field will not be suffer but district has booked expenditure for 3 batch and no physical training details available in the FMR.

o) **ARSH Training for AWWs:** The District has booked expenditure of Rs.3.27 Lakhs and the budget is Rs.3.85 lakhs i.e. for 22 batch 12 batch up to Sept & 10 batch in Dec & March quarter because per 35 AWW will be trend and work of the field will not be suffer but district has booked expenditure for 19 batch and no physical training details available in the FMR.

p) **DPMU Mobility support and Filed Visit:** The district has booked the expenditure of Rs.4.80 Lakhs against the approved budget of Rs.6.00 lakhs and Rs.1.50 lakhs P.M. which is Rs.1.80 lakhs excess against the approved budget and for which there is no visit report submitted by the DPMU staff and ATR of CMO.

q) **Visit of BPMU Staff:** The district has booked expenditure of Rs.13.02 lakhs against the approved budget of Rs.4.80 Lakhs which is Rs.8.22 lakhs excess against the approved budget up to Sept-2013.

r) **Selection & ASHA Training:** The district has booked expenditure of Rs.9775.00 without any budget approved under this head for the FY-2013-14

s) **ASHA incentive for mobilising Expenditure over and above of Approved PIP:** The district has make expenditure of Rs.9.15 lakhs under ASHA incentive for mobilising against the approved budget of Rs.7.40 lakhs which is 247 % of the approved budget.

t) **IEC & BCC Expenditure over and above of Approved PIP:** The district has reported expenditure up to Sept-2013 of 157% of the approved Budget for the FY-2013-14.

u) **Referral Transport & Support Service Expenditure without any approval under PIP:** The district has made expenditure of Rs.0.16 Lakhs & Rs.1.10 Lakhs for which there is no approval under PIP.

High unspent Balance with agencies units : The Statement of fund position advance with agencies as on 30th Sept-2013 ;

(Rs. In Lakhs)

Pool	Total unspent Balance as per SFP 30th Sept-2013	Advances with Agencies(Including Releases to sub	% of Advances

		District & other agencies)	
RCH Flexible pool	**264.15**	**215.66**	**82%**
Mission Flexible Pool	**933.85**	**865.22**	**93%**

The District should monitor the advances with CHC/PHC and other agencies, so that the pace of utilisation can be improved.

OBSERVATIONS

- **HR position in Finance and Accounts:** There is sufficient Finance and Accounts staff at each level and there are no vacancies at any level.
- **Maintenance of Books of Accounts:**
  - **(i) Cash Book:** The Cash Book is maintained but not written up to date.
  - **(ii) Ledger Accounts:** Ledger Accounts maintained but are Incomplete.
  - **(iii) Bank Reconciliation:** The Bank reconciliation Statement is not prepared regularly.
  - **(iv) Cheque Issue Register:** The cheque issue register is not maintained properly.
- **TALLY ERP: ERP 9 software:** The District is not using the customized version of the TALLY but they are using TALLY ERP-7 software at district level.

- **Concurrent Audit:** The Concurrent Auditor at district level is being appointed for the FY-2013-14 but no report has been submitted by the Auditor till date although two quarter report is due.
- **Decreasing Trend of Expenditure:** TheDistrict has reported **e**xpenditure of 74 % utilization of funds for the FY-2012-13 and 39% expenditure up to Sept-2013 for the FY-2013-14.
- **Expenditure Reported Less than 40%:**
  - **(a) Utilization for the FY-2012-13:** Tribal RCH (36.8%), procurement (26.00%), Support services (23.27%), other expenditure under NRHM (19.51%) and Training under immunization (5.58%).
  - **(b) Utilization for the FY-2013-14:**

(i) **RCH Flexible Pool:** Maternal Health (24%), ARSH (13.37%), Human resources (23.11%) and Training (13.13%).

(ii) **Mission Flexible Pool:** Health action plan (29%), PanchyatiRaj (2.05%), Mainstreaming of AYUSH (25.30%) and IEC-BCC NRHM (33.67%).

