



NRHM

COMMON REVIEW MISSION

November 2007

National Rural Health Mission
Ministry of Health & Family Welfare
Government of India
Nirman Bhawan, New Delhi.

Contents

	Title	Page No.
1.	Executive Summary	<i>i to ix</i>
2.	Common Review Mission Report	1 to 78
3.	Recommendations	79 to 96
4.	Analysis of Progress State-wise on 24 Para-meters	97 to 144
5.	States Summary Reports	145 to 158

EXECUTIVE SUMMARY

The National Rural Health Mission is mandated to bring about an “architectural correction” of the public health system so as to make it “equitable, affordable and effective”, with an enhanced capacity to absorb the increasing outlay on health. Such architectural correction is organized around five pillars, each of which is made up of a number of overlapping core strategies that are envisaged to eventually impact on 14 critical areas of concern. These are considered the essential cornerstones of an effective health service system.

This Common Review Mission (CRM) was set up as part of the Mission Steering Group’s mandate of review and concurrent evaluation. It conducted its appraisal in November 2007, 16 months after NRHM got final cabinet approval in July 2006 and the actual processes started up. The terms of reference set out the task of the NRHM CRM as, assessing the progress of the NRHM on 24 parameters, which relate to the core strategies and the central areas of concern. Based on these, the CRM was mandated to identify the constraints being faced and to make recommendations on the areas that need strengthening and course correction. The Review Mission was made up of 52 members- central and state health government officials and public health experts. After a one-day orientation briefing by the various divisions at the ministry in Delhi, the team divided into 13 groups and left for the selected states: Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal.

At the state level, there was an initial one-day briefing, after which the team divided into two groups and each went to visit one or two districts. The district visits lasted two to three days and the appraisal was done using a protocol that indicated the minimum number of each type of facility (and villages) that should be visited and the thematic areas that must be covered in the inquiry. Upon returning to the state headquarters, there was an interaction with civil society groups, after which the reports were finalised. Finally, the common review mission teams presented their observations and findings to the host state department heads and NRHM facilitation teams for their feedback.

Key Findings

General Patterns

- a. There is a general trend towards strengthening the services provided by the public health sector, with increasing access and improvements in quality, reflected in increasing utilization of the facilities. This increased utilization can be attributed to the overall increased attention and investment that the public health system is getting, the increase in institutional deliveries consequent to the Janani Suraksha Yojana, the filling up of vacancies, the untied funds being used to fill gaps in infrastructure and maintenance, and the improved availability of diagnostic services and drugs. However, there is still much to be done to call them 'fully functional' as per the Indian Public Health Standards(IPHS), and even these improvements are varied, with peripheral facilities receiving showing less changes while the district hospitals developed relatively more.
- b. There is a varied performance of the NRHM across states. Different programme components have taken off at different rates. States that had better baselines and that had similar programmes in place have been quick to take off.
- c. An increase in attention to the functioning of public health systems, the fact that the systems functionality in states and their bottlenecks are now receiving attention is a major contribution of the NRHM framework. A number of innovative strategies and measures are emerging locally in an effort by the state personnel to meet the overall objectives of NRHM.
- d. An increase in public investment by the center has helped in many ways. However the system continues to lag behind in fund utilization and there are challenges in both programme management and governance to be overcome before the capacities to absorb more funds and deliver better services are in place.
- e. As a rule the directions in which NRHM is proceeding as visible at the district level seem appropriate and welcome – but the scale of roll out and the rate of roll out seem inadequate. Part of this is due to administrative constraints and perhaps issues of governance. Part of this is due to the time it takes to overcome inadequacies in human resources for health that

- results from a lack of planned growth in this sector. And part of it is due to the poor investment in public health services in the recent past. In many areas therefore the initiatives taken under NRHM would take time to manifest as improvements in service delivery and in health status.
- f. Whilst the impact of the NRHM strategies could be observed and commented upon by the CRM in terms of the structural and functional aspects of the health care facilities and the management processes, it was not possible in such a review process to assess outcomes in terms of MMR, IMR, fertility rates or health status indicators. At any rate on theoretical grounds it is too early to expect changes in these parameters.

Performance of NRHM Strategies

- a. The ASHA programme is one major component on the ground. By allowing a space for communities to actively participate and by creating awareness and facilitating people's access to services, the ASHA programme has received a wide welcome from communities. However this programme requires considerable facilitation and much more attention to strengthening of key processes to sustain.
- b. The Janani Suraksha Yojana (JSY) is another visible and welcome component, but is challenged by the slow rate of growth in infrastructure and personnel to meet the demand generated by the shift to institutional deliveries.
- c. Untied funds have been another successful component at all levels, from the sub-centre to district hospital, empowering local health care providers and closing many critical gaps in service delivery. As more guidelines evolve and confidence to spend increases, rate of utilization of these funds would increase with more visible outcomes.
- d. Hospital development societies (Rogan Kalyan Samitis- RKS) have been formed in most states and are with the provision of untied funds to them are acting as enablers of facility development. However, their role has been limited by the perception of RKS as an alternative financing device and the consequent emphasis on user fees as cost recovery. Composition

of the RKS and processes of functioning are also not always conducive to community participation.

- e. In most states *panchayat* standing committee members are involved in the District Health and Family Welfare Societies, Rogi Kalyan Samiti, the Village Health and Sanitation Committee (VHSC), and selection of ASHAs (as well as certification of SC/ST/BPL families for JSY). Actual devolution of facilities to *panchayats* is a feature, only in West Bengal, Kerala and Nagaland. In states like Tripura and Tamil Nadu, the *panchayat's* role was found to be proactive and very valuable. Progress on VHSCs becoming functional has been slow, due to problems of states taking time to set up the enabling framework.
- f. Most NGOs while being appreciative of the NRHM maintained that the scope for NGO participation was very limited. In particular there was keenness on coordinating with the ASHA programme and other community processes, on assistance in ANM and *dai* training, and in BCC work. On the other hand there was widespread dissatisfaction in government divisions with the NGOs performance.
- g. The IPHS standards have been widely circulated and are acting as a valuable bench mark for facilitating states to reach desirable levels of both infrastructure and human resource provision. One immediate benefit has been the attention given to improving the nursing personnel deployed, and in states where this has actually been achievable, the outcomes are immediately visible. However often IPHS has been read only as a prescription of inputs, and not as a prescription of outputs or as a service delivery guarantee. A focus on ensuring appropriate quantity and quality of service delivery outcomes to match any given level of inputs is not in place. In some states notably Tripura there is a conscious effort to reach the service guarantees specified and to convey this to the public.
- h. NRHM strategies and the IPHS have led to filling up of existing posts and the creation of new posts. However, shortages continue due to a lack of availability of sufficient nursing personnel and specialists. One priority is therefore the expansion of nursing and medical education in areas where

human resource is scarce. In parallel multi-skilling of nurses as practitioners, and medical officers for specialist tasks is an additional strategy that some states have put in their PIPs but is yet to be operationalised. Poor performance due to lack of accountability was also noted.

- i. Emergency ambulance services as public-private/public-NGO partnerships are doing well in many states. In Andhra, Tamil Nadu and Gujarat with a toll free telephone number and a central control room they have had remarkable success.
- j. Setting up of integrated State and District Health Societies with representation of all relevant departments is a step forward towards integration, and one that is found in all states. However complete integration between different divisions of the health department on financial management, monitoring and use of human resources is slow.
- k. One major development of the NRHM is district level planning, which is complete or near complete in almost all states. Despite a mixed picture in terms of quality, it has brought various data together and made a basic skeleton of a plan which can be subsequently revised and built upon. However, the plans are yet to become documents that inform local health service development, programme implementation or community monitoring. Village plans prepared based on household health data and with involvement of PRIs are still an exception.
- l. Progress has been good in the setting up of district and state Programme Management Units. The PMU has brought management skills on contractual terms into the health team, but the integration of PMU staff with the rest of the system still remains a challenge. This effort needs to be examined against and coordinated with the techno-managerial role played by the district programme officers. Coordination between the directorates and the programme management unit in the state level also remains a challenge.

- Financial Management procedures have been improved in most states, with the use of e-transfer for funds upto the districts and a large induction of personnel with financial management skills for attending to this aspect.
- m. The Mission notes that the Integrated MIS Format for flow of physical performance data were found at all levels including the lowest (ANM). However multiple reporting is still in vogue, earlier forms are not yet abolished and there are many other constraints in data collection and flow. Copies of reports sent above are not being maintained at that level. HMIS is not used adequately to inform planning and responsive corrective action. In Gujarat, Andhra Pradesh and Tamil Nadu systems of monitoring of general facility functioning are in place and use grades to rate facilities into four categories, with pressures to improve performance of poorer facilities.
- n. While the various components of NRHM are oriented to increase access and outreach to the underserved, most CRM teams found it difficult to assess the impact on equity within this review's framework. Some CRM teams have reported a high utilisation of JSY by the SC and BPL groups.
- o. The review mission also points to a number of important governance issues that are acting as programme constraints.

Some Key Recommendations

The remaining 5 ½ year time frame of the NRHM gives us ample opportunity to strengthen its positive elements and make mid-course corrections.

At the Central Level

- Ensure timely release of funds to the states for various components of NRHM, especially Janani Suraksha Yojana.
- Work with states to evolve a common nomenclature for the facilities such as PHC and CHC as this influences much of the planning process and budgetary allocations.

- Build systems for actively promoting cross learning from the varied experiences of different states, and accelerating changes and innovations in poor performing states through appropriate facilitation, capacity building and technical assistance.
- Develop a monitoring and support system that not only identifies lack of progress, but is able to respond and reach out to assist in areas and states showing limited progress.
- Develop guidelines for integration of the activities of various programmes and the general health services. To integrate all the disease control programmes the way forward is to build in the preventive, promotive and curative care for communicable, chronic diseases and non-communicable diseases into the definition of fully functional health facilities and the provision of promotive and preventive services. Thus one needs to develop their standard treatment guidelines, their essential drug lists, their referral systems, their support systems for capacity building, logistics, and monitoring, and their Behaviour Change Communication (BCC) work.
- Develop guidelines for a more integrated approach within programmes too: for instance integration of assistance at deliveries with neonatal care and with post partum sterilization: by building the natural links between these dimensions, found to be low in the states.
- Develop guidelines for more integrated management structures too at the various levels- directorates and mission programme offices at the state level or sub-center facility committee and the ASHA programme with the Village Health and Sanitation Committee (VHSC) at the village level.
- The institutional framework proposed for the state level health systems management has evolved differently in different states and it would be useful for more active cross-learning of experiences. Also to ensure and support the creation and functioning of the minimum institutional arrangements at the state needed for effective programme management.

At State and District Levels

In programme management.

- The institutional framework at the state level to strengthen health systems management is the urgent priority. The directorates, the programme management unit of the NRHM, the SIHFW, the state health systems

resource centers, the community leadership support units, the infrastructure development support units and the drugs and supplies procurement and logistics management units are all essential and must have the appropriate professional teams and enabling structures to manage a vast and growing public health system. Clear role definitions and coordination mechanisms along with team building efforts should ensure that the conflicts between different structures of management are overcome.

In attaining fully functional health facilities:

- Rational restructuring of the health services, with the IPHS service guarantees and guidelines for infrastructure and human resources as the organizing principle, needs to be pursued more vigorously. Though these benchmarks may not be possible for each state to reach immediately, given their vastly differing baselines, each state should develop a clear road-map showing how this would be attained in a phased way. Such plans should guide the allocation of resources and the measurement of outcomes.

In Improving Workforce performance:

- Building a network of district, regional and state level training institutions led by the SIHFWs that ensures that the level of skills needed for service delivery at every facility and in every health programme are in place, is one of the most important areas of health sector reform that is urgently needed. Putting this in place at every level along with teams/centers for providing assistance and the institutional memory for district planning is another priority.
- Pre-service training institutions for generating multipurpose workers, both male and female, and their supervisory staff, which have gone into dysfunction in the last decade, need to be revived, expanded and strengthened.
- There needs to be a systematic examination of the compensation packages and incentives being provided to the various health service cadre, and the opportunities for advancement in their careers along with a fair transfer and posting policy. These are some of the most sensitive indicators of good governance and a system of measuring and rewarding these needs to be built up.

- Multi-skilling of doctors and nurses and para-medicals is needed as a general strategy to provide the skill mix for reaching service guarantees under current human resource constraints.
- Making available graded standard treatment guidelines and essential drug lists and formularies, which could guide the wide range of health care providers actually providing health care.

In HMIS and Decentralised Data-based Planning

- The HMIS must be rationalized to make it user-friendly and ensure quality data while reducing the work- load of the peripheral health workers and eliminating redundant formats.
- Village level planning under *panchayat* leadership remains a goal that we must develop as a core activity of planning. This requires active facilitation of the village health and sanitation committee.

District health planning must be taken to its next level- where the district has sufficient capacities to make its own plans, where budgetary resources flow according to the plan, where the plan is widely disseminated and is used as the measure against which outcomes are socially audited. States and Districts need the time to learn and improve. However, to achieve this, there needs to be an agency or team which acts as an institutional memory of the plans and pro-actively pursues their implementation. Like the role envisaged for the SHSRC at the state level, there is a need to infuse new methods of problem analysis and solution search appropriate to local needs. In this connection greater non-official involvement, especially of local professional and development and public health expertise resident in NGOs and research institutions, who are capable of planning should be sought.

Common Review Mission Report

Background:

The National Rural Health Mission represents a major departure from the past, in that central government health financing is now directed to the development of state health systems rather than being confined to a select number of national health programmes. There are many considerations behind such a shift. Such a shift is important for improving the health of public health systems because all national health programmes taken together account for only a small part of morbidities – in the range of about 20 to 30% only. Another reason for this shift is because investment in health systems development is essential for good results even for national disease control and RCH programmes. Also for investment in health funding to impact on health equity and on poverty, larger funds have to flow for health systems to those very states whose ability to raise resources internally are most limited and who have a greater burden of poverty and inequity and therefore a greater burden of disease to bear.

As in our federal polity, health is a state subject, the NRHM requires states to submit sector wide well integrated state plans which it then jointly with the states, appraises for consistency with the NRHM framework for implementation – a common framework that the center and the states have agreed to and around which a national consensus has been built. Based on this appraisal the state plans are approved and the NRHM then provides the financial resources and technical support needed to implement these plans.

The NRHM framework represents a conscious decision to strengthen public health systems and the role of the state as health care provider. The NRHM recognizes the need to make optimal use of the private sector to strengthen public health systems and to increase access to medical care for the poor. But given the uneven growth of the private sector, its current situation in regulation

and the issues of access to the poor, the public health care provider remains the mainstay of public health policy. There has been concern on whether such an approach is pragmatic given the poor record of performance of the public health systems. The NRHM framework is built on an understanding that low and declining public investment in health care and the many structural problems in the way the public health systems have been organized are the main reasons why the public health system has been functioning poorly and this must be addressed through increased public expenditure and through architectural correction of the public health system.

The NRHM is therefore about increasing public expenditure on health care from the current 0.9% of the GDP to 2 to 3% of the GDP. The corollaries of such a policy directive are not only an increased central government budgetary outlay for health, but that the states also make a matching increase – at least 10% of the budget annually including a 15% contribution into the NRHM plan, and that the center – state financing ratio shifts from the current 80:20 to at least a 60:40 ratio in this plan period. Another important corollary is that the state health sector develops the capacities to absorb such fund flows. There are currently many constraints, especially in the EAG states to absorbing these funds, and the poorest performing states which require the largest infusion of resources have some of the greatest problems in being able to expend the funds already with them. This is one of the main reasons why a process of reforming and strengthening the state health systems needs to go hand in hand with the increase of fund flows.