(iii) **Immunization Component:** RI strengthening project (review meeting, mobility support, outreach services etc) (11.21%), In cold chain maintenance (28.08%) and ASHA incentives (22.62%)

- **Poor Utilization under the JSSK Scheme:** It has been observed that fund utilization are very poor i.e. Borigumma, Dasmantapur, Lamtaput, Mathalput and Sub divisional Hospital and Jeypoor.
- **Poor Utilization Under JSY Scheme:** Out of the approved Budget of the District of Rs 441.71 lakhs Rs. 22.59 lakhs has been released and Rs 127.17 lakhs has been spent till September, 2013.
- **Financial Management Training:** Training to the Finance and Accounts staff occurred in last financial year and for this year also training was given to finance and accounts personnel in April.
- **Payment to JSY Beneficiaries:** The Payment to JSY beneficiaries from this FY, Account Payee cheque. But in most of the cases it is very difficult for Tribal Mother to open Bank Account. In that case the cheques are expired and they are needed to be revalidated. This takes a lot of time.oWhich creates a problem to Beneficiaries/mother to get the cheque in time.
- **Low Utilization Block Level for the FY-2012-13:** It has also been observed from Block wise data, that in some Blocks the expenditure in previous year was very poor, like Kunduli Block, narayanapatanum, Boriguma and Nandapur.
- **District Hospital; Nil Expenditure under Immunization:** It has also been observed that in District Hospital, there was no expenditure incurred under the head of immunization.
- **Low Utilization at Block Level for the FY-2013-14:** The Blocks which has % of utilization is less than 35% are as under: Bandhugaon, Boipariguda, Borigumma, Dasmantpur, Kotpad, Lamtaput, Nandapur, rayanapatna, Rabanguda and Sub Divisional Hospital.

- **Recommendation for improvement of expenditure:** Proper Monitoring Immediate care and initiatives should be taken care for improve of expenditure for above mentioned block.
- **Low Trend of Utilization at Block Level:** It has also been observed that in two blocks the financial utilization is persistently poor like Narayanapatanum, Boriguma and Nandapur in previous year and this financial.

- **Poor Reporting of Expenditure:** It had been observed that infrastructure facilities are good in SDH. But expenditure statement of SDH is not up to the mark.
- **Integration with DCP's:** The integration with DCP's Finance and Accounts staff is required.

VIII. MEDICINE AND TECHNOLOGY

Drugs, equipments and diagnostics

The State has formulated policies for procurement of drugs and equipments. Joint Director (SDMU) holds the authority to procure drugs & equipments through inviting tenders.

State has also developed a web based software application called Odisha Drug Inventory Management System (DIMS) which is available at http://dims.nrhmodisha.in. DIM is a comprehensive online system which gives detailed information about drugs and consumables from central supply unit to the health facility at the end. It features modules like inward stock entry, transfers, special inwards, outward against indent, quality and special cases, etc. It has also a feature of displaying 'near expiry' notifications 3 months prior to the expiry dates of medicine stocks so that the stocks nearing expiry dates might be expeditiously utilised on priority.

Drug repository at CHC Jajpur Road

Trained personnel are available at Jajpur District Drug Store to operate the system but at the Koraput District Drug Warehouse the data entry operator is operating the software and at the Block level the BDMs are being used for data entry in DIMS. This results in duplication of efforts – first the pharmacist makes a manual entry of issue of drugs and then the BDM has to enter the data in DIMS. It would be more appropriate to train the pharmacist in using DIMS and provide him the necessary infrastructure (computer with internet connection) so that he may update the records directly in the DIMS.

Common EDLs have been prepared for all the facilities. However, efforts are afoot to prepare separate EDLs for each type of facility. EDLs and status of availability of drugs are displayed in most of the facilities in Jajpur District.

Procurement

Most of the drugs and equipments are procured centrally. However, District Drug Stores have been authorised to procure some drugs as per requirement. For procurement of drugs by District Drug Store, tender is widely published and successful supplier is identified as per prescribed processes. Thus, the system of procurement of drugs is transparent and complies to the prescribed rules.

The District Drug Store issues drugs to the Block CHCs which use these drugs and issue them to the PHCs and Sub Centres under their jurisdiction.

The availability of drugs at District is monitored using Drug Information Management System. The system gives information as per the expiry data and date of procurement of the drug so that the earlier expiring and earlier procured drugs can be used or issued earlier using FEFO and FIFO systems respectively.

Storage & Supply

Normally the drugs are indented before their stocks come to an end. DIMS helps in assessing the availability of drugs at any point of time. It takes about 15 days for the State to supply indented drugs to the District Drug Store. The District Drug Store normally issues drugs to Block CHCs on the day CHCs indent the drugs and Block CHCs, in turn, issue drugs to facilities under their jurisdiction on the same day as the indent is made. Thus, uninterrupted drug supply responsive to utilization patterns is mostly achieved.

With increasing availability of drugs at various levels, there is need to expand the storage capacities of the drug stores. This may be achieved by constructing new drug stores and / or installing more racks in the drug stores. This will help in better management of drugs.

There seems to be no similar system in place for AYUSH drugs. The State may consider incorporating a module in DIMS for AYUSH drugs. This will enable uninterrupted supply responsive to utilisation pattern of AYUSH drugs.