The NRHM is thus also about health sector reform – or in its language – an “architectural correction” of the public health system so as to make it “equitable, affordable and effective.” Such architectural correction is organized around five pillars, each of which is made up of a number of overlapping core strategies.

- a) **Increasing Participation and Ownership by the Community** (what is often referred to as communitisation). This is sought to be achieved

through an increased role for PRIs, through the ASHA programme, through the village health and sanitation committee, through increased public participation in hospital development committees and district health societies and in the district and village health planning efforts and by a special community monitoring initiative, and through a greater space for NGO participation.

- b) **Improved Management Capacity.** The core of this is professionalizing management by building up management and public health skills in the existing workforce, supplemented by inculcation of management personnel into the system. Another major component of this is the creation of institutional capacities for improved management in the form of functional programme management units, strengthened directorates of health services, strengthened and outcome oriented state institutes of health and family welfare that ensure that the workforce in every facility has the necessary skills to deliver its service guarantees and the creation of state health resource centers that act as strategic planning units and managers of change. Increased decentralization in management, public participation and accountability in the management through participatory decision making structures like the hospital development committees and the district health societies is another major strategy of improving public health system functioning.
- c) **Flexible Financing:** The central strategy of this pillar is the provision of untied funds to every level- to the village health and sanitation committee, to the sub-center, to the PHC, to the CHC and district hospital. Even the strategy of providing a resource envelope to each district and state which the district/state has to use against an approved plan that it develops is an unprecedented level of financing flexibility. Financing packages for demand side financing and various forms of risk pooling where money follows the patient are also major strategies declared by the NRHM. The Janini Suraksha Yojana is one major, almost overwhelming example of the demand side financing option, so much so that in many places the

NRHM is being identified with it . But the challenge of the NRHM is to be able to build more comprehensive packages that ensure allocative efficiencies within the public health system and that address equity concerns for the entire range of curative care needs.

d) **Innovations in human resources development for the health sector:**

The central challenge of the NRHM is to find definitive answers to the old questions about ensuring adequate recruitment for the public health system and adequate functionality of those recruited. Breaking a vicious cycle where poor performance of the workforce has justified poor attention to solving the fundamental problems of human resource development, the NRHM lays down a minimum human resource requirement for each facility level and follows up to ensure that states agree to a road map to close these gaps. The most important outcome of this is the dramatic increase in the number of nursing and allied staff being brought into the system. Contractual appointment route to immediately fill gaps as well as ensure local residency, incentives and innovation to find staff to work in hitherto underserved areas and the use of multi-skilling and multi-tasking options are examples of other innovations that seek to find new solutions to old problems. Expansion of professional and technical education and increasing access of weaker sections to such education are also a core strategy.

e) **Setting of standards and norms with monitoring:** The prescription of the IPHS norms marks one of the most important core strategies of the mission. This has been followed up by a facility survey to identify gaps and funding is directed to closing the gaps so identified. Gaps in equipment are relatively easily addressed. Gaps in drug supplies need an adequate drug procurement and distribution policy. Gaps in infrastructure require an efficient mechanism of completing civil works in time with quality. Gaps in human resource require expansion of education plus workforce reforms and innovations. And to ensure that states are seized of this task and have built road maps to close these gaps and are traversing down these

road maps they have set themselves, the NRHM aims to provide adequate technical facilitation and monitoring support.

Each of these five pillars and the many core strategies that they are composed of must eventually impact on 24 critical areas of concern which the NRHM framework for implementation identifies. These 14 areas of critical concern are essential cornerstones of an effective health system. The first and most important of these is the responsibility of creating what the framework calls “Fully functional Health facilities.” Whether it is a sub-center, or a PHC, a CHC or a district hospital- the NRHM framework spells out a service guarantee expected of that level and the outcome most expected from the Mission is that each facility is able to fulfill this guarantee. The entire list of the 24 critical areas is as given below:

1. Fully Functional Facilities- from sub-center to district hospital
2. Increasing and Improving Human resources in rural areas
3. Accountable health delivery
4. Effective decentralisation.
5. Reduced MMR, IMR and TFR
6. Action for Preventive and promotive health
7. Disease surveillance
8. Hamlet to hospital referral linkage
9. Health information systems
10. Planning and monitoring with community ownership
11. Equity issues: Women Empowerment; securing entitlements for SCs/STs/OBCs and minorities.
12. Convergence - with HIV/AIDS; AYUSH; chronic diseases, malnutrition, safe drinking water - with community support.
13. Chronic disease burden
14. Social security to poor – for reducing impoverishment and bankruptcy related to ill health.

Timeframes of achievement:

The NRHM was inaugurated in 2005, but it took quite some time to finalise the Mission content and final cabinet approval was in July 2006, with funds started flowing to states thereafter. Thus though the Mission is now two and half years old, in terms of actual processes starting up it is now 16 months old. The time frame of the Mission is upto March 2012- another five and half years remain.

The Common Review Mission

The Mission Steering Group which leads this programme has called upon the NRHM to have adequate mechanisms of review and concurrent evaluation so as to steer the programme effectively. The Common Review Mission was set up as part of this mandate.

The terms of reference of the common review mission set out the task as assessing the progress on the mission on each of the core strategies and its impact on the central areas of concern and the constraints that were being faced. Based on these to make recommendations on the areas of the Mission which need strengthening and course corrections.

The Review Mission and Its Methodology

The Mission was made up of 52 members who between them visited 13 states selected for the review. Of the 52 members, 30 were officials from the department of health and family welfare, 4 were from the states and the rest were from the different divisions of the ministry. Of the 20 non-official members, three were former union health secretaries, and the others were public health experts from the leading public health institutions which had been working with the National Rural Health Mission.

On the 14th of November the entire group assembled in the committee room at Nirman Bhavan, chaired by the health secretary Shri Naresh Dayal. After a briefing by the various divisions the team divided into 13 groups and left for the states. The states chosen were Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal,

On the 15th of November there was a similar one-day briefing at the states, after which the team divided into two groups again and went to visit one or two districts each. One of these two districts had been purposively chosen, for the state to explain what it had been trying and the other district was chosen by the CRM team. The visit to the district lasted two to three days and the appraisal was done using a broad protocol that indicated the minimum number of each type of facility that should be visited and the thematic areas that must be covered in the inquiry.

On the 19th of November the teams returned to the headquarters and with further interaction with the state team and with one interaction with civil society finalized its report. On the 21st of November the common review mission teams presented their observations and findings to the host state before bringing this part of the Mission to a close.

It was decided that as soon as all these mission teams submit their final report, the draft of the findings would be presented before the entire mission team at a national consultation.

FINDINGS OF THE MISSION

The findings of the Mission are discussed as two main sections - the national overview report and the state specific reports. The first section, which is the national overview report, is made up of four parts.

First, a brief summary of some general patterns seen across the states. Second an assessment of the core strategies that characterize the NRHM thrust and most evident in the field. Thirdly progress along the areas identified as critical areas of concern. This is largely made up of a discussion on fully functional health facilities and health human resource management. And fourth and finally a section listing the main recommendations and follow up action that the CRM calls for.

SECTION I – NATIONAL OVERVIEW

1.0 General Patterns

- a. There seems to be a general trend towards strengthening the share of services provided by the public health sector and increasing access and quality.
- b. There is a varied performance across states. In each state different programme components have taken off at different rates. States that have better baselines and that have similar programmes in place have been quick to take off. States with health systems development programmes under bilateral donors have various fund overlaps
- c. An increase in attention to the functioning of public health systems, the fact that the systems functionality in states and their bottlenecks are now receiving attention and critique is perhaps the major contributor at one state. The fact that it is a systems approach lined to horizontal integration at state and district levels has led to highlighting a much wider level of problems than merely programme specific reviews would have.
- d. An increase in public investment, the very fact that lack of funds can no longer be the reason has helped in many ways. However the fact remains that actual increases in terms of funds absorbed by the system still continue to lag behind and there are challenges in both programme

management and governance to be overcome before the capacities to absorb more funds and thus deliver better services are put in place.

1.1 *Increasing performance of health systems:*

Of the 13 states visited almost all have reported increased performance in terms of absolute attendance and to a lesser extent in terms of quality of care. This is most obvious for institutional deliveries where the JSY has put pressures on the public health system, and to a large extent of outpatient attendance in general – but it is more mixed with in patient attendance or surgeries or diagnostics etc. However even in these though rate of improvement may not be commensurate, the trend is still upwards.

Thus of Bihar, one of the weakest performers in terms of public health services the CRM report states that there is an “ Increase in Block PHC OPDs from 39 per month 2 years’ ago to over 2500 per month now for many months, and from 7000 institutional deliveries in government institutions in October 2006 to over one lakh such deliveries in October 2007.... Given the low utilization of public services in Bihar as reported by NSSO 60th Round 2004-05 (5% out patient and 11 per cent in patient treatment in Government institutions), this is indeed outstanding. There is a confidence that the public system shall deliver quality health care services and people are flocking to the public system to utilize services even on holidays and over weekends. There is still scope for improvement in the supply side and quality of services, which, hopefully, will receive priority attention in the months to come.”

It is important to start with this quotation for not only was the base line one of the poorest for this state, even the unfolding of the NRHM programme has been very poor, and most of the core strategies described in the next section are not yet in place.

At the other extreme, from a state with a known record of very good performance like Tamil Nadu also the CRM reports that “after the start of the NRHM, the number of cases in public health facilities have increased considerably in PHCs, and there is diversion of a number of cases from the private institutions to the public facilities. The team was informed that as a result of this, some of the private medical colleges have even started to offer incentives for delivery in their hospitals.

In states like Assam and Tripura and Madhya Pradesh the trend is not as clear – where after exclusion of institutional delivery the trend is for some facilities to be reporting stagnant or even decreasing attendance due to a shift of manpower etc. However the same states also report sharp increases from many other facilities. The methodology of the review does not help us to reach precise estimates of the actual increases in case loads being handled in the system as a whole- and therefore this observed trend are something of a tentative observation- encouraging but requiring a much better HMIS to confirm.

It would be useful to conclude the observations on increase with this cautionary quotation from the Gujarat report for Gujarat has perhaps the best monitoring system in place for tracking patient loads: “There has been an impressive increase in Op/IP for the state as a whole. In both districts visited the trend was visible. Often the increase is related to the competence and commitment of the doctor posted at PHC which sets off a virtual cycle of all round PHC improvement and patient satisfaction. The Team would like to note that the overall increase in a district often hides much variation among PHCs. This is also evidence of exclusion which may arise out of many reasons such as left out, drop outs, pushed out, denied etc- each type of exclusion demanding a different response. Monitoring that tracks variance and underserved areas is the only basis for ending exclusion and for consolidating the ASHA programme.”

1.2. Varied performance between states:

Though there is a general trend for increasing performance the increase in performance varies across states and much more so when seen for each core

strategy and central concern of the NRHM. The variation seems to depend on baselines – states with better health systems taking better advantage of the provisions of NRHM. Also states which are already familiar with a specific NRHM core strategy having introduced it already able to do much better in implementing it. All show forward movement, which area it shows differs: where they were already set in that direction, it accelerates easily like RKS and ASHA in Rajasthan, like ASHA and village committees in CG. (CHC in Kishangarh as contrast to CHC Thana Gaji - the contrast is not permissible). Where it is a new strategy being introduced it takes time.

We also note that no state has been able to roll out all the core strategies that it has chosen to include in its PIP. Change is difficult to initiate, and much more difficult to accelerate and state leaderships have been able to focus on only some of the changes that they themselves want to carry out. It is also likely that other than monitoring, which has received a fair degree of attention, a much higher level of technical facilitation is required from national center to states and from the state centers to the districts to be able to improve performance. Human resource development is another critical constraint which is very sensitive to base lines of human resource development capacities.

1.3. Renewed attention on public health systems:

Performance is attributable to core strategies and increasing investment – but often it is merely the renewed attention on functioning of public health systems that is the key.

There are many examples of changes that took place now – that required no policy change and no resources. They merely happened because after a fairly long period of neglect, basic issues of the public health system had once again caught administrative attention.

One example of this is the ANM and MPW training schools that in almost every state had fallen into complete disuse with no further ANMs being trained –

despite of a growing vacancy situation. In the years since the Mission began one of the areas of considerable intervention is the reopening and expansion of ANM schools. Though expansion needed NRHM funds the functioning of existing schools already had funds in place which were not being utilized. Vacancies long vacant are being filled again especially for nurses and for pharmacists and MPWs. Drug supplies budgets have been increased and so on. A large gap in infrastructure that had developed over the years is now receiving a flow of funds. As the Uttar Pradesh report observes: “We note that the NRHM has awakened a live debate at every level about why did it take so long to the government to wake up to so many rather obvious and basic needs. In particular untied funds given to facilities, and the renewed attention to closing human resource gaps, the ASHA scheme with its thrust towards community participation and the pressure brought on public health systems to perform by the JSY scheme has been seen as the major harbingers and potential triggers of change.”

It is useful to try and understand why there was such stagnation in investment in the public health system and a rapidly declining share of the budget over the nineties. Some of it may be due to macro-economic trends. Some of it is attributed to a few chosen national schemes taking up increasing funds at the cost of health systems developments. Some of it was perhaps due to a loss of belief in the ability of the public health system to deliver despite investment. Perhaps the most likely explanation rests in that health systems development was a state subject, the financial crunch felt in many state economies in this period was disproportionately passed on to the health system, Whatever the reasons the most obvious and perhaps major contributor to change is the way the NRHM has brought back the attention to the development of health systems. It should have further gone beyond health systems to the maintenance of public health as a whole – but as we shall see later, there is still some way to go for this.

1.4. Again as a rule the directions in which NRHM is proceeding as visible in the district level seem appropriate and welcome – but the scale of roll out and the rate of roll out seem inadequate- again mainly due to administrative constraints and perhaps issues of governance.

2. CORE STRATEGIES AT WORK

2.0 Communitisation:

There are seven core strategies that make up this key pillar or category of reform. These are the ASHA programme, the village health and sanitation committee, the enhanced role of PRIs and decentralisation, the role of NGOs the role of public participation in hospital management committees , the role of public participation in the village and district planning process and community monitoring. Of these the last was not observed any where in the review and this component is at an early state of take –off. Public participation in hospital development committees is discussed in the section on RKS and public participation in planning in the section on district and village planning. So the discussion here below is confined to the first four of these – ASHAs, village health and sanitation committee, PRIs and role of NGOs.

2.1 ASHA

The roll out of the ASHA programme numerically is impressive. The ASHA programme is by formal definition confined to the special focus states, and to the tribal areas of all other states. However states like Andhra Pradesh have already extended this programme to the entire state and most other states seem favourably inclined to such a proposal. It is thus very important to make an assessment of the ASHA strategy as it stands now and chart out its future directions.

a) Selection:

Almost all the states visited have completed their ASHA selection. The quality of selection varies. In most states the decision has been made by the ANM in consultation with the panchayat, or vice versa. In states where the panchayat system is more vibrant like in Tripura the participation of the panchayats has been more. The understanding of the importance of prior social mobilization is poor. The *gram sabha* meeting as the site of selection has also largely not been adhered to.

However despite these short-comings the observations from most states are that the resultant ASHAs are quite enthusiastic and capable and though better selection would have helped the programme could still proceed. Three criteria are almost completely fulfilled. All are women, almost all of them are married or have been married, and all the ASHAs met were residents of the habitation where they are appointed ASHAs. We heard of some violations of the last clause but this is clearly rare and easily remedied.

There is also a trend to auto-correction since poorly selected ASHAs, who were expecting regular remuneration or a government job, tend to drop out and replacements could be done better. In places where selection is not complete there is much to be gained from reiterating the selection process.

Important variations are Chhattisgarh and Rajasthan. In Chhattisgarh, the existing *Mitanins* are declared ASHA equivalents and they have been performing well in this slight modification of their role and support systems. In Rajasthan the *Sahyoginis* of the *Anganwadi* centers were declared ASHAs - and re named ASHA *Sahyoginis*. Of the 42, 000 target some 37,000 have been selected and renamed thus.

a) Training

One of the best reports of training are from Andhra Pradesh. This good quality of training and this is attributable to an organization at the state level that is

specialized in this function and nodalising it. Also to a provision of 21 days of residential training in the very first round. In Chhattisgarh, where the programme had begun two years earlier the 10th round of training and some 25 days of training is nearing achievement.

In other states about two thirds or more of the ASHAs have received the first round of training which varies from 5 to 7 days but less than 10% have received any further training. This is really behind schedule and reflects the weakness in building up systems to manage such a massive programme effectively. Memory of key issues in the training curriculum was weak – but given the fact that one year has elapsed since the training, this need not by itself be a comment on the quality of training. The lack of periodic training however is a serious set back to the programme.

Where-ever staff loaded with many other responsibilities are also given ASHA as one more additional task, and where the programme leadership has insufficient autonomy and delegation to continue at a desirable pace of work, the programme is getting slowed down to sub-critical rates.

In Bihar, the second training phase proposal developed by the Bihar State Water and Sanitation Mission (BSWSM) and approved by the SHS focuses on drinking water and sanitation. The training, to be conducted by BWSM and SIHFW is scheduled to start in January 2008 at a cost of 38 crore rupees. Training resource teams at State, district and block level are planned, with 12 day training for the District Learning Team. The ASHA training is proposed to be done through a 12 day non-residential course in all 534 blocks over a six month period. The NGO network through which the Total Sanitation Campaign was conducted will play a role. The CRM suggested that the first districts could act a pilot to assess this new strategy.

b) Drug Kits:

Drug kits have been given to all Mitans in Chhattisgarh and about 50% of ASHAs in Rajasthan and Assam. They are not yet distributed in Bihar and await

the next round of training. In the states of Uttar Pradesh, procurement is not completed. This again is too slow and deprives the programme of much effectiveness. Organizing procurement remains a bottleneck in most states.

c) Payments:

Performance based payments are able to incentivise the ASHA and act as adequate encouragement for her to perform these tasks. However across the states payments to ASHAs are invariably delayed and on many occasions denied. The challenge seems to be to set up a system of payment that is accountable and reliable, yet swift and dignified.

There is one view that such a payment is not possible and it is worth considering a regular though small part payment. The government of Rajasthan has done just this by combining this with their Sahyaogini scheme. To begin with, assistants in the anganwadi centres under the Department of Women and Child Development (originally called *sahayoginis*) have been renamed Asha Sahayoginis. Asha-Sahayoginis are paid a monthly stipend of Rs. 500 (over and above which they receive incentives for different tasks); they are required to do 10 household visits daily; and they function out of the anganwadi centre. This has led to better integration of ICDS and health; greater accountability (as the ASHA - *sahayogini* is required to work half day) and greater coordination of ASHAs with Anganwadi workers. On average, an ASHA earns around Rs. 2000 a month.

This innovation in paying ASHA - Sahayoginis in turn is to still leave some problems. ASHAs tended to concentrate only on those activities that offered them incentives and to earn more. As a result, many critical areas such as child care, counseling, etc. that were not tied to incentives remained neglected. There are also reports of several instances of conflicts between ASHAs and Anganawadi workers arising out of the incentives. This was particularly so in the case of JSY where the two workers would often fight over who gets the incentive amount. We also heard of some families that do not want the ASHA to accompany the pregnant woman to the health facility; as they can then collect the transport charges themselves. In particular there is urgent need to separate

the transport compensation from the ASHA incentive and make these non transferable. Similar conflicts can occur in other situations notably the sterilization incentive which in practice few ASHAs are getting anywhere, as others can claim it first. Some states, notably Tripura have issued an OM formalising the incentive structure for payments to ASHAs on all heads, but most are yet to do so and incentives remain limited to JSY incentive, the immunization incentive and the DPTS incentive.

d) Support:

Support is needed keep the ASHA enabled and empowered by creating a favourable environment and providing her with social recognition and helping her in her work. It is also needed as on the job training.

This has been addressed in different ways in different states but few have a systematic plan of action for this. On the whole almost no state reports a regular schedule of meetings of ASHAs at the local or block level, and on the job support or training. There are some efforts at social mobilization- but they are weak. The village health and sanitation committees could have helped but in most states are not yet functional. In some sectors however based on individual initiative of a medical officer or a LHV etc regular meetings have started up and in these sites both knowledge levels and functionality is much better. In Tripura bright red coats and blue kit bags have been given to the ASHAs have given them a unique sense of pride and identity. This need is felt by organizers for organizing support but there is little clarity of how exactly this can be initiated and done.

The JSY and immunization incentive link ensures that there is some live contact with the health and anganwadi system, but in most states there is a need to enhance these contacts.

Without underplaying the role of payments and financial incentives there is a major need to enhance non financial incentives as well.

There is a provision for a full time structure of five block level facilitators and a full time district and state team, but this is not set up in any state. In Rajasthan there is an ASHA Resource Centre which is not very functional and an ASHA Mentoring Group. But in all other states the ASHA state mentoring groups have not really come up, reflecting the sharp limitations in understanding community processes. Participation of NGOs experienced in community health work would enhance the quality of ASHA capabilities. The logistics of the programme are fairly complex and a strong state level team with high motivation would help to see the ASHAs make a significant difference to health. The provision and replenishment of ASHA drug kits, the monitoring of payments and above all keeping the periodicity and pace of training in a timely manner needs such a command unit to manage the programme.

Involvement of PRIs was there at the selection stage but this has not been maintained after that stage. Training of PRI members about the ASHA role would help in the support process.

e) Role clarity and Monitoring:


As a general rule ASHAs are active- their main work being linked to JSY and immunization. This is largely attributed to the influence of the incentive. While this is true, the Mission also notes considerable lack of role clarity and thus monitoring and direction. Indeed most department functionaries are clear about these two functions and the role of ASHA as a DOTS provider, but are unable to name other roles- much less describe other roles in such a way that it can be supported and monitored. Systematic use of this ASHA workforce for health education and where relevant essential newborn care and first contact care for the sick child or for malaria control needs to be clarified in a district specific manner -for these are known to be life saving interventions that CHWs can achieve and these could lead to measurable outcomes for the programme.

Despite these constraints ASHAs we met were enthusiastic and looking forward to more training and being more useful and going beyond JSY and immunization. The focus on empowering the most socially excluded groups in society and of reducing inequalities should be given priority and though there were expectations of the ASHA in this regard, there has not been much discussion of this as the programme unfolds. Once role clarity is achieved a monitoring plan based on what outcomes and processes are expected could be put in place.



ASHAs are easily one of the most vibrant dimensions of the NRHM roll out that this could be so despite all the limitations just points to the great potentials of community involvement. Providing ASHAs with a more effective support and leadership – as also incentives – and deepening all the community processes of ASHA is one of the most urgent requirements. Despite the fact that the states are seriously grasped of this programme, there is a need to bring in more technical support and civil society partnership at the district and state level so as to be able to understand and build community processes for the ASHA programme and through the ASHA programme.

A catalyst in the form of an active mentoring group or activists drawn from NGOs working in partnership with the district administrations could make a big difference.

2.2. Village health and sanitation committees

-  The village health and sanitation committees are another key strategy of communitisation. The village committee is being given a small fund of Rs 10,000 which forces the states to plan out institutional mechanisms— an order constituting the committee, a bank account with signatories, an accounting and decision making process, a finalization of the relationship between this committee and the panchayat health committee, guidelines for expenditure of the money and finally

mechanisms for capacity building and for supporting village level planning. Simple though the idea is, it still requires considerable decision making and facilitation. This may be one reason why despite widespread welcome of this strategy, progress has been slow. It is likely that in the next round once these hurdles are crossed the progress will be much faster, with only the skills of village level health planning remaining to be done. The sub-center facility committee and the ASHA programme also needs to be integrated with this structure.

-  West Bengal has constituted 16,770 VHSCs out of its target of 44,175 and 12,000 would be finalized this year. In Tamil Nadu 12169 VHSCs are functional and have use the Rs 10,000 largely for 'cleanliness purposes.' Some PHCs have provided free food for mothers who came for delivery with self help groups paid to do this provisioning.
-  No Village Health and Sanitation Committees have yet been formed in Tripura, CG etc but the process is ongoing and in most states nearing completion.

2.3 Involvement of PRIs:

The involvement of panchayats takes a number of forms.

Actual devolution of facilities to panchayats is a feature only of West Bengal- of the primary health center and sub-center and in Kerala and in Nagaland.

In most states panchayat standing committee members involved in RKS and District H&FW Society. Even within this there are varied levels of involvement and in a state like Tripura where the panchayat's role is proactive this has been very valuable. This level of involvement has been at times very helpful. .

In Tripura the CRM reports and instance where the Panchayat had invested Rs. 62 lakhs in Kathailia PHC for renovations, construction of meeting hall and purchase of surgical instruments. The PRIs are themselves demanding extensive training on their role in various management structures under NRHM. Involvement of PRIs at PHC level is hampered (as in Bamutia PHC) as Block Panchayat Chairman has to head these RKS, which are

spread across in the block. As a result PRIs are not always available for signing and approving vouchers/expenditures for RKS of PHCs which are located far from the Block HQ.

In Bihar the elected representatives of the PRI are members of the RKS and PHC Committees. The name, designation and contact telephone / mobile numbers of all the members of various committees are displayed at respective health facilities. The initiatives for inter-sectoral convergence for public health activities including involvement of PRIs & VHSC are to be taken up.

In Tamil nadu involvement has been maximal at the gram panchayat to sub-center and PHC level with panchayats raising funds, providing meals and actively managing VHSCs. But PRI involvement at higher levels is reported to be much less.

In all states they are involved in selection of ASHAs and in forming village health and sanitation committees.

Another major role for panchayats is in that JSY beneficiaries are being certified for BPL/SC/ST by panchayats. The expenditure on JSY beneficiaries is discussed in the RKS meetings, in the presence of PRI and other members. JSY money for home deliveries is paid by the BDO, who receives funds from District H&FW Society.

However as of now there are few states that have had panchayats doing household surveys for ascertaining local health indicators and disease burden or doing any form of village planning. In Tripura PRIs were sensitised during a micro health planning exercise undertaken during early 2007, but they did not receive formal training in NRHM and their role in planning, implementation and monitoring of various components is limited.

2.4. NGOs and their role:

The CRM team invited the NGOs for discussions in a number of states – especially in Bihar, Uttar Pradesh, Rajasthan, and Madhya Pradesh. Some groups like Janani are involved as service providers with reimbursement by the

government. They have done 4,035 tubectomies and 1200 NSVs. They work through franchised clinics. They mentioned problems of coordination and delays in payments as problems. However as a rule there are few NGOs that the CRM came across in this role.

Most NGOs while being appreciative of the NRHM maintained that the scope for NGO participation was very limited. NGOs felt rebuffed and their services as not sought adequately. In particular there was keenness on coordinating with the ASHA programme and other community processes, on assistance in ANM and dai training, in BCC work.

One specific experience discussed was the PPP arrangements with NGOs for service provision at the PHC level. There was widespread dissatisfaction from both NGOs and government and the programme had literally broken down. An NGO who took up ten APHCs under a PPP arrangement for three years said that it was difficult to work and the funds were insufficient. He said that they were due a payment of almost sixty lakh from the district health society for want of counter signature by the CS. They have discontinued the contract since March 2007. Overall, about Rs. one crore dues are outstanding for the 36 PHCs that were earlier outsourced. Even in the MNGO programme there were major complaints of payments due to them since three years. After formation of the SHS funds have not been released to old MNGOs. Another NGO working in Sheikhpura and Begusarai also has 7 months payments due to it.

The CRM team visiting Bihar suggested “introduction of conditionalities to ensure Government responsibility and accountability in partnerships was suggested; a nodal person responsible for management of NGO partnerships preferably at state level; and payments made electronically within a stipulated number of days, third party appraisal and community monitoring as correctives.

3. The Rogi Kalyan Samiti and the flexible funding options:

The NRHM provides a major part of its funding through untied funds available at the level of utilization. Thus to every sub-center there is a Rs 10,000 given as an untied fund plus another Rs 10,000 available as a maintenance grant. To every

PHC there is a fund of Rs 25,000 available as an untied grant plus another Rs 25,000 available for maintenance grant plus possible funds available for upgrading it into a 24 * 7 hour service. To every CHC there is an untied grant of Rs one lakh available plus maintenance grant plus funds upto Rs 40 lakhs for upgradation to IPHS standards.

There is also an understanding that in future districts would be given a resource envelope within which they would be free to make their plans. States already have their annual resource envelope notified to them.

In addition, the NRHM looks at other ways of financing health care – that is other than the direct expenditure incurred for the provision of public health services. One such set of options is known as demand side financing- where the funds follow the patient. Of the various demand side financing options the one known best and the most widely utilized is undoubtedly the Janini Suraksha Yojana programme. The fund for sterilization compensation is similar.

The NRHM also provides space for flexible funding in terms of supporting a number of public private partnership options. The progress upon many of these lines is discussed below.

3.1. Rogi Kalyan Samiti:

- 3.1.1. The Rogi Kalyan Samiti can be equally discussed under three heads – as a form of communitisation/public participation (this includes its role in increasing accountability), as part of a strategy to improve the quality of management and therefore facility outcomes and as a form of providing flexible funds for facility improvement. The Rogi Kalyan Samiti under the NRHM is not seen as a vehicle of cost recovery though states are free to decide their policy in this score.
- 3.1.2. Experience with the rogi kalyan samiti as proposed under the NRHM and the untied funds given to it have been broadly very positive. In the context of the untied fund the RKS is a vehicle that

ensures its proper utilization and forms a framework of both accountability and outcomes for it. The experience with this and its relationship to the NRHM understanding of the RKS as a hospital management committee to improve quality and accountability and facilitate flexible state funding which ensures equity in care is varied across the states:

- In Bihar Rogi Kalyan Samitis have been established in all hospitals and health centers and their impact is clearly visible in outsourcing of Ambulance services, uninterrupted electricity through Generators, dietary services, provision of Linen supplies, cleanliness services and environment. Services are generally of good quality. The untied funds were available at Medical College hospitals, District hospitals and 24x7 PHCs and have been used effectively for the above activities.
- In Tripura all RKS have been established and have received untied funds and spending, mainly on facility renovation and purchase of needed instruments, furniture, etc. The spending of untied funds is in the range of 50 to 70%.
- Rajasthan has done particularly well in this area. Rajasthan Medical Relief Societies (the RKS equivalent) were existing upto CHC level prior to NRHM. However, these societies were extended upto PHC after launch of NRHM. Started in the late 1990s, they now cover all 45 District and sub-District hospitals, 354 out of 352 CHCs and 1,489 out of 1,503 PHCs. These three sets of institutions have started receiving Rs. 5 lakhs, Rs. 1 lakh and Rs. 25,000 respectively every year as untied funds. A well-thought out set of guidelines govern the functioning of the RMRS. For instance, free medical care is provided to everyone below the poverty line, pensioners and senior citizens. The rest are required to pay a modest amount for services ranging from Rs. 5 for registration to Rs. 30 for ECG and blood tests and Rs. 60 for X-rays. The guidelines also prescribe how the moneys collected ought to be spent – 25 percent on purchase of medicines and so on. These inflows combined with the direct transfer of

untied funds from NRHM have led to the accumulation of reasonable sums of discretionary funds at each level.