The State is implementing a web based software application called Reproductive Health Commodities Logistics Management Information System (RHCLMIS). This system deals with collection, processing and reporting of logistics data to ensure tracking of the entire supply chain which includes assessing status of supplies in the pipeline. RHCLMIS enables indent, issue, receipt, stock updation and item and batch wise information of RCH items through SMS and URL www.rhclmisodisha.com. However, the system is in its initial stage and its use is not wide. When fully functional, this system will facilitate in reducing supply imbalances and in regulating the flow of family planning supplies to the end users. It is claimed by the State that such a system is being used for the first time in the country for family planning programme.

ProMIS is not operational at State and District level. There seems to be no system in place for monitoring the availability and utilisation of available equipments. This can be remedied by

incorporating modules in DIMS which may highlight the health facilities where any equipment is not available according to the prescribed norms. This module may also highlight the available equipments which are lying idle for more than a specified period so that the reasons of non-utilisation of such equipments could be investigated. There is a team at State level (SEMU) for maintenance of equipments.

"Trained personnel are available at District Drug Store to operate the Odisha Drug Inventory Management System (DIMS). However, at the Block level the BDMs are being used for data entry in DIMS. This results in duplication of efforts – first the pharmacist makes a manual entry of issue of drugs and then the BDM has to enter the data in DIMS. It would be more appropriate to train the pharmacist in using DIMS and provide him / her the necessary infrastructure so that he / she may update the records directly in the DIMS.

The State is implementing software applications like Odisha Drug Inventory Management System (DIMS), Reproductive Health Commodities Logistics Management Information System (RHCLMIS), Drug Testing and Data Management System, e-Blood Bank, e-Swasthya Nirman, NRC Tracker and SNCU Tracker. These software applications need to be inter-operable so that integration among them and HMIS and MCTS may be effected as per requirement."

The following text will replace the AYUSH para (i.e., para 4) under Storage & Supply heading:

"AYUSH drugs are not included in the DIMS. Further, AYUSH doctors do not have pharmacists. The AYUSH drugs may be included in DIMS and pharmacist may be entrusted the responsibility of dispensing AYUSH drugs as well."

Quality Assurance

The State Drugs Testing and Research Laboratory (SDT & RL) is responsible for testing and analysing statutory drug samples under the provisions of Drugs and Cosmetics Act 1940 and Rules thereunder to assess the quality of drugs. The State is implementing Drug Testing and Data Management System which is a web based software application for facilitating the entire process of drug testing at laboratory and managing the data flow generated from the testing process. The system enables instant registration of the sample; category-wise segregation of samples in terms of dosage; due

attention to short expiry samples for timely reporting by an alert mechanism; standardization of procedure; tracking of sample status and enhanced efficiency and transparency of laboratory and its human resources.

- A free medicine for all diseases has been initiated by the state. However, it is not visible at the facility level.
- The state also has a "Jan Aushadhi" scheme under which medicines are available at discounted prices through stores situated within the facilities.
- While a dispensary for free medicines exists within the DH, there is a limited stock of drugs there. A pharmacy/ store for paid medicines (@ 10% discount) exists at the facility.
- The essential drug list was displayed in some facilities. However, the location was not close to the OPD/IPD/pharmacy. Plus, the stock of medicines was not specified on the same.
- The record keeping at dispensaries, especially related to daily utilisation was either non-existent or very poor.
- There is no defined system for regular indent of drugs to the dispensary.
- The state is proposing to set up Orissa Medical Corporation on the lines of TN Medical corporation for procurement of drugs at the state level.

IX. NATIONAL URBAN HEALTH MISSION

NUHM aims to improve the health status of the urban population in general, particularly that of the poor and other disadvantaged sections. This could be achieved through facilitating equitable access to quality health care, through a revamped primary public health care system, targeted outreach services and involvement of the community & urban local bodies.

Institutional Arrangements and Preparedness for NUHM

The Government has issued G.Os directing the districts that following arrangements are envisaged in terms of institutional set up for the Mission. The notifications issued in the month of August stated the following:

1. The State Health Mission & State Health Society will look after the NRHM & NUHM under National Health Mission.
2. The Mission Director will been re-designated as Mission Director, National Health Mission and will look after both the Rural and Urban Health Missions.
3. Additional Mission Director, NUHM will be appointed in the rank of Joint Secretary.
4. The Chairperson of concerned cities/ ULBs will be included as a member of the District Health Mission and Executive Officer, Municipality as a member of the District Health Society.
5. The District Health Mission and District Health Society will look after both NRHM and NUHM.
6. The City Health Mission, City Health society will be established in 4 cities i.e Bhubaneswar, Berhampur, Cuttack and Rourkela.
7. At State level, 'Urban Health Cell' will be established to work the with following manpower at SPMU, NHM, Odisha:
    - State Programme Manager, Urban Health
    - Consultant, Convergence and Community Processes
    - Data Manager,
    - Accounts Manager