- In Tamil Nadu, the Patients Welfare Society and their untied fund has been welcomed and are reported by the mission as achieving marked improvements in the appearance, in the patient amenities provided and the overall environment of the facility. The funds for sub-divisional hospitals are considered inadequate.
- In Madhya Pradesh, the Rogi Kalyan Samiti in one District hospital which was analysed showed a heavy reliance on user fees as a source of income, and the major chunk of RKS expenditures on routine heads like salaries and medicines, which should be largely met through Departmental funds. A state level analysis of RKS data showed large financial fluctuations and significant divergences between income and expenditure in several years; large scale non-reporting or inadequate reporting from RKS institutions to state level, with RKS from one-third of districts not reporting at all; an unacceptably large 'others' category in reporting both total incomes and expenditures; and over one-third of RKS income coming from user fees which is regarded as a regressive form of financing. These findings suggest the need to move towards a different model of RKS in M.P. given the availability of untied funds under NRHM." The report also notes that, "Only 2.47% patients were exempted charges for services on basis of BPL, although MP has 37% BPL population." There is also a concern that the untied fund given to MP's RKS is not visibly reflected in the accounts and the reasons for these needs to be ascertained.
- In Chhattisgarh, Rogi Kalyan Samitis have been re-named *Jeevandeep* samitis and have developed a charter of improving the quality of services in a measurable manner. The level of achievement is certified after external verification and stars of recognition and incentives are awarded to the best performing facilities.

- In Jammu and Kashmir alone, this is yet to be operationalised-symptomatic of the relatively poor take off of the NRHM in this state.

3.1.3. However the RKS approach is not without its problems. One of the most persistent problems with the RKS is the apparent reluctance for utilisation of funds, the lack of awareness or of delegation of powers. Even where there is a long tradition of working with such societies, officials are still not comfortable about spending the money. Part of the reasons for this lie in mind-set of vertical programme management and poor delegation of powers. Part of it lies in the lack of clear enabling orders and guidelines, and sometime confusing contradictory statements that place arbitrary ceilings on what can be spent. Many states have now crossed these problems but others are still to do so.

3.1.4. The other issue relating to RKS is the equity dimension. All RKS provide for exemption of those with a BPL card and pensioners and a very ambivalent and ill defined strategy of dealing with other categories of the poor. Equity of access is not a part of monitoring at any level, and the old perception of RKS as an alternative financing device and the consequent emphasis on user fees as cost recovery may not have completely gone. Indeed in the state which gave the programme this name it seems to be flourishing. Equity between facilities and the linkage of untied funds to this consideration has also not begun. West Bengal has mechanisms of moving money to facilities with fewer collections, but almost all states are allowing each facility to retain its fee collection plus giving the same amount of NRHM grant to each facility irrespective of the collected amount.

3.1.5. If equity linkage is one challenge, performance linkage to both quality of care and volume of care provided is another issue. The flexibilities of funding have not yet been called upon to play such a role and thus better performing, high volume of care hospitals may

not be getting the assistance they deserve even as funds get locked up with relatively poor performers.

- 3.1.6. The component of communitisation/public participation is also limited. For instance in UP, the only non-medical member of the RKS is the PRI representative, and no other form of community involvement in the decision-making or running of the institution.

3.2. The Untied fund for the sub-center:

- 3.2.1. This is one strategy of the NRHM that has widespread appreciation from all levels of the system. and a very high level of utilization. In all states these bank accounts have been opened, the funds have been received and largely (60 to 70%) spent. ANMs at the sub-centre have been particularly benefited by inflow of untied funds every year. They have used this money to improve the condition of the sub-centre and to equip themselves better.
- 3.2.2. There are a number of small long standing gaps – either in infrastructure maintenance, or in small conveniences like curtains or furniture that is essential for quality of care or in minor equipment like BP apparatus. Across the states the untied funds have been used to close these gaps. It has also given a sense of responsibility, recognition and confidence to the ANM. In most places there is a joint account operated between the ANM and the *pradhan* of the local gram panchayat, and though the team heard of complaints, no team actually met anyone who had such a conflict to relate. More often than not there is a committee in place to administer these funds. Where there is such a committee and some broad guidelines in place pressures from vested interests on these funds are minimal. Gujarat is an exception that the second signatory is the school teacher and not the *pradhan*.
- 3.2.3. There is some reason for concern that when the second tranche of money is received, there is insufficient clarity and ideas about how to

expend it, now that the obvious immediate needs have been met. At this stage having a village plan or village plans and a sub-center development plan would be helpful but some degree of skill building is required if the ANM and MPW is to be able to make these or even to participate in its making. In its absence the expenditure of the second round of Rs 10,000 would be slower and perhaps with less relevance to access and quality of care issues.

3.3. Janini Suraksha Yojana:

- 3.3.1. This is easily one of the most visible developments of the NRHM and therefore requires careful consideration. Every one of the 13 review teams tried to make their assessment of this programme. Reading across their findings there are many areas of commonality and some divergence.
- 3.3.2. One common finding across the board is a sharp rise in institutional deliveries. For example the Bihar team reports that institutional deliveries in government facilities have risen dramatically - to 4,25,253 between April-September 2007 – a jump of 62 percent over the corresponding period in 2006. Almost all of this can be attributed to the monetary incentives offered under the JSY.¹ We found, for instance, that between 1995-2003, the CHC in Kishangarh conducted, on average, 33 deliveries a year. This rose to 75 during 2004-05 and to 275 in 2006. Between January-mid November 2007, the CHC had already conducted 919 deliveries.
- 3.3.3. The second common feature across states is that the increase is largely on the public health system and this has in turn put tremendous pressure on the public health system to improve its performance. This indeed represents a reversal of privatization of the

¹ In rural areas, Government of Rajasthan pays Rs. 1400 to every woman who delivers in a government facility; and an additional Rs. 300 to cover transportation costs. The health worker accompanying the woman gets Rs. 500 (Rs. 400 paid at the time of delivery and the remaining Rs. 100 at the end of completing DPT 3)

earlier period, which has been always described as not occurring by conscious choice but as imposed on the poor due to a lack of services of any quality whatsoever in the public sector. This phenomenon of de-privatisation is best seen in a state like Tamil Nadu where near 100% institutional delivery had already been achieved, and where the impact of JSY was to shift patients from the private sector to the public sector. In terms of impact on the poor, in a situation where there is no reimbursement for private care fees and where fees in the private sector are soaring, this de-privatisation is a step forward. A more detailed assessment from the Andhra Pradesh by the mission team compares two districts to show that the % of total deliveries that happens in public institutions remains the same across districts and seems to be capped by the capacity of the public health system. Further increases in institutional delivery are achieved by spilling over into the private sector and in a poorer district no such movement occurs despite JSY. In Chhattisgarh the failure of the public system to respond to absorb the increasing flow of referrals for delivery is being felt by the referring community health workers and not adequately by the health system. But in all states the pressure is invariably on the public system and not on the private.

- 3.3.4. The third major cross state finding is that the ability of the system to deliver quality of care has been limited and at its current levels of efficacy may not be as yet adequate to make a dent on the issue of maternal mortality. To some extent the provision of labour rooms and basic equipment has kept pace because of the availability of untied funds. But the rate of skilled birth assistance training is not at pace with the expansion of institutional delivery and in the absence of the expanded set of skills that SBA training provides the impact on maternal mortality would be low. There is also across states a marked reluctance to book them as in-patients and institutional deliveries may paradoxically not be reflected in IP statistics. The root

reason is that post delivery 2 to 6 hours stay is the dominant practice when what is required is norm of at least 24 to 48 hours post delivery stay. Integration with neonatal care and with post partum sterilization and other aspects of RCH are also low. Quality assurance protocols and their monitoring especially as regards cleanliness disposal of wastes, etc would also help improve quality of institutional delivery.

- 3.3.5. The fourth major finding across states is that though human resource requirements have expanded consequently and though the NRHM provides for more nurses and ANMs in the system, recruitment is slow and limited because of absolute scarcity of potential recruits in the open market quite constrained. The opening of more institutions for ANM and nursing schools is far behind schedules in those very states and areas where this is needed most.
- 3.3.6. There is some concern that in the absence of increased skills or increased staff what the JSY represents is a shift from ANM assisted delivery provided at home to ANM assisted delivery provided at the sub-centers, with a much less absolute increase in institutional delivery in the true sense of the term. However the ability to reach the desired level of care is now much enhanced as many sub-systems are in place, and with more skills imparted, better quality protocols and with linkages to other components of RCH and to referral transport systems a substantial improvement in care at pregnancy and early childhood is at hand.
- 3.3.7. Issue of timely payments to the pregnant women and of payments not reaching ASHAs due to number of inessential clauses added in (e.g. ASHA stood stay for 48 hours in the facility for getting a fund, or her name should have been entered at the time of pregnancy registration) or due to plain carelessness are also common across the states. Most state governments are however more seized of this problem as compared to the earlier ones and many states like

Rajasthan have simplified the system of making payments under JSY. Women who deliver in institutions are given a bearer cheque that can be cashed the same day irrespective of whether they have an account. Transparency in maintaining accounts and constraints in flow of funds and their timely accounting are other problems some of the states are facing.

- 3.3.8. Many health officials and workers expressed concern over the future of the JSY especially since coverage extends to all women and funds flow does not seem to be matching the growing demand. There is also very little likelihood that such a demand side approach can be extended to any other medical condition, given the costs.
- 3.3.9. Even more controversial and questioned is the increase in compensation for lost wages paid to men and women under sterilization. In the case of women, the demand for sterilization was high; and the real constraint was in terms of ensuring safe good quality service. With men, most health workers felt that money – and that too Rs. 1100 – could not be the determining factor. They also felt that introduction of money often corrupts the system and given the huge demand and the failure of the system to be able to meet this demand, such money was quite unnecessary. We note that in most states little of the sterilization “motivator” incentive flows to ASHAs anyway and many states have liberalized rules for this scheme such that a wide variety of persons can be eligible for this. Given the fact that amongst contenders for the motivation incentive (Anganwadi worker, ANM, *pradhan*, male worker etc) the ASHA has the least bargaining power this is not surprising. And read along with the fact that motivation in most districts is no longer necessary, the system may just be handing out a out of the record compensation package to its own employees and the local elite. This needs to be studied immediately.

- 3.3.10. There is good public awareness of the JSY programme in all the states except in J&K and in an entirely different context, Tamil Nadu (the JSY - like Dr. Muthhulakshmi Reddy scheme). Publicity works up about the programmes as well as details of its rules are widely available in most states visited.

3.4. Other PPP or risk pooling initiatives:

The mission focus did not lead to any significant examination of these options. However it did encounter some form of PPPs in most states.

- 3.4.1. The NGO partnerships, especially the MNGO programme did come up in many state reviews and these have been discussed earlier.
- 3.4.2. In West Bengal, there has been a number of initiatives in establishing PPPs that strengthen the public system. This includes a number of ANM training schools, outsourced 3 mechanised laundry units to service 30 government hospitals in Kolkata, construction of night shelters and toilet complexes, outsourced diagnostic units for 87 government hospitals and plans for a further 74 block PHCs and for emergency transport a total of 334 ambulances. In Tamil Nadu and Andhra Pradesh PPPs are most prominent and almost exclusively in the domain of providing ambulance services. Tamil Nadu in some of its schemes is limiting the emergency ambulance service to neonates or to emergency obstetric care, in which case its viability would need to be examined. Gujarat, Chhattisgarh, Madhya Pradesh, Orissa, West Bengal have all gone for contracting out mobile medical units to NGOs. In Bhopal, the CMES (Center for Emergency Maternal Services) which is run in a public-private partnership with a local NGO has software that compiles data on pregnant women with mechanism for reminders on their EDDs and other health relevant dates. Accordingly, the NGO makes phone calls and keeps track of the actions to be taken at their end during the entire pregnancy till the

childbirth. The same NGO also provides emergency transport service to nearest accredited private institutions for deliveries when they receive phone calls requesting for the transport. In Gujarat the Chiranjeevi scheme has been able to build a workable model of PPPs for provision of comprehensive emergency obstetric care and institutional delivery which has been widely appreciated. Institutional deliveries have shot up and the rate of emergency obstetric care provision approaches the desired norms – being neither too high nor too low. However the report has raised some larger cautions for discussion. In Bihar a major effort at contracting out PHCs to NGOs has come to a standstill and been reversed due to serious problems of both design and implementation.

3.4.3. The overall picture from most states is clearly a picture of a limited and carefully chosen use of public private partnerships most of which are being used as supplements to strengthen public health care provision. Most important and universal of these PPP innovations, indeed the only one which represents a general trend is the emergency referral transport system and the mobile medical unit. On the latter the Andhra report is overwhelming in its praise- *“if our founding fathers were drafting the Constitution today, they would have included this facility as one of the fundamental rights”*.

3.4.4. There is also considerable innovation taking advantage of the flexibility provided and using state funds. The results are mixed with some being promising and some not doing well.

4. Improved Programme management

One of the central pillars of the corrected architecture of the health sector that the NRHM intends to achieve is improved health sector management. The NRHM has five core strategies that address this dimension. One is the creation of the integrated district and state health societies as measure of horizontal integration and convergence, better governance and participatory decision making. The

second in the induction of a number of contractual staff with management skills – programme management, data management and financial management. A third is the building up of the state level institutions. The directorates of health services, the state programme management units of the registered societies, the SIHFW or equivalent, the state health systems resource center and an autonomous body or empowered cell for management of procurement and another for civil works are some of the institutions that need to be created or strengthened. These many bodies are not necessarily duplications. Rather they are institutional forms of specific skills and a body of domain specific experience for which an experienced team and an institutional memory needs to be built up. With a clear demarcation of roles and deliverables for each of these institutions, programme management could be made much more effective than it is today. Though potentially all of them could be telescoped into one or two institutions the leadership competencies required are such that separate structures have in practice been more viable than bringing them all under one roof.

4.1. State health societies and district health societies have been created in all states. The level of integration however varies. In most states district health societies of the TB, malaria, blindness and leprosy control programme have separate accounts and may also be retaining their separate registration. In most states, the state health societies have brought all these programmes under the common health society, except for the AIDS control society. However each has a sub-account and makes their state plans independently integrating them at the level of the final document only. This could be seen as a failure of integration, or alternatively it could be seen as the level of integration that programme managers and different stakeholders are comfortable with. For purposes of operationalising the NRHM objectives such integration should be adequate. Further integration could be achieved as and when the vertical programmes perceive the need for more systemic coordination and for

improvement of health systems that impact on the performance of their programmes.