    Till positioning of the above manpower, PFI-HUP will provide manpower and continue technical support to the Urban Health cell.
8. City programme Management Unit will be established in 4 cities i.e Bhubaneswar, Cuttack, Rourkela and Berhampur will have the following manpower:
    - City programme Manager
    - City Data Manager
    - City Accounts Manager
9. One Assistant Programme Manager, Urban Health will be placed at existing DPMU, NRHM in 5 District Headquarters namely, Balasore, Baripada, Bhadrak, Puri and Sambalpur and having more than one lakh population.
10. In the first phase, State plans to extend the Mission to 6 towns/cities this financial year. These target cities are **Bhubaneswar, Cuttack, Berhampur, Rourkela, Balasore& Jeypore**.

Existing Health Programmes in Urban Areas:

Various schemes, programs implemented in the state for Urban areas and their objectives are as follows:

Schemes and Programs	Aims / Objectives
Housing and Urban Development Department	
Jawaharlal Nehru National Urban Renewal Mission (JnNURM)	Integrated planned development in selected cities which includes Basic Services to Urban Poor. The main objective of the scheme is to have holistic slum development by providing adequate shelter and basic infrastructure facilities to the slum dwellers.
Urban Infrastructure Development Schemes for small and Medium Towns (UIDSSMT)	Aims to improve the infrastructure in towns and cities which includes water supply projects Implemented by Public Health Engineering Organization (PHEO).
Integrated Housing and Slum Development Program (IHSDP)	Focuses on improving living conditions of the urban poor residing in slums by providing housing and basic infrastructure like water supply and sewerage.
Rajiv Awas Yojana (RAY)	For the slum dwellers and the urban poor for a Slum Free Odisha through tackling the problems of slum in a definite manner by availing the basic amenities to them as in the rest of town / cities.
City Sanitation Plan (CSP)	CSPs are formulated in eight cities of the state to universal access, safe management of human excreta, including safe confinement, treatment, disposal and associated hygiene related practices. It emphasizes on physical infrastructure and on behavior change outcomes, proper usage, institutional reorientation etc.
Package Sewerage Treatment Plant (STP) in District Head Quarter Hospitals	Making hospital premises healthy and pollution free it has been decided to install package sewerage treatment plants in the District Head Quarter Hospitals of all 30 districts.
Integrated Low Cost Sanitation (ILCS)	Designed to cover the economically weaker section of the society. It constructs on convert low cost sanitary units through sanitary two pits pour flush latrines with superstructures.
Women and Child Development Department[4]	
Urban Integrated Child Development Schemes (ICDS)	ICDS is seeking to provide an integrated package of services in a convergent manner for the holistic development of the child. Each ICDS project is headed by a CDPO further divided into 5-6

[4] Annual Activity Report 2011-12, Women and Child Development Department

	Sectors. Each sector is headed by supervisors who oversee the work of 20-25 AWCs. In Odisha there are 20 Urban ICDS Projects. There are total 1981 AWCs and 132 mini AWCs in Urban Odisha.
Mamta (State sponsored scheme)	Mamta is a conditional cash transfer maternity benefit schemes. The beneficiary gets a total incentive of Rs. 5000/- in four installments, subject to the fulfillment of specific conditions. Payment is made by e-transfer from CDPO to the beneficiary account.

The Urban Slum Health Centre (USHC) located in the Key Focus Area(KFA) for deprived slum population(migrant laborers, street children, daily laborers, rickshaw pullers, homeless persons, children, pregnant women etc.) are being implemented by the NGOs under PPP in the State. Further 108 ambulance services, diet, security, cleanliness services are outsources to the private agencies in the urban areas.

Under NUHM emphasis will be on establishing synergy with other programs like JnNURM, RAY, UIDSSMT, SJSRY and ICDS to optimise the outcome. Convergence with various programs will include sharing of relevant information, joint planning, implementation, monitoring of the program, capacity building of officials of allied departments and ULBs on urban health, water, sanitation and nutrition etc.

Various institutions and forum like State Level Coordination Committee (SLCC), City Level Coordination Committee (CLCC) and Ward Co-ordination Committee/ Ward Swasthya Samiti (WSS) will be used for

Convergence:

To facilitate convergence among interrelated sectors, various convergent forums have been formulated. State Level Coordination Committee, brings together department of HUD, H & FW and WCD, etc. Further, City Level Coordination Committee (CLCC) is proposed for target cities to address local issues. This year, Ward Level Coordination Committee (WLCC) or WKS is proposed in all 243 wards of six target cities and towns with representation from H & FW, W& CD, S & ME, H & UD, civil society and ULBs. For community level convergent action, MAS (Mahila Arogya Samiti) has been proposed.

Manpower:

- One ASHA shall be selected for an area having more than 1500 slum population or 300 Households.
- Any slum area having less than 100 households will be tagged with nearby slum for ASHA selection and an additional ASHA would be selected if the population is more than 1500 or slum having more than 300 households.
- **Mahila Arogya Samiti (MAS):** It is a forum of Women Group of the slums who desire to contribute to well-being of the community with a sense of social commitment and leadership skills to look after their health and its determinants in holistic manner. MAS will be formed covering 50-100 slum households. The size of members in the group would be 11-15 depending on the slums. 176 MAS have already been formed in 168 slums of Bhubaneswar city with the support of HUP-PFI, hence the experience HUP-PFI will be utilized in formation and strengthening of MAS in other part of the city.

There are 37 Urban Health Centers (UHCs) functional in the state. UHCs are operating with the mandate of providing primary health service delivery with the support of NGOs in slums since 2007. UHCs provide OPD, counseling and Referral services in the slum areas. Community mobilization, promotion of health seeking behavior, awareness about health schemes & entitlements through outreach activities are done with the help of Community Level Link Volunteers.

Odisha Health & family Welfare Department has also partnered with Bhubaneswar Municipal Corporation for management of urban slum health projects in Bhubaneswar city.

1,80,893 community bed nets have also been impregnated in urban slum areas under the project.

Jajpur CHC covered urban (municipality) area. The ANMs at the facility shared the issues of working in urban area, such as

- Covering large population of over 10,000
- Having no assistance for immunisation – no AWW, no male health worker, no ASHA.
- No Anganwadi center / fixed place for Immunisation

Accredited Social Health Activists (ASHA) have already been engaged in Bhubaneswar, Cuttack, Balasore and Rourkela cities .

X. GOVERNANCE AND MANAGEMENT

Programme management structures are well in place at the state, district and block level in the form of SPMU, DPMU and BPMU respectively. State Programme Management Unit is adequately staffed with 151 staff. Currently, there are 12% vacant posts at SPMU, 16% vacant posts at DPMUs.

SPMU houses various thematic cells with Management Consultants supporting planning, implementation and monitoring of thematic programmes at state and district levels. They also provide inputs into the implementation and monitoring of district programme interventions as and when required.

There is strong convergence between the Programme Management Unit and the Health Directorate. Mission Director (heading the SPMU) work together in coherence with all Directorate officials, and report to Commissioner cum Secretary.

On the lines of State Health Mission, District Health Missions have been established in the state since 2005. District Health Mission is headed by the Chairperson, ZilaParishad. District Magistrate acts as the co-chair and Chief Medical Officer acts as the Mission Director at the district level. In order to support District Health Mission, every district has an integrated District Health Society (DHS) which merges within itself all existing societies as vertical support structures for different national and state health programmes. The DHS is responsible for planning and managing all health and family welfare programmes in the district. DHS acts as the addition to District Administration's capacity, particularly for planning, budgeting and budget analysis, etc. DHS provides a platform where Zila Parishad, Urban Local Bodies, District Health Administration and District Programme Managers under NRHM get together to decide on Health Issues of the district and delineate their roles and responsibilities.

Chief District Medical Officer (CDMO) is the in-charge of releasing salaries of the staff getting monthly salary less than Rs. 20,000 within the district. For rest of the staff (having monthly salary of more than Rs. 20,000), the authority to release salary lies with the MD, NRHM. CDMO also holds

the authority for need based recruitment of all categories of Nursing and Paramedical staff under NRHM or Adhoc basis for his/her district. Recruitment of Doctors accrues at the state level only.

Devolution of Financial powers: Financial powers have been devolved to the level of DPMUs. District Programme Managers & District Accounts Managers are empowered for financial decision making and can sanction Programme Management budget (up to Rs 20,000 at a time).

Performance appraisal: Increment of 5% of the monthly salary is given to the Programme Management Unit and the Clinical staff after completion of every term of 11 months. . At the state level, the reporting officer appraises performance of the employees and recommends for the incentives. To calculate and release performance incentives at the district and block level, a composite index system comprising of 300 pt. scorecard has been adopted with physical and financial parameters as the critical process/outcome indicators. A composite field monitoring team of technical and management experts has also been identified for the purpose. The incentives can go maximum up to 20% of the base payment which can be withheld with the discretion of MO I/c in case of BPMU staff and CDMO in case of DPMU.