- 4.2.** There is however much more to be done to ensure that these societies are able to provide better governance and better transparency and participation. Key officials of these bodies as of the department itself are changed far too often to get adequate experience. Where there is some continuity, like in Gujarat or Tamil Nadu or in West Bengal, the difference is positive and visible. But in the EAG states like Bihar and Uttar Pradesh, where the problems are most the changes are also most frequent. Meetings need to be more frequent and meetings need to become major sites of decision making. The composition of these bodies and the efficiency with which they function and deliver needs further studies to draw lessons for optimizing this strategy. Based on such studies indicators of good governance could be developed so as to be able to estimate what contribution this element makes to poor performance
- 4.3.** Progress has been good in the inculcation of contractual staff with management skills at the district and state level. District and state PMUs as per NRHM norms have been established at state and district levels in Tripura, Rajasthan, Assam, Orissa, Madhya Pradesh, and Chhattisgarh. District and Block level Managers have added new energy to the system of health care delivery. There is a 15 to 30% vacancy situation in most of these states but that is not unexpected. Processes are on for establishing Block level PMUs. Indeed the experience has been found useful enough to call for its replication at the block level and most states are planning for block level programme managers and block level accountants. We note however that the states of Uttar Pradesh, Tamil Nadu and Andhra Pradesh did not exercise this option as yet. Uttar Pradesh has a number of posts at administrative level in the district, and West Bengal, Tamil Nadu and Andhra have different forms of administrative cadre. It is worth considering whether this has a correlation. However even these states are opting for these posts- seeing

the experience of the other states. We also note that there are a number of unresolved workforce issues with this cadre- no increments, no regular appraisals, no clear extension period or security of contractual tenure and no career graphs. These need to be managed on a priority basis.

4.4. The institutional framework proposed for the state level health systems management has evolved differently in different states and it would be useful for more active cross-learning of experiences. Gujarat has set the prototype and benchmark for a state level institution to manage infrastructure development. Tamil Nadu has created the benchmark of the state level institution to manage drug and supplies procurement. Andhra has a similar institutional arrangement to Tamil Nadu which also manages infrastructure. Bihar is planning a construction corporation. Chhattisgarh currently represents the benchmark for an institution to manage community processes. Rajasthan has started an ASHA resource center. Other states are considering similar structures but none have started up. State Health Systems Resource Centers have not started functioning as envisaged in any other state and there are no special efforts to strengthen SIHFWs. Obviously the institutional framework at the state level to strengthen health systems management is an urgent priority.

4.5. Nine District Child Health Coordinators out of 18 have been hired for implementation of IMNCI in Rajasthan. There are suggestions to consider more district programme managers for different functions. Before we consider these, one needs to look at the techno-managerial role played by the programme officers of the district. There is a need to consider the technical staff available at each district who are playing managerial roles. Most states have four or five programme officers under different vertical programmes but this is not the same as having a cadre of deputy chief medical officers allotted different programmes as Uttar Pradesh has it. Tamil Nadu has created a public health cadre of deputy directors of public health who are interchangeable with the assistant professors of preventive and social medicine in the state medical colleges and these

younger officers committed to a career in public health management are in charge of primary health care in the districts. It is worth noting that these two states have not opted for the district PMU staff.

- 4.6.** The integration of PMU staff with the rest of the system still remains a challenge. At the moment, they are seen as agents of a new programme NRHM whose sole function is to ensure that monies coming from NRHM are properly accounted for, as there is not enough trust in the existing system to do so. This is creating some tension with the regular staff attributed to the difference in wages. There is also a sub-optimal use of the skills of the PMU staff, most of them being relegated to secretarial support functions rather than management and planning functions. The trend to have separate trainings for them and plan for PMU staff exclusive of the other administrative staff is not helping. Workforce management principles for contractual staff have also not stabilized. Integration rests on not only being able to take care of these concerns of both the PMU staff and of the regular staff and instead of setting one against the other, to work out ways of team building by training and supporting them together.
- 4.7.** Financial Management procedures are being improved. One major step forward is the use of e-transfer for funds upto the districts. This has occurred in most states but is yet to happen in Bihar and J & K. The other is the increase in accounting staff under contractual appointment at the state, district and block level. West Bengal has appointed one regular government accounts officer at the district level from its accounts and audit cadre and I is planning to raise it to two. It has hired contractual block accounts managers for all blocks at Rs 8000 per month. The Finance Manager and other supportive staff at State level are in position. The financial powers were delegated adequately to the districts, MOs i/c and various committees. The system of concurrent audit is unique to Madhya Pradesh and is very effective in ensuring timely reports, and is worth replicating by other states.

5. *Functioning against norms:*

- 5.1.** The establishment of standards and norms is another key pillar of the NRHM framework. The IPHS task force laid out the standards for sub-centers, PHCs, CHCs, sub-divisional hospitals and district hospitals. Each of these standards specifies the population norms it should fulfil as well as the human resources it should deploy as well as the services packages expected of it. The IPHS mainly specifies the norms regarding infrastructure, equipment and drugs and supplies. In addition the NRHM framework for implementation specifies the service guarantees for each level of services.
- 5.2.** One observation with respect to assessing progress against norms is the variable nature of nomenclature. PHCs could mean at a one per 30,000 norms or at one per 1 lakh norm. It could mean no beds, or six beds or 30 beds. It could mean one doctor or two doctors or four specialists plus two medical officers depending on the context of usage. The term CHC could be reserved for a 30 bed, 6 doctor hospital or it could be used loosely for a PHC, so designated on paper with no accompanying changes. There is a need to agree to some standard usages at least within states, and work out their correspondence with IPHS terms to help the process further.
- 5.3.** The IPHS standards have been widely circulated, but more often than not they have been read as a prescription of inputs, and not as a prescription of outputs or as a service delivery guarantee. Thus there is almost no effort to increase service delivery outcomes for a given level of inputs. This is most evident in a state like J&K where inputs are adequate, but there is no corresponding output. But even in other states this picture was often obtained. For example the District Hospital in Alwar, the CHC in Kishengarh and the sub-centre at Dhani were fairly well-equipped in terms of facilities and staff and delivering services. However, conditions were not as good in the CHC at Thana Gaji and the PHC at Harore, nor were they delivering even the services that they were capable of. In the

absence of such outputs that match the current level of inputs it is not useful to pay attention only to expanding inputs. In some states notably Tripura there is a conscious effort to reach the service guarantees specified and even to convey this to the public. In most states the public is unaware of the service guarantees of the IPHS and there are no efforts to display this.

5.4. The major strategy form in which IPHS standards are to be implemented are in the form of facility surveys that have been completed or are nearing completion in almost all of the states visited. This is being used to close the gaps between what is required and what is present. While conducting the facility surveys for the health facilities, Medical Officer should be a part of team so that he will also aware about the gaps in the health facility. Though this strategm is enough to close gaps in hardware, it is inadequate to close gaps in human resources, its motivation and its skills. The programme has reached the stage where it is seized of the hardware gaps.

5.5. In a number of states like Rajasthan, Tamil Nadu, West Bengal, Andhra Pradesh, Orissa, there are state partnership plans with bilateral or multilateral funding agencies that seek to improve health systems. NRHM inputs have further supplemented the efforts and they have been quick to build on this.

5.6. Innovations in Human Resource Management: This is another core strategy of the NRHM. The NRHM is committed to finding solutions to some of the key constraints that the public health sector has been facing- in terms of recruitment and deployment to rural areas, in terms of workforce skills and in terms of workforce performance This is discussed in detail later in section 6.0

III- IMPACT ON CRITICAL AREAS OF CONCERN

1. **Fully Functional Facilities:** Fully functional sub-centers, PHCs, CHCs, and division district hospitals:

1.1. This is assessed under the heads of sub-centers, PHCs, CHCs, sub-divisional hospitals and district hospitals, laboratory and diagnostic services, infrastructure and maintenance gaps, drugs and logistics issues, and waste disposal systems.

1.2. **Sub-centers:**

1.2.1. Most states report an improvement of services due to filling up of vacancies and improved monitoring and due to the untied funds that has overcome many small constraints and given confidence. The main services available in the sub-center are immunizations, ANC services and DOTS. In most states the sub-centers were not the main site of delivery and often they were conducting none – mostly referring delivery cases to health facilities and not actually conducting deliveries. Sub-centers in AP or in Tripura and West Bengal do not perform delivery. Similarly IUD insertions were not a feature of sub-centers and this was attributed to poor demand for these services. There was an insistence in these states that ANMs could not be persuaded to do these services though in fact they are done by ANMs in many states. The SC records and registers were found to be up-to-date and properly filled up. They also had records of JSY beneficiaries in their area. The untied funds had made a big difference to the sub-centers. The second ANM could make a difference but at no place visited had this happened and therefore it is difficult to judge. It would be important to break the belief that activities like deliveries cannot be carried out by ANMs, in those states where this is a problem before appointing the second ANM. In some states there is a clear road map evident as to how the second

ANM would be put in place. In most states there is a decision to do so but not much of a road map.

- 1.2.2. To call it a fully functional sub-center the roles of the male worker in disease control, the role of both male and female workers in first contact curative care need to be enhanced. The core RCH activities depend on the vaccine delivery system, and the efficiency and quality and regularity with which outreach services are organized and the community processes that support her. The improvement in vaccine delivery and the improved quality and regularity of the immunization session expanded into the health and nutrition day are recorded from most states visited- though in quality of care per se there is no evidence either way. Infrastructure and drugs and supplies continue to be major constraints and these are discussed further below.

1.3. PHCs:

- 1.3.1. The situation in PHCs varies very widely across the states. The problem of assessment is also confounded by issues of nomenclature. Most states still refer to the facility of one per block or per 1.2 lakh population as the PHC and the facility of one per 30,000 as additional PHC. (The area being catered to by one such additional PHC is referred to as a sector). In such cases the CHC is a subset of the block PHCs which have been re-designated thus . In some states such re-designation implies that administrative sanction for posts in conformity with the CHC has been sanctioned. Sometime such sanction is only intended. Others like the Mohanpur CHC has 20 beds and there is a fully functional lab (all routine tests, sputum and slide examinations), X-ray (60mA) etc , but it is not a FRU as OT is not functional and there are no Anaesthetists. And nor is there a plan of moving it to IPHS norms. Thus the definition of a CHC and what people understand by this is variable.

- 1.3.2. Ideally for a block of population of 1.2 lakhs there should be at least four sector PHCs catering to 30,000 each and one CHC. There is some need for clarity whether one of the sector PHCs should be incorporated into the CHC or should be over and above it. (4 PHCs plus one CHC in a block of 1.2 lakh population of 3 PHCs plus one CHC). If it is incorporated into it the staff of the PHC should be additionally available in the CHC. In practice of course the number of PHCs per block is often less than three and this is one area where the gap between the norms and the situation on the ground is maximal. This for example the mission reports from Tripura that the coverage of the PHCs varied from 5000 to 1.2 lakhs.
- 1.3.3. Out patient attendance is varied but most states except J&K report sizeable increases. In Tripura the OPD attendance was around 100 per day for all the PHCs. Functional bed strength varied from six to ten beds with bed occupancy being more than 100% in summer and monsoon seasons. Cases admitted at present were mostly fever cases. On an average the PHCs were conducting 20-50 deliveries per month. By any form of measurement this is a 24*7 PHC- and though the full package of services as specified in the IPHS is not yet in place it is well on the way to achieving this. In other states the increase is less dramatic and less uniform. Orissa and Rajasthan report general increases. Increases in Chhattisgarh, Madhya Pradesh are more varied. In J&K there is no definite evidence of increase. Bihar the increase is in block PHCs - the situation in sector PHCs being less clear.
- 1.3.4. The factors that have helped most, other than a general seriousness to revive them are the contractual appointment of staff in PHCs especially of nurses. Thus Tripura which has implemented it has performed much better than say Uttar Pradesh, where there is no special effort seen to increase nurse strength in the PHCs. Tamil Nadu, has made 780 of its 1421 PHCs into three nurses PHCs and

the rest would be made so in the coming two years. On the other hand it is clear that it is not going for the two ANM option. Planned, phased and well thought out, Tamil Nadu remains a leader in most reforms that it chooses to act on.

1.3.5. Many states have put special effort into filling doctor vacancy in PHCs, an old problem. Uttar Pradesh has had a policy of using ayush doctors as one of two doctors posted at the PHC was from ayush stream. In Chhattisgarh ayush doctors had been recruited to close medical officer gaps and the existing vacancies were much limited. In Orissa and in a number of other states pre-PG compulsory rural posting in the public service has helped fill substantial gaps. In Tripura there were with two or more doctors per PHC as required as per IPHS norms. We note however that AP still reports low case loads of even of institutional delivery in 24 hr PHCs due to lack of manpower- despite having one of the largest number of medical colleges, all of which is in the private sector.

1.3.6. Hardware gaps continued to trouble despite facility surveys and despite untied funds. For example in Bihar no PHC had a generator, causing problems in maintaining cold-chain in case of power-cut for more than 24 hours. However the funds are in place, the gaps are clearly delineated and there is every reason for confidence that with some enabling support these gaps can be bridged within this year.

1.4. CHCs:

1.4.1. In CHCs the criteria of “fully functional” is to achieve a level of good quality in patient care as well as basic surgical and emergency services. This is in respect of the RCH programme equivalent to the creation of a FRU or Cemonc center- but as most of the inputs required for these two are the same for any basic surgery and referral care, other than the skills- creating a CHC as per IPHS standards and a FRU or a Comprehensive emergency obstetric care center are not

that different a task – except for the skilled human resource component.

- 1.4.2. With this understanding, there is a need to synchronise the FRU and Cemonc creation goals with the health facility development goals. The overlaps must also be clearly stated so as to prevent duplication of efforts. Thus if a block has a rural hospital or a sub-divisional hospital or a district hospital, does it need a separate CHC or FRU or just adequate staff in the district/sub-divisional hospital.(Similarly if a sector as a CHC or block PHC in it does it plan for a 24 hour or for that matter any PHC. If a section has a PHC in it does it need a sub-center?) These seem obvious answers but in practice there does seem to be duplication occurring due to a complex of reasons (e.g. often PHCs/CHCs are under a different directorate from the sub-divisional hospital etc) that leaves both institutions short of human resource.
- 1.4.3. There has been a marked increase in the functioning of CHCs – both in terms of the quantity and range of care they offer. Bed occupancy at the CHC in Alwar, for instance, was 70 percent now; and in the summer months, it rises to 100 percent. This improvement is not uniform across the states but the graph is upwards. However many state reports give a more varied picture.
- 1.4.4. Of more concern is that most CHCs visited are still functioning at the level of PHCs, unable to make the transition to regular full occupancy in patient care and a wide range of specialist services. The critical gaps are in specialists and in nurses though there are sufficient examples of facilities where these were in place but services had not reached the benchmark. There is obviously a need to address all three aspects of workforce- recruitment, adequate skilling and performance though better accountability and support to get to the levels of service delivery required. Of both PHCs and CHCs the observation has been made from many states that even RCH is

often translating in the ground into antenatal care and care at delivery and immunization. The other components, fixed sterilization day per week, safe abortion services, adolescent clinics, RTI/STI clinics, infertility services, newborn care, institutional care for the sick child, care for the sick malnourished child, all lag behind. This is not an availability of human resource problem. It is a skill and workforce organization issue. In short, to make every block PHC into a CHC is still a long way ahead and many states seem to have settled for making the district and sub-divisional hospitals functional rather than trying for a goal that they have little confidence in reaching.

- 1.4.5. One other interesting observation of a CHC in Gujarat is worth recording. “In the current year a total of 133 medico-legal cases were dealt with by the CHC. In the current year a total of 15 post- mortems are conducted by the CHC.” The legal obligations of the district health system and even of district hospitals and CHCs are less discussed on literature and not the object of studies. Yet this is an important role that the public health system delivers for which there is no substitute. The level of assistance and capacity building this needs has to be estimated and this function also needs to be brought within the planning horizon.

1.5. Sub-divisional hospitals and district hospitals.

- 1.5.1. In contrast to the experience with CHCs, there is not only a marked increase in the load that district hospitals and sub-divisional hospitals, all the changes expected of the CHC are happening here in almost all the states visited. Indeed the criteria of a good district seem to be largely influenced by a well functioning district hospital. For instance, at the District Hospital in Alwar, we found that apart from institutional deliveries, there was a noticeable increase in in-patient treatment, out-door care, surgical operations, laboratory investigations.