Supportive Supervision is done at various levels in the state, viz.

a) **District Nodal Officers** *(at the rank of Addl. Directors)* looking after 1 or 2 districts, visit on fortnightly basis with the focus on resolving administrative issues for smooth implementation of the programme.

b) **Domain Specialists** *(Programme Officers for different thematic areas)* pay supervisory visits at least twice a month to address the identified Quality and Operationalization issues in their domains.

c) **Integrated Monitoring Teams** constitute Consultants with cross domain specializations (Programme, Finance, MIS) from SPMU which visit on monthly basis. Each team has been assigned 3-4 districts. The agenda of the visit remains to be management support in the areas of Programme, Finance & MIS for strengthening programme implementation.

Overall coordination of all monitoring teams is overseen by the Consultants from the SPMU, who provide necessary support for the field visits, prepare consolidated ***district observation-cum-action taken reports*** and do follow ups with all directorates for necessary administrative reforms, if required any.

Rationalization committee, formed in December 2011, has reviewed staff positions under NRHM vis-à-vis the Job responsibilities and deliverables, and the scope of merging the posts into Govt. of Odisha (GoO). Committee has recommended for: a) Identification of similar positions under GoO for relocation of staff; b) creation of new posts under the upcoming Directorate of Public Health thereby creating avenues for absorption of Programme Officials.

The State Program Management Unit and 30 District Program Management Units have been established in the state with 29 District Program Managers. However, major difference between the number of Block Program Management Units and number of Block Program Managers in position is 16. BPMUs are the first stage where the Sub-Centre and villages' demands are consolidated. The unavailability of staff at this level can affect the process of decentralization adversely.

1. Statement showing Allocation, Release and Expenditure since Inception:

(Rs. in Crore)

Year	Allocation	Release	Expenditure
2005-06	**198.29**	**206.43**	**135.39**
2006-07	**284.88**	**220.18**	**199.19**
2007-08	**383.52**	**387.16**	**295.07**
2008-09	**392.88**	**388.05**	**334.05**
2009-10	**457.57**	**470.18**	**646.74**
2010-11	**494.09**	**549.44**	**664.37**
2011-12	**568.53**	**693.89**	**727.75**
2012-13	**653.52**	**534.49**	**715.46**
2013-14	**629.98**	**434.65**	**375.97***
Total	**4063.26**	**3884.47**	**4093.99**

Note: Releases are Central releases only; however the expenditure is inclusive of Central Grants and State Share.

'* Expenditure for 2013-14 is updated up to 30th Sept, 2013.[source SFP & SFP Sept-13]

F. RECOMMENDATIONS

Short Term

Monitoring Quality of Skill based Training:

- Quality of clinical skill based training, especially SBA, BEmOC, IUCD and PPIUCD insertions should be monitored so that the trainees are able to timely identify and refer the risks during labour at various stages.
- Quality of NSSK training of ANMs also needs to be monitored so as to ensure that the ANMs are able to provide Essential Newborn care services at NBCCs

Training and Post Training follow up

- The MOs of the PHCs should be trained in Minilap and MTP for improving the availability and accessibility of RMNCH+A services within closer reach in the periphery than the higher facilities. ANMs at PHCs and Subcentres also need to be trained in IUCD insertion.
- Post training follow-up of the trained service providers at the place of posting to ensure that the taught skills are being utilized appropriately.
- The State should ensure performance monitoring of the trained providers for PPIUCD at DH
- The State and district level trainers should closely monitor and identify bottlenecks appropriately and take timely action for mid-course corrections in terms of improving their skills or the supply position for effective service delivery.

Supportive Supervision needs to be done at all levels of care (with the help of checklist), more so at the DPs and VHNDs for strengthening of quality provision of Antenatal, Intranatal, Newborn and Postpartum care as despite having trained providers and adequate supplies, either some services like PPIUCD insertion are not performed or quality of care needs improvement.

Line-listing of severe anemia- Though the State has taken initiatives following the recommendation of the previous CRM for line-listing of severe anemia, yet adequate monitoring and follow-up is required in terms of improving the coverage of line-listing of anemia cases during pregnancy in facility as well as during VHNDs.

State needs to ensure PPIUCD trainings are going as per the plan, and **actively initiate and monitor the PPIUCD services** on facilities where trained service providers are available in motivating the clients.