1.5.2. This is probably because with human resource constraints being less restrictive, the system responds to the rest of the NRHM inputs promptly and positively. The untied funds utilisation, the rogi kalyan samiti functioning, the improvements in bed occupancy, the closure of diagnostic gaps are all much faster. Much of this is perhaps responsive to the general increase in interest in strengthening public health systems, and part of it is responsive to the increased referrals from the Janini Suraksha Yojana programme and the increased referrals consequent on improvements of functioning of the peripheral facilities and of the ASHA programme.

1.6. Laboratory and diagnostic services;

- 1.6.1. This has improved at the district hospital level, some improvements made in the CHC level and tapers to even lesser levels of improvement in the PHC and sub-center level. There is little focus on reaching IPHS standards as such except for the visible diagnostic of ultrasound and Xray machines at the district hospital and CHC.
- 1.6.2. There has been a NRHM focus on sharing of laboratory infrastructure and equipment and the technician between the various vertical programmes, as one of the most recognized issues of horizontal integration between programmes. But as the Mission showed this recognition of the need to do this has not yet translated into such action in the field. There is a need to reiterate this goal and keep up the pressure to achieving it.
- 1.6.3. In Bihar in view of the gross shortfall in laboratory technicians, the State opted for private sector participation in provision of laboratory services. These services have been outsourced and the timings of sample collection are well displayed at the health facilities. The available x-ray machines are provided to the outsourced agency. The outsourcing has been effective in ensuring the services at 24x7 PHCs. These services are in the process of being extended to all other PHCs and other health facilities including Medical Colleges.

- 1.6.4. Court cases impede laboratory technician recruitment in West Bengal and Orissa.

1.7. Logistics and supplies:

- 1.7.1. Most states visited the absolute availability of drugs and supplies have improved. Indeed in no state was poor quality or access to care attributed to this. Nor were there complaints of lack of funds for drugs and supplies.
- 1.7.2. However regularity in drug supply was poor in most sub-centers visited. This situation regarding regular supply was more varied in PHCs and CHCs visited and reasonably acceptable at the district hospitals visited.
- 1.7.3. The central problem seems to be that in most states except Tamil Nadu the distribution is still supply driven and not automatically responsive to changing patterns of consumption. Thus a fixed set of supplies reach every facility in the form of kits or quotas with a varying periodicity. There would be a quick stock out of high turnover drugs and a wastage of low turn over drugs. In one instance large amount of baby face masks to be used in OTs were lying in the store. This is clearly a waste because such a large number can't be used at any facility in the jurisdiction. There are many such examples of what we call supply driven logistics.
- 1.7.4. The problem is worst at the sub-center level where by definition drugs are supplied in the kit mode. As we go higher there is more space for indenting and responsive supplies to indents and the problems decrease. Considerable facilitation is needed to put the logistics system in place in other states like what Tamil Nadu has done.
- 1.7.5. Good distribution and logistics needs a sound procurement policy- the benchmark of which is the Tamil Nadu system. Most states are committed to moving towards this- and many states like AP, Gujarat, West Bengal, have made some strides in this regard- but no where

has it reached the benchmark levels. In west Bengal the budgets are communicated to district CMHOs and the rate contract for each drug is fixed at the state level. The state is also considering establishing a WB warehouse corporation for procurement of drugs and equipment. As an issue of good governance this needs to be monitored.

1.8. Infrastructure and maintenance issues.

- 1.8.1. Lack of adequate buildings of their own remains a problem. This problem is maximal for sub-centers where rented space is often not adequate space. (For example four of the six SCs visited inwere running in donated/rented buildings, but had adequate space, except one (Bhabanipur). In PHCs and CHCs more often than not they are in government buildings but with sizes less than specifications as per IPHS norms.
- 1.8.2. Most state visits report considerable activity in the civil works area- some going as far as to state they found it everywhere they visited. Since in many states this represents a catching up after years of stagnation this is not unexpected. Also in many states much of the funds is locked up in civil works and is slowing down rates of expenditure. Logistics and drugs and supplies: Stock register showed frequent stock-out problems in all the SCs, especially for PCM. DOTS and malaria drugs were available in sufficient quantity. It was observed that stock of any particular medicine was allowed to fall below average monthly consumption and reach zero balance before new indenting.
- 1.8.3. It seems that whereas PHC constructions would be able to be matched by human resource and equipment to reach the desired outputs, the same cannot be said of the construction of CHCs where the human resource gaps and skill gaps remain far behind. On district hospitals and sub-divisional hospitals, however since manpower is less of a constraint, inputs of infrastructure are matched by expected outputs in terms of increase in services.

1.8.4. Cleanliness and maintenance is an issue and the situation is varied across the states. Most states have used their untied funds and the special maintenance grant towards this end. Many states have added in considerable investment of their own. Thus except for three states- Bihar, J&K and Madhya Pradesh, the reports talk of a high level of cleanliness in all the facilities visited. This was particularly so in Uttar Pradesh where cleanliness was receiving the highest political priority as well.

1.9. **Waste Disposal Systems.** In most states sub-centers were using disposable syringes for immunisation and were not using sterilisers. In contrast hub cutters were often rusted and unused. Syringes and needles were not decontaminated and proper disposal mechanisms for needle disposal in pits are not in place. Similarly the segregation of waste at source in PHCs and CHC and district hospital was not observed in most of the states visited. Though instructions are known there is much more facilitation and training needed to achieve this. Even where PCB has certified the facility the minimum requirements of waste disposal were not being met.

1.10. **Summarising:**

Increased confidence in government facilities: We found a general increase in the use of government health facilities that signals a positive change in people's perceptions regarding government health facilities. Observing the improved facilities at the time of deliveries has made people regain their confidence in government services. The better position in drugs and supplies, the increase in manpower, the use of untied funds, is reflected in the increased use of government facilities.

2. Human Resources for Health:

2.1. This is discussed in terms of numerical adequacy and the requisite skill mix. Then we discuss issues of workforce management and then issues of capacity building and finally to issues related to workforce performance.

2.2. Numeric Adequacy and the skill mix:

- 2.2.1. One major step undertaken by the NRHM has been to increase the total number of posts by firming up norms (under IPHS) of how many posts are needed at each level and offering to fund them for contractual appointment. There was a condition attached that funding for contractual appointments would flow only if there are corresponding efforts to fill up regular posts by the state government.
- 2.2.2. These measures together led to a considerable filling up of existing vacancies. Madhya Pradesh for example has filled up all male worker vacancies and many other states are following in this. ANM vacancies in most states are less than ten percent- and this is a precondition for the second post. Similarly medical officer posts in PHCs have received attention and a variety of means of recruitment have lowered the vacancy position considerably. Thus even without actually expending NRHM funds, most vacancies except that of the specialist posts and to some extent of nursing have received a push to fill up vacancies.
- 2.2.3. The IPHS has raised the nursing posts in the system considerably. Instead of one the NRHM is now willing to fund two ANMs per sub-center. Instead of none or one nurse at best that current PHCs are deploying, the NRHM is recommending and funding upto three nurses per primary health centre and nine per CHC. Most states who have become seized of this opportunity are struggling to find the ways of filling these posts up- for that many nurses or ANMs are simply not available for hire. West Bengal leads in the roll out of this component. The government has taken the decision to appoint married women resident in the local area, as chosen by the panchayat to this second post. The revised sub-centre building design can house two ANMs and costs Rs 8.5 lakhs to build of which a 3.6 lakh share is being picked up by the state government. The State has established 49 ANM training schools including an existing

18 and 3527 ANMs are under pre-service training and certification programmes. Most of these new ANM schools are under PPP arrangements and once this sudden increase has been met the state can cut back to a regular smaller number of schools for annual replenishment. Tamil Nadu has chosen another route, more appropriate to its stage of development. It has no ANM training schools and does not intend any. Instead it is able to produce 6000 staff nurses every year from its 21 government and 53 private nursing schools. Its ANM (called VHN cadre) exists but under its present rules it is a cadre promotion of anganwadi worker who after ten years service qualifies through the 18 month training programme leading to a much older entry point. The state has chosen to focus on increasing nurses in the PHC and not go for the second ANM option in the sub-center. Rajasthan is actively recruiting nurses and to a large extent has been successful in doing so. Bihar reports the posting of 2nd ANM in 40% of Sub-Centres. Chhattisgarh on the other hand has not yet started though it is stated in its PIP. Uttar Pradesh has started but states that it is unable to find qualified nurses- partly because they have defined their qualifications in an improper manner leading to an artificial scarcity. Tripura and most other states have started but have found only a small part of the workforce needed. This in turn has brought pressures on a rapid revival of existing ANM schools and a rapid increase in new ANM schools and nursing schools in all these states. However on the ground except in a few states it is going to take a few years before the positive impact of these changes are felt. Gujarat efforts in expanding the nursing/ANM force is also limited reflecting, perhaps a poor confidence in this cadre being able to make a dent. Their focus on the PPP approach is seen as filling the gap, and vacancies at government institutions remain one of the highest (43%- without the expanded post sanctions under NRHM).

- 2.2.4. The IPHS has raised the norm for medical officers in PHCs to two per PHC (additional PHC or sector PHC). Tamil Nadu already has this in place. Few states like Chhattisgarh have created that many posts in the state sector itself. But Chhattisgarh has not started filling these posts up two years after its creation. Others are considering filling it as contractual staff under NRHM, but no state has started doing this as yet for the second MO. However states have filled up the first medical officer post with either a compulsory pre-PG rural posting of a fresh graduate, or an AYUSH doctor. Both of these are without specific induction training and that would limit their utility. However there is therefore a sharp improvement in medical officer vacancy situation in a number of states. UP has sanctioned a post of an allopathic medical officer (MOIC) and one of a AYUSH medical officer (MOCH) for each PHC and this is a step forward if they implement it uniformly, and provide the drugs and other support to the AYUSH practitioner. At present its implementation is patchy. West Bengal has given powers to GPs for recruiting medical officers in underserved areas for outreach services for 3 days in a week. On the other hand some states like Gujarat; a good performer by many scores is not doing well in this and is still facing problems of doctors and nurses shifted away from places they are posted in, on deputation orders.
- 2.2.5. For the CHC, instead of 11 specialists as recommended by IPHS most states have sanctioned a more manageable earlier norm of 4 or 5 specialists and 2 or 3 medical officers. The IPHS recommendation for specialists appears to be set too high to act as a reference point.
- 2.2.6. Specialist shortages cripple the system. Some of it can be improved by rationalization – like gynecologists and anesthetists not being posted in the same place. But such improvements though important to show the government's resolve would still not be adequate to make up for the gap. It is also worth noting that the usual

approaches to posting and transfers of staff, based on seniority and cadre, when applied mechanically to specialist's leads to considerable problems in service delivery. The need to build up a specialist cadre and a postings policy for them around the "service guarantees" that each facility has to ensure remains a challenge.

2.2.7. New recruitment of specialists has been given priority in many states. But the turn out is limited. Joining rate against advertised posts is 15 to 20% in West Bengal and there are similar reports in most states which have tried the regular route.

2.2.8. The route of contracting in specialists from the private sector is at the policy level unanimously accepted, but in practice, either due to lack of private sector where it is needed most, or due to the nature of relationships between professional practitioners, very few states have been able to make a big difference by such contracting in.

2.2.9. Lack of satisfactory remuneration is another major constraint. The current payments are far too low to attract or retain specialists. In many states regular employment still starts at Rs 8000 per month and contractual at 10 or 15,000 per month. Again manpower recruitments at specialists level could be augmented if we are able to pay market rates which the Andhra report points out is available option under GFR 2005 rules. However this rule has not yet been evoked in the context of finding specialists for rural service, and this may be one option that needs to be considered further. Madhya Pradesh however has been able to make some headway in finding specialists by offering a larger initial package with a good performance based incentive thrown in.

2.3. Increasing professional and technical education.

2.3.1. The gaps between the generation of skilled human resources and their requirements are large and growing and only a massive expansion of nursing education can meet the demand. Of 400 posts

of Nurses advertised in Tripura only around 70 joined and similar reports are there from most states. Every state had gone through the experience of letting their ANM schools wind down and were now in the process of reviving them as well as opening new schools. A state wide assesement of the situation reads thus:

- Tripura: Only two ANM training centres in the state, with one in south district. Both put together are producing 50 ANMs every 1.5 years. One MPW (Male) training centre functional in Agartala is expanding to 100 seats. Nursing college started functioning under PPP for GNM courses
- Rajasthan: 5 new ANM training centres are being established. MPW (M) training centers are non functional in the state. State expressed that GNM may be allowed to function against the post of MPW(M).
- Bihar: reviving 12 ANM schools.
- Orissa: There has been a 33% increase in seats in the existing ANM schools and a starting up of new nursing schools.
- Uttar Pradesh: Has 49 ANM schools of which 27 are possible to make immediately functional. However only one batch has been turned out between the mid nineties and now. The next batch is yet to join, though a decision in this is taken up. Male MPW schools are limited and not functional.
- Tamil Nadu – no new ANM schools and all earlier schools converted to nursing schools. 21 government run and 53 private nursing schools. Male MPW schools are also not considered.
- West Bengal:Has established 49 ANM training schools including reviving an existing 18. There are 3527 ANMs are under pre-service training and certification programmes. Male MPW schools are not functional.
- Madhya Pradesh: At present 29 existing ANM schools run by the government have been revived or started up and proposals from 19

districts for setting up private ANM schools are in pipeline to augment the creation of ANMs. Sponsored development of faculty and select technical cadre in private schools is being used to accelerate progress.

- Chhattisgarh: Has 6 ANM training and 3 MPW training schools. These have been revived. Their plans include expansion to 16 ANM schools and as many nursing schools with ANM schools being prioritized for distant blocks. However despite being on the plans for two years, operationalisation has not begun.

2.3.2. The situation is similar to nurses but relatively less acute for MBBS doctors. This too is partly because most states are not aspiring to meet the IPHS recommendations. Regional variation is also high. Bihar is finding doctors though it has a shortfall of medical colleges, as many have graduated in colleges outside. In contrast Tripura is not. For an advertisement of 300 posts of Doctors, only 67 turned up. No local “production” of doctors as state medical college will pass out the 1st batch in 3-4 years. Two medical colleges running in the state with 100 seats each, with one under PPP. Only MBBS being offered apart from DNBE at the govt. medical colleges. When they are in full production Tripura should have a big excess, one years output being equal to the needs of the entire public health system. But currently they remain in deficit.

2.3.3. Quality of professional education is a problem and this problem is exacerbated by the rapid expansion of the courses. On one hand there is a set of restrictive rules that do not necessarily guarantee quality but which seriously impede the expansion of professional education. On the other hand there are no faculty development programmes or in built systems of quality control or any effort to match the skills being provided with the skill requirements of the public health system and no formal ways by which this can be enforced either.

- 2.3.4. There is a similar situation as regards paramedical technical education. Though schools for technicians are expanding the systems of regulation, faculty development and quality control and skill match with public service requirements are all very poorly addressed.

2.4. Multi-skilling:

- 2.4.1. Multi-skilling is one major option for getting the skill mix required within the available human resource of the department. There are three areas where such multi-skilling has been encouraged under the NRHM. One is in paramedicals especially for laboratory technicians and for curative clinical skills and first aid skills in pharmacists and other paramedicals posted in remote areas. This has been taken up in two states, Tripura and Chhattisgarh, and in the latter progress is slow. In Tripura all Supervisors had received multi-skill training. In other states this measure has not attracted attention.
- 2.4.2. Multi-skilling of nurses: The specific proposal in this regard has been for the creation of nurse practitioners, in a context where there are no women doctors and often no doctors at all. Some functions like RTI management need women doctors and indeed in all functions this is welcome. Counselling, adolescent clinics, regular follow up in non communicable disease, are other functions that nurses can perform. This is in the PIP of number of states but only Andhra Pradesh and to a limited extent West Bengal has begun work on this.
- 2.4.3. Multi-skilling medical officers for specialist's tasks: Multi-skilling for specialist skills needed for emergency obstetric care is the area where the most visible advance has been made. The systems for this have been put in place and the legal challenges have been engaged with. Paradoxically the programme proceeds fastest and best where it is least essential as the potential availability of specialists is highest- Gujarat and Tamil Nadu, and slowest in the states where it is most

needed. The success in the first two states points out the universal validity of this approach and in a much more modest way Chhattisgarh too has shown that it can be done. Most other states have started up these courses but again it would be a year at least before the results starts showing in terms of increased service delivery. One aspect worth noting is that in many states a fair number of medical officers are providing surgical and anesthetist skills and they are under pressures to stop doing so. However given the fact that as recently as 20 years back this was the main form of surgical skill availability in the public health system, it would make more sense to prioritize such officers for certification through short term courses so that the start up times are much reduced.

2.5. Improving Workforce performance:

- 2.5.1. Pooling of resources at block level as a way of getting the right skill mix both at the PHC and at the CHC is been proposed – but there are few instances seen of it being practiced. *Mandal* level pooling of resources – by which we prioritise making one facility at the *mandal* headquarters highly functional was seen by the Mission as an option suited to the Andhra situation. A *mandal* being approximately one thirds the size of the block this approach offers much greater advantages than even the usual block pooling. The presence of an excellent referral system makes it even more attractive and effective. However one has to understand the constraints and why this suggestion has not taken off in most states.
- 2.5.2. The issue of government specialists doing private practice was another major issue that was raised. Andhra report in particular quoting a case from Nalgonda states that this “has become a vested interest in the public health provider, not to operationalise emergency obstetric care. To make the matter worse the ANMs and ASHAs under the MO in charge may become agents for taking the C-section

cases to the private clinics being run by them and earn some extra bucks.” This report has called for better monitoring of hired specialists as an immediate measure of improving workforce performance. The mission group visiting Rajasthan saw the need for a comprehensive policy on compensation within which the private practice issue should be addressed.

2.5.3. Incentives have been proposed widely and are in place in Madhya Pradesh, and a number of states. Except for hardship allowance however in most states few incentives have actually been paid out. Again it is probably early days in this strategy and also a lot of caution in embarking upon this route for improved workforce performance.

2.5.4. The issue of a lack of a transfer and posting policy impeding workforce management and workforce morale has been reported from many states. Again it is worth noting a clear alternative experience. The review mission to Tamil Nadu notes that the state “follows a very sound system of transfer of doctors and paramedical staff as transfers are affected only on requests and that too against clearly available vacancies. This year only 10% of the total numbers of posts were having transfers. Transfer procedure involves counseling and transparency wherein the list of vacancies is put in the public domain and doctors can put in their requests for their posting to the place of their choice.”

2.6. Improving workforce skills for service delivery:

2.6.1. Improving workforce skills in house requires a systematic programme of in service training. Current training programmes are almost completely linked to the national health programmes and even within these divided into IMNCI, SBA, adolescent and reproductive health, training in IUD insertion, training for different types of sterilization surgery and for safe abortion etc etc, each of which is proceeding independently of the other. There is no way of even measuring how many facilities now have all these skills in place and

are using it and the training institutions are not charged with ensuring that each facility has the requisite skills in place. There have been efforts to build up district and regional training centers and state institutes of health and family welfare, but they are limited to transmitting, as unchanged as possible these above packages to a fixed number of persons every year with little certainty of what becomes of it after they have left the training hall. Beyond these fixed RCH and RNTCP type training packages no other dimension of the IPHS specified service package is currently being addressed. A national stewardship role for in-service skill development consistent with the NRHM mandate, which builds the SIHFWs into effective state level leadership roles, is an urgent priority.

- 2.6.2. Even with available human resources and skills more could have been done and if the district had a training node /center which addressed skill gaps, facility by facility, then far more could be done. Putting this in place along with a team/center for providing assistance and the institutional memory for district planning is another priority.
- 2.6.3. Making available graded standard treatment guidelines and essential drug lists and formularies which could guide the wide range of health care providers actually providing health care. There are AYUSH doctors providing modern medicine care without as much as a book to refer to. Both MBBS doctors and AYUSH doctors have to fall back on MIMS which is far more appropriate than their text books in the context of their use. However MIMS is hardly a desirable for the health system and the earlier the state circulates standard treatment guidelines the better. Both Maharashtra and Chhattisgarh and the armed forces medical division have graded guidelines that could be easily borrowed from and built upon. This is essential to reach the NRHM objective of comprehensive care.
- 2.6.4. There is a considerable effort into public health management training that has begun. One set of trainings relate to the three month

professional development course, where different state institutions have been accredited to deliver the training package. Another is the training programmes being organized for PMU contractual staff. An effort to start a diploma in public health in a number of institutions is also underway under the leadership of the NIHFV.

2.7. Integration with AYUSH system

- 2.7.1. Regular doctors for Ayurveda and Homeopathy exist under state cadre. This is apart from AYUSH doctors recruited under NRHM and co-located at PHC/CHC/ SDH level to provide AYUSH services so as to mainstream AYUSH and make it more accessible to the public even as it helps to make the public health facility more functional. Most states have now started undertaking this. AYUSH health care facilities are being provided under the program *EK HI CHAT KE NICHE* (Under one Roof) in selected institutions of Rajasthan
- 2.7.2. AYUSH doctors and staff are playing supportive or trainer roles in ASHA programme and in RMP sensitisation to start for referral of TB cases in west district in December 07, it has not started yet.
- 2.7.3. Another distinct role is the appointment of AYUSH doctors in PHCs as medical officers against the regular medical officer of the modern medicine stream, because of the failure to fill it up with the regular doctor. The understanding is that curative care would be provided as per AYUSH but he would see all other public health programmes. However neither is there the logistical support for the former curative task nor do the necessary training inputs to make him capable of doing the latter seem in place. Nor are there inputs for the curative role at least at paramedical level that he could play. However in most remote areas these doctors are now closing the service gaps and providing a good degree of patient care.

2.8. Summary:

2.8.1. Where there are recruits available in the market, the larger pool of posts created are being filled up rapidly. There has also been a lot of pressure to fill up regular vacancies under the state budget. However in most critical areas even where states have charted a road map it will take a few years before the impact will start showing. And what is a matter of concern, in the EAG states, much more facilitation is required before they are able to chart out and start moving on such a road map. In the area of human resources for health it has taken this long just to break from a cynicism of “nothing can be done” to the central questions of getting manpower to serve in rural areas and provide quality service in an accountable manner. This cynicism underlies the complete closure of ANM training schools and the lack of expansion of professional and technical education in the public sector and the failure to address many long standing and festering issues of workforce management. The NRHM has opened up a wide number of possibilities for action. It has brought some of the key areas of human resources for health into the actionable zone. However there is much that remains to be done and a very high degree of facilitation and change management needed before the poor performing states are able to get going and even longer before the impact of these changes are reflected in health statistics.

3. Accountability:

3.1. Measures of accountability envisaged under the NRHM are the process of review against norms and programme objectives clearly set by the programme for each state and district. At the community level the panchayats and the community monitoring process and the participatory management committees of the village and district as well as those constituted for each facility have the main role to play. Other than these

committee structures, a formal process of evaluation and reviews are also being put in place.

- 3.2. Though in most places the issues of gaps in provisions and human resource are the main problems there are other places where all the investments are in place but there is very poor performance for no reason other than poor accountability. In particular the mission team to Jammu & Kashmir notes that there is adequate medical staff and perhaps an excess of paramedical staff and “major investments have been made in infrastructure, equipments, supplies and even availability of human resource is good- but there is very poor performance and outputs due to rampant private practice, unnecessary referrals. Even where skills are in place surgeries are not being done.”
- 3.3. The recent revealing of large scale unaccounted funds with senior health department official in Madhya Pradesh leading to his suspension, and such other complaints are a matter of concern, especially given the increasing flow of programmatic and untied funds under NRHM. These need to be addressed by greater delegation and decentralization of financial powers along with more effective financial monitoring, and full transparency subjecting major financial transactions to public scrutiny. If these combine with partnerships with the private sector, such problems would only increase given the lack of regulation of the private sector and its un-official links with the government sector.
- 3.4. Some of these are no doubt governance issues and there is a need to develop indicators for good governance and be able to measure what part of a lack of service delivery is due to constraints of human resource, skills or infrastructure and what is due to poor governance and the lack of accountability.

4. Decentralisation:

- 4.1. This has been discussed along with communitisation. In brief though there has been a considerable , even dramatic increase in space for involvement of panchayats, decentralization in the devolution of ownership over health facilities has almost not occurred except in Nagaland and in part in West Bengal and Kerala.
- 4.2. In terms of transfer of funds, West Bengal has specified that funds for the VHSC will flow to village committees from the Zilla Parishad and be reported back through them. Further annual maintenance grants of sub-centers, PHCs and CHCs would flow via the Zilla Parishad to the corresponding panchayat tier (sub-centers to gram panchayat, and PHCs and to block panchayats) and be reported back through it.
- 4.3. Areas where panchayat involvement has increased and made a difference in almost all states is the *panchayat pradhan* signatory in the untied fund for the sub-center, the panchayat involvement in the village health and sanitation committee, the panchayat involvement in the Rogi Kalyan Samiti and the district health society. These are tentative steps forward in the road to effective decentralization, but they seem to be, despite some misgivings, creating a right atmosphere for further changes. In Gujarat the reports of forward movement even in these limited steps are negative.
- 4.4. As the processes of village planning and district and block planning improve, and as panchayat involvement in these processes increase the capacities of these structures to govern health improves. In states like West Bengal panchayat level cadre are being developed and paid for through panchayats making for considerable local accountability.

5. Reducing maternal and child deaths and population stabilization.

- 5.1. The major change in this period is undoubtedly in Institutional deliveries – this has been discussed earlier.

- 5.2. A number of states have proposed and continued with TBA training anticipating that SBA training would take time and the shift to full institutional delivery would take longer. TBA training being undertaken in tribal (ADC) villages under various schemes under DM. Home deliveries still preferred in tribal pockets with difficult access to health facilities.
- 5.3. The other major thrust has been in immunization. The immunization programme has been strengthened by many measures- approval of an alternative vaccine delivery mechanism, a computerized immunization management system, careful closure of cold chain gaps and a general transition to a 'fixed day fixed time' schedule for every village- when the children and women to be immunized are gathered in. This last has taken the form of a village health and nutrition day. Most state visits report the positive impact of many of these developments. It is technically difficult to measure increase in immunization in a short appraisal visit, but both vaccine delivery systems and health and nutrition days were seen to have become major features of the district health programme. Taken along with the support from ASHAs and the strengthening of sub-centers with an untied fund and better community support, a favourable impact can be expected.
- 5.4. The IMNCI roll out however was not as visible in the states visited. And other aspects of child care intervention especially institutional care for sick newborns were also limited on the ground- at all levels. In Bihar, even at the medical college level it was inadequate. This is probably because the process is at an intermediate stage and has not yet reached the service delivery level- but it is worth examining further, whether we are on the road map. In West Bengal a pioneer in institutional new born care, five district hospital level units with corresponding stabilization units at the block level have been established – on the Purulia model. Each district unit has 4 medical officers and 6 nurses trained to manage this unit. This is the best progress report in this front, but even this is too slow a rate of expansion.

- 5.5. Contraceptives available at all levels but rate of utilization is difficult to estimate. There seems to be adequate demand for services but the ability of the systems to deliver needs to keep pace. In some states it was reported that IUD is not popular, but it was also observed that IUD insertions were done only by MOs at RH/SDH level and the ANMs were unable to do this. NSVs are improving but still low and some states show decline in sterilizations. There is a need to re-examine a comprehensive way in which service delivery in these areas, especially in sterilisation can be improved- now that demand is no longer the problem and that lack of sterilization providers is a growing issue. Once a week sterilization services in all PHCs and CHCs seems a distant and perhaps even receding goal, unless urgent action is taken.
- 5.6. RCH programmes have suffered from the lack of human resource planning in the past and should gain the most from such planning under the NRHM. However this would take time and till then there would be a need to persist. Similarly in house skill development is critical and given the slow progress of training in so many states one needs to examine whether a more active national facilitation and strengthening of institutional mechanisms to play this role is called for.

6. Preventive and Promotive Health

- 6.1. The Disease Control Programmes, the nutrition related programmes, the school health programmes and de-worming and anemia management programmes, the oral hygiene and dental health programmes, the role of village health and nutrition day as a health promotion programme, and the behaviour change programmes all impact on preventive and promotive health. The NRHM per se facilitates all these strategies to the extent that it provides a forum for appropriate district level planning and for integration with the rest of the health sector work.
- 6.2. Integration across programmes has been a key theme. Sharing of laboratory technicians and laboratory facilities has been noted as a

priority. Some states report achieving this- others that it has not yet been achieved.

- 6.3. The control of malaria and Kala-azar received priority in areas where these diseases are prevalent. It is difficult to estimate changes but the systems in place for their control have been strengthened by the introduction of ASHA, by the filling up of MPW vacancies and medical officer vacancies and by the improvement of laboratories .
- 6.4. Work on the elimination of kala-azar has accelerated. The Bihar report states “Kala-azar is present in 31 districts. Kala-azar control has regained priority since 2 years. Spraying with DDT which was not done for 16 years has been restarted. The state Government ensured their primary thrust on control of Kala Azar through provision of free transport, free testing, free supply of drugs, and free diet to patient attendants and payment of Rs. 50 per day for the loss of wages. All the PHCs visited have admitted Kala-azar patients, tested the patients and confirmed cases are treated as per the protocols. The procedures for payment of Rs.50/day are yet to be streamlined as lump sum payments are made instead of daily payment for loss of wages. The teams visited the MSF Kala-azar unit established in District Hospital, Vaishali and the patients were fully satisfied with the facilities provided. Adequate arrangement has been made for treatment, assured drug supply and financial support for patients and one attendant. Partnerships have been established with MSF (Doctors without Borders). The RMRI, (ICMR research institute) does a variety of good research including basic laboratory, entomological, sociological and operational field research.”
- 6.5. From various states school health programmes, de worming and pediatric anemeia control campaigns, BCC activities, oral hygiene campaigns have been reported. Other missions have not examined these activities and to the extent that they were reported they seem to be exceptions, the programmes remaining confined to RCH and disease control areas.

6.6. One issue reported from Bihar and Uttar Pradesh particularly, has been the problems of managing so many rounds of pulse polio campaigns. This draws away a bulk of the human resources. The Bihar report states “Of the 3 polio cases in the state, about 24 had received 4-5 doses of OPV. Many children receive around 10 doses of OPV. The Government of India were requested to take this up as a policy issue. While so many resources focus on this problem the much more widespread and serious problem of anemia and malnutrition are relatively neglected.”