48 hours Stay during Postpartum period needs to be utilized appropriately by YASHODAs, Staff Nurses and other service providers for providing **counselling services on acceptance of contraception** apart from the counselling done for breastfeeding and nutrition.

The citizen's charter at the Subcentres should include at least **two days fixed for IUCD services** and ANMs posted at Subcentres should be trained in interval IUCD.

Appointment of RMNCH+A Counsellors: Vacancies of RMNCH+A Counsellors need to be filled up immediately and their services should be monitored for the promotion of PPFP/PPIUCD services.

Strengthening of IEC:

- State needs to expedite the printing and display of IEC material on: a) *'ASHA se mango'* to promote spacing through ASHA contraceptive delivery scheme; b) Sterilisation and IUCD advertisements outside the facilities could serve wherever such services are available
- IEC activities on JSSK entitlements should specifically emphasize on provision of free referral transport services for sick infants under the scheme.
- IEC material for PPIUCD given to the State (during the Workshop) needs to be disseminated to all health facilities in all districts.

Maternal Death Review and use of HMIS Data: Maternal Death review should be validated by the technical competent staff and the underlying social causes must also be recorded. Suggestive measures specific to each maternal death should be provided and followed up.

Expedite **construction of MCH wing** at the Jajpur and Koraput District Hospitals since the no progress over the construction has been seen over the last two years.

Improve **EmOC services at CHCs and PHCs** so as to shift the delivery caseloads from DH Jajpur to peripheral facilities.

Scaling up of BSUs- All the higher facilities conducting C-sections need to be upgraded with BSUs on priority. There are still 319 FRUs of the total 385 FRUs which don't have functional BSUs.

ANMs should be sensitized to include **women from the migrant populations** also to provide for ANC services.

Ambit of JSY scheme to avail benefits should be extended to Govt. Medical Colleges as well since many referral cases of pregnant mothers get devoid of the JSY benefits there and end up spending out-of-pocket expenditure.

The State should conduct a facility wise gap analysis and plug in the gaps in infrastructure, manpower and equipment to fully functionalize these facilities to reduce overcrowding at the DH Koraput. The 7 ANMs posted at the DH Koraput for outreach services at the PPC could be rationally deployed to such PHCs along with staff quarters in case of remote areas to ensure retention of manpower.

State should focus on **building residential quarters** for Service Providers at those facilities on priority where retention of Human Resources is an issue. Currently only a limited number of quarters are available in the district Jajpur and Koraput even at the higher facilities.

State needs to **increase the sanctioned strength** of MPWs, SNs, Specialists, Doctors and LTs since the current sanctioned strengths are way below the IPHS requirements.

State should conduct a **gap analysis of all its CHCs and designated FRUs** to understand the factors and deficiencies that inhibit their functioning as an delivery point and FRU. The State should prioritize plugging these gaps such as availability of HR, blood storage unit to focus on making these functional delivery points and FRUs to provide C-section services.

The vacant posts of Data Mangers, DEOs, Epidemiologists and Microbiologists may be filled up under IDSP and equipment such as Autoclave, Hot air oven, deep freezer etc. should be procured to optimize the functioning of all Public Health Lab Activities.

Need to fill the vacancies of District Vector Borne Disease Control Officers, Lab technicians, Multi-Purpose Workers in Subcentres and several vacancies in State Leprosy Unit. Reorientation of ASHA and Health workers on use of bivalent RDT, reorientation of Lab technician on microscopy should be conducted.

Under NPCB, It issuggested that in all the OPD complexes, waiting room for OPD patients and dark room for refraction may be provided. 31 Eye Surgeon posts are vacant and should be filled up.

Under NPPCF, Extensive IEC & BCC activity need to be carried out and training of MOs & Paramedical Workers regarding signs and symptoms of fluorosis is needed for the success of the programme.

Long Term

Specialist cadre may be introduced and separate career progression pathways for specialists may be built so as to encourage specialists in joining the services

State should take immediate steps to improve the **Residential accommodation facilities**, in a phased manner, providing the same in the difficult and very difficult areas to ensure availability and retention of HR in these areas.

Considering the 'Time to care' criterion, the shortfall of health facilities would be higher in Koraput. Thus the State should **consider relaxing the population norms** for construction of health facilities especially so in the case of special districts with sparse population.

It is essential that **integration between NRHM Mission Directorate, FW Directorate and SIHFW** be brought about for monitoring and implementation, especially for the Family Planning Programme as currently there is disconnect in reporting to GOI with regard to training as well as service delivery.

Initiate the process of increasing the capacity in terms of infrastructure and HR of Jajpur road CHC to prepare for increasing caseloads due to increasing industrialization. *(Action required at the District level)*

The State should in long term, after operationalizing its CHCs and FRUs, focus **on improving the proportion** of **PHCs acting as delivery points**

TB notification should be implemented specially to involve Private sectors. Ban of serology test in private sectors should be ensured.

It is suggested that all vacant posts including the post sanctioned by GoI may be filled up on priority basis. In the high endemic blocks of leprosy, ICDD may be done frequently.

G. Positives and Challenges

POSITIVES

- Timely disbursement of the incentives is directly done into the bank accounts of ASHAs on 10th of every month through an e-transfer system.
- There is a mechanism of awarding the best performing ASHAs at District and Block level.
- Gradation of blocks (Type A, B, C, D) based on the performance of ASHAs has been done. Best performing ASHAs are selected as ASHA SATHIs to supervise and monitor the work of ASHAs in poor performing blocks. These ASHA SATHIs also get preference in admission into ANM and GNM courses.
- Doorstep delivery of contraceptives and motivation of women for IUCD insertion by ASHAs have been a hit in expanding reach of Family Planning services.
- Odisha has launched e-Blood bank facility, a first of its kind in the country. This web enabled system enables electronic monitoring of blood collection, testing, storage, usage and disposal in the 59 govt. blood banks across the state. It also allows the users to get blood group wise stock availability status in the Blood Banks.
- AYUSH MOs, apart from administering AYUSH OPDs are also handling Adolescent Family Health Clinics (AFHCs). They have been trained in SBA and ARSH training, and are involved in the outreach activities too under NRHM.
- Web enabled application called *"Nikshay"* has been launched with the object to improve TB surveillance in both public and private sector in the state. This application digitizes patient data from the public and private sector facilities on notification.
- State has undertaken several measures for Dengue control, viz. Massive IEC campaign called "Malaria Dengue Diarrhoea"; Regular multi stakeholder meetings; Involvement of District & Block Administration staff; deployment of volunteers in awareness, active surveillance & eliminating breeding sources; training of master trainers in Dengue vulnerable districts.
- Microfilaria Rate (Mf Rate) has been showing consistent decline from 2.5 in 2004 to 0.4 in 2011 which may be attributed to the increased compliance to drug consumption in the state over the last years.

- "Mo-Mashari" *(my mosquito net)* scheme for pregnant women and students and inmates in tribal residential schools and NidhiRath campaign for creation of community awareness about benefits of using mosquito nets has given positive impact on the Malaria control programme.

CHALLENGES

- Construction of MCH wing at DH Jajpur and Koraput has been sanctioned for over the last 2 years but no progress was seen.
- Many of the Subcentres (3118) are working in the rented buildings where an ANM is not provided with the residential accommodation or if provided –lacks basic amenities like Toilet, bathroom etc.
- Low uptake of PPIUCD was seen in Jajpur and NIL uptake was seen in Koraput despite the adequate availability of trained manpower.
- Currently, quite less proportion of PHCs (11%) is acting as the delivery points despite the availability of considerable number of trained manpower in the state. This leads to large number of even the normal delivery cases getting skewed to the higher facilities making them crowded.
- Abortion services are not available at the PHCs. Only the District Hospitals and some select CHCs are providing the Comprehensive Abortion Care services.
- In Koraput, 14 out of 17 maternal deaths had Anemia as the underlying cause. This raises the need of quality monitoring of ANC services by DQAC in the district.
- Low awareness was observed on entitlement of free referral transport services for the sick infants under JSSK scheme.
- Residential accommodation facilities for staff were not available even at the higher facilities like DH and CHC-FRUs in Jajpur and Koraput.
- There is a huge shortfall of staff in the categories of MPW (M), Staff Nurses, Radiographers, and Specialists with respect to population based IPHS norms. State needs to revise the number of sanctioned posts to catch up with the rising requirements.

- There is no Specialist cadre in the state due to which the specialists, at times, get the postings not relevant to their specialist skills.
- Huge dearth of MPWs in the Sub-centers which need serious consideration for smooth function of malaria programme and other disease control programmes.
- Lack of counseling support given to the women who are unable to follow IYCF guidelines such as women with “not enough milk”.
- Monitoring &Supervision visits are undertaken by District Accounts Manager and District Programme Manager but neither the reports were available for verification nor was there any ATR by CDMO on the same visits. This is despite the fact that payment under this head is made up to 80% of the budget available.
- Maternal Death review wasn’t found done as per standards in Districts Jajpur and Koraput. The underlying social cause was found missing for most of the cases and the suggestive measures undertaken as recorded were also not befitting the case scenarios.