7. Disease Surveillance:

7.1. IDSP programmes report a variable take off. In some states they have yet to be established whereas in other states centres are operating at all levels, and registers are being maintained and training has been received by supervisors and MPW/ANMs. ACMOs or other suitable officers of the districts have been declared District Surveillance Officers and sites for Data Collection Centres were identified. In other states where this much has not happened these efforts have to be prioritized for early implementation. In some states computer hardware has been received but software is not installed yet. In others facilities are ready but waiting for data-entry operators to be placed.

7.2. Tamil Nadu is one state that showed the entire processes of IDSP in place and functional.

7.3. Hospital based data is an important source of information that the system must use. No hospitals are recording diagnosis in in-patient registers and case records are weak or absent. This hampers assessment of local disease burden preventing preparation of epidemiological profile of the area.

8. Hamlet to Hospital Linkage- the hamlet

8.1. There are two aspects that can be discussed under this head. One relates to the structures at the hamlet level. The main development in this regard is the ASHA programme. Some states have also experimented

with training RMPs in a limited way for this role. Anganwadi workers also provide a first contact curative care.

- 8.2. The second aspect related to the referral transport system. In the past the main effort has been in making a fund available in the panchayat or in the peripheral health facility that can be used for hiring and paying for transport when there is an emergency. In most states this is still the dominant form and its use is largely limited to transport for emergency obstetric care.
- 8.3. The new and rapidly emerging form of referral transport which is increasingly becoming synonymous with emergency ambulance services is the outsourced ambulance service. Tamil Nadu has such a system which is outsourced in each block to an NGO and coordinated by a district level control room. Both ANMs and control room and the ambulance drivers have been provided with mobiles and recently there has been a move to a single emergency number.
- 8.4. The benchmark for emergency ambulance services has however been established by Andhra Pradesh which has, with private partnership, evolved a remarkable system which within Indian circumstances is actually able to reach patients and deliver them in increasingly short cycle times of upto 30 to 60 minutes in most circumstances. A simple call to a toll free number 108 leads to an ambulance access in as low as 20 minutes in the villages visited. Moreover the ambulance has trained attendant and adequate emergency care equipment for stabilizing the patient in wide variety of circumstances.
- 8.5. In Tripura there is serious work to use tele-medicine facility, linked with the state medical college in Agartala to forge a PHC to tertiary care referral linkage. This enables specialist consultation for required cases. This is being funded by the state's own funds. Almost all states are experimenting with tele-medicine, but a benchmark programme with clear patient care or health systems benefits that can be replicated is still not established.

9. Health Information System (HIS)

- 9.1. NRHM aims to strengthen monitoring and as part of improved management and better monitoring it needs a functional health management information system. The NRHM emphasis is also on integration of monitoring across the different programmes and with the Integrated Disease Surveillance Programme.
- 9.2. The Mission notes that the Integrated MIS Format for flow of physical performance data were found at all levels. Including the lowest (ANM). However multiple reporting is still in vogue, under different programmes, and earlier forms are not yet abolished. Copies of reports sent above are not being maintained at SC level. Reporting under NRHM is being undertaken by the contractual staff and often differs from the record-based reports or programme performance reports.
- 9.3. The reports required are bulky and the periodicity of data flow is irregular. There are many data elements that are difficult to source. Systems of validation are not yet in place. One important observation is that the use of HMIS data as a regular tool of data management is not the rule.
- 9.4. In Bihar, the State Health Society data collection centre was visited and appraised of the daily collection of data from the Health Centres including number of deliveries, utilization of ambulance services, telephone, 24 hrs electric supply, working condition of Generators, etc.. The Data Centre has been very useful in improving the feedback on programme performance and in also reducing absenteeism at health facilities.
- 9.5. In Gujarat, Andhra Pradesh and Tamil Nadu systems of monitoring of general facility functioning are in place and use grades to rate facilities into four categories, with pressures to improve performance of poorer facilities.
- 9.6. There is a need to publish/disseminate District and facility profiles/reports that are prepared to the subordinate facilities and also be available for scrutiny by the general public. District health reports not being prepared.

Facility survey reports were not found in the facilities and it is suggested that copies of these reports should be retained at facility level also.

9.7. Lastly quoting from the Gujarat report, “it must be recognized that unless the remote area problem is integrated into the district health mission plans, progress will not be quick or easy. It would be useful to devise special indices for such remote areas; it will bring out the true disparities often hidden in averages for the districts. Our field visit indicated the urgent need for such data collection.”

10. Planning and Monitoring with community ownership:

10.1. One major development of the NRHM that has already occurred is district level planning. This process is complete or near complete in almost all states. In Rajasthan 26 districts out of 32 have prepared district health plans with the technical support of identified 6 Non-government agencies. 23 district plans out of 26 have been appraised. In Chhattisgarh all district prepared the plan in 2005-06, but since have not updated or revised it. In Bihar the District Health Plans have been prepared for two districts and is in process for the remaining districts. The UNICEF is assisting the state in preparation of the District Health Action Plans in these two districts. In the rest of the districts, work had been assigned to a consulting agency, where there has been a discord and the matter went to courts and has now gone in for arbitration. In J&K district plans were outsourced and this did not have the desired results with outcomes still not available. In Uttar Pradesh district planning was outsourced to SIFPSA and was completed in all districts with reasonable quality. Awareness about the district plans was however low amongst senior district health administrators. In Orissa all districts have completed their plans. In Tamil Nadu and Andhra the district planning is still more of a disaggregation of state data and allocations and does not meet the process requirements of the exercise.

- 10.2. Despite this mixed picture the overall view is that district planning to the level that it has happened is a step forward. It has brought various data together and made a basic skeleton of a plan which can be subsequently revised and built upon. Planning improved over the years and districts need the time to learn and improve. However there needs to be a agency or team within the district which acts as an institutional memory of the plans and for nurturing/pro-actively pursuing their implementation processes.
- 10.3. At the district level also like the role envisaged for the SHSRC at the state level, there is a need to infuse new methods of problem analysis and solution search appropriate to local needs. In this connection greater non-official involvement, especially of local professional and development and public health expertise resident in NGOs and research institutions, who are capable of planning should be sought having regard to the dynamics of power relations in rural areas.
- 10.4. Village plans prepared based on household health data and with involvement of PRIs are still an exception. In this regard the *swasthya panchayat* experience flowing from Chhattisgarh is worth learning from. A joint exercise of PRI members and Mitanins and their support organizations have measured status of health and health service delivery on a number of parameters and used it to calculate a health index and rank panchayats according to this.
- 10.5. The plans have not become documents that inform social audit or community monitoring. Indeed one of the challenges of the coming period is to improve the quality of community participation.

11. Equity:

- 11.1. The NRHM addresses equity concerns in a number of forms. Firstly it seeks to gather data with dis-aggregation for gender and for SC and ST. In this the strategy of gathering such data needs revision from being part of routine data to becoming part of sample surveys – for operational

reasons. Disaggregated data by population groups do not exist. There is obvious need to develop workable methods of tracking equity concerns at the programme management level.

11.2. All schemes of community participation, but especially ASHA, by empowering weaker sections and local communities serve the cause of equity. ASHA being women, it is access of health care by women and children that gets facilitated most.

11.3. All NRHM efforts to get all peripheral health facilities to become functional is one of the most basic of ways in which social protection for the poor is provided and the health sector reaches out to hitherto under-served areas.

11.4. For outreach to even more remote areas the mobile medical units and the outreach sessions are specific vehicles that the NRHM promotes. It has been difficult to assess the impact of these vehicles. It is also too early. In most states visited these units have become recently functional or are still in the stage of procurement. In Tripura a helicopter service to reach a particularly remote set of tribal hamlets has been sanctioned and is functional. In Andhra Pradesh free bus passes to pregnant women for three visits for antenatal care has been attempted. In Tamil Nadu in remote hilly and forested areas of Dharmapuri and Krishnagiri a concept of birth resorts is introduced under the state plan- which provides for pregnant women in the last month to move to a temporary home nearer a site that can offer institutional delivery. But in remote areas even the bus service does not reach.

12. Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water, etc. with community support

12.1. Representation of all departments in District H&FW Society is one first step forward in this direction. Integration of all these dimensions into the district plan is another step forward. Specific circulars and meetings have been held at national and state levels to facilitate this.

- 12.2. Though not observed during the review mission visit, Family Health Awareness Campaigns are an important interface of the National AIDS Control Programme with the rural health services. However, there is need for a greater information base with health personnel at all levels so that they can manage HIV positive cases with ease. Experiences of the evolving systems of ARV therapy through the public hospitals linked to social support by NGOs and CBOs need to be drawn upon for health services as a whole.
- 12.3. Where there are some tentative efforts made into entering health related sectors the relationship and overlap with other departments needs clarification. West Bengal for instance reports a pilot scheme for additional nutrition package for malnourished children, but the review mission notes that this is very similar to the existing ICDS and may indeed be a duplication.
- 12.4. One successful home grown model of convergence is the Madhya Pradesh “Bal Shakthi Yojana” scheme. Of this the MP report states “*Bal Shakthi Yojana* is a fairly successful scheme aimed at addressing severely malnourished children, i.e., children who come under grade 3 & 4 of malnourishment, who have been identified in the villages and who are now being taken in rotation to Nutritional Rehabilitation Centers (NRCs) in district hospitals, along with their mothers/ guardians, for training and counseling and other necessary supports, including intensive observation and medical treatment, in nutrition, hygiene, and health care under the guidance of paediatricians and nutritionists. Noticeably, apart from the stay arrangements, the transport cost for travel to the centre and the loss of wage earnings for the mother/ guardian accompanying the child are also covered by the government, to encourage access to this scheme. A follow up card is made through which the ANMs and AWWs carry out 6 months follow up to ensure sustainability. At present 40 NRCs are operational and it is planned to increase the number to 100 by the end of

2008. A visit to an NRC at the Elgin Hospital in Jabalpur showed a very positive picture of success of this scheme.”

12.5. However despite these first steps, much more needs to be done before the objectives of convergence are realized. Village sanitation committee have not yet merged to form health & sanitation committee and at the district level many societies function autonomously within the health sector and for each sector. .Linkage with the PRIs or a lead role for PRIs helps, but by itself does not ensure convergence. Benchmark plans that demonstrate convergence and that when implemented yield measurable outcomes are still to be evolved. This would be a focus in the coming days.

12.6. The Gujarat report notes that, “the role of the collector as the head of the district health mission can be crucial. By placing health in a wider social context within DHS he can create natural linkages between the health and sanitation and water supply, girls education, nutrition, forests, housing etc. sectors. There is a clear necessity for the district health society to address not only health care determinants but social determinants of health status. And this can happen only with greater association of PRIs and will need informed support of professional analytic resources, and accordingly be made a specific **task** of the State Health Resource Agency.

13. Chronic Diseases: Addressing burden of chronic diseases

13.1. This is another area where work has to begin as part of the NRHM and where the overall approach that is going to be followed is not clear. Some states have made some tentative plans for cancer control or for geriatric care in their state PIPs but expanding these into full fledged and adequate strategies is some distance away. New vertical programmes for a number of non communicable diseases is mooted at the national level, but its relationship to the current processes of the NRHM is unclear.

The real way forward is to build in the preventive, promotive and curative care for chronic diseases and non communicable diseases into the definition of fully functional health facilities and the provision of promotive and preventive services. Thus one needs to check their standard treatment guidelines, their essential drug lists, their referral systems, their BCC work to see whether the main concerns of chronic disease as appropriate to that region and its disease burden have been incorporated. There was no clear evidence of these concerns having been fully taken on board.

14. Social Security: *Social security to poor to cover for ill health linked impoverishment and bankruptcy*

- 14.1. No community health financing/demand side financing initiatives being under taken at community level were observed- except for the JSY scheme.
- 14.2. Risk pooling options are being proposed, but no such programme could be witnessed by any of the teams.

15. Over arching issues:

- 19.1. One of the key issues is that the over- all budgetary outlay increases – and this is taking states and central budgets together. The picture on what is happening to the state budget rests on statements made, and independent data based assessments are not available for review. These statements are made in good faith, but in addition to the state's statements it would be useful to institutional mechanisms in place for annual detailed budgetary analysis for every state and for the center, which is tabled and reviewed, and is available for NRHM's decision making on compliance to this central objective.
- 19.2. Andhra reports a steady increase in budget – 15.83% in the previous year and a further 29% increase in the current year. The report for each state is being compiled.
- 19.3. One of the issues of concern is that we do not quite know enough about what is happening to budgetary allocation between different heads. In West Bengal, for example, the mission observed that in one BPHC the

state budgetary support for salary, travel and routine expenses had declined though the State has communicated to the GoI the 10% increase in health outlay and 15% contribution of state finances to NRHM. The Madhya Pradesh report also points out that though total revenues raised by user fees for the state may be a modest 10 crores, less than 1%, at the facility level a large proportion of financing may actually be coming from user fees, much of it paid by the poor. There is clearly a need to assess what is happening to facility level expenditures as related to state level budgetary projections and how budgetary allocations are moving with the fresh infusion of funds. There is also no clear projection on how collections from user fees are moving. The institutional mechanisms to look at this, let alone monitor this on a real time basis have not yet begun.

19.4. The other major issue understands the failure of utilization of funds disbursed to the states. The actual position in this would be presented in an annexure. The key question is to understand in each states context the causes for poor utilization. Seven sets of causes may be contributing.

19.4.1. Delays in disbursement at national level and at state levels – itself often due to non submission of accounts and utilization certificates.

19.4.2. Delayed/snags in the pipeline- (the transfer of funds at each level after the decision is made): a technical issue.

19.4.3. Inability to expend funds due to poor programme management arrangements, mainly lack of delegation of powers and lack of management personnel: largely a capacity issue but with some governance elements.

19.4.4. Lack of capacity to account for the expenditure and submit utilization certificates, especially the problem of a minority of lagging performance units delaying the submission of the major part of the good performing units.

19.4.5. Inability to flex financing structures to be able to account for funds in the pipeline especially in civil works without losing

- 19.4.6. Delays in decision making, especially administrative and technical decision-making bottlenecks as regards policy and strategy: a governance issue.
- 19.4.7. Other issues of governance – a lack of leadership, often due to frequent changes and unfilled key posts or a failure to take decisions due to influence of vested interests some of which presents as delays in accounting and in decision making.
- 19.4.8. Inability to expend funds due to structural constraints- the human resource is just not there or the systems are too poorly functional to be able to expend:
- 19.5. NRHM intervention helps take care of pipeline snags by e-banking, of programme management arrangement and accounting delays by additional staff, often contractual and their training. But it is really stymied by issues of governance and structural constraints.
- Institutional mechanisms to track expenditure and fund flow and monitor issues of governance are also a challenge that the NRHM must address. To do so in a federal structure calls for administrative monitoring to be accompanied by suitable policy changes to facilitate such monitoring. It also needs the generation of a political will and political mechanisms of doing so.
- 19.6. Structural changes require time. For example the review shows that more nurses could dramatically increase outputs, and therefore increase expenditure but the states that need them most are just beginning to decide on setting up nursing schools. Or more drugs need to be procured, but the institutions that can handle procurement as flawlessly as the TNMSC benchmark take time in the building. Or district planning could dramatically increase fund flows- but to build institutional structures that can retain the memory of last years plans and professionally learn and improve on it from time to time takes a few planning cycles to establish- after the will to do so has been generated. Does the NRHM have that much time. Will the political gains hold? What are the low hanging fruits in a tree where mostly fruits hang high!!

19.7. Structural changes, and for that matter any pro-equity change requires political, administrative and technical facilitation. There is welcome attention today on monitoring by the NRHM and this must be further strengthened. But the system now needs to actively engage in facilitating these changes. Facilitation involves constant dialogue with partners at every level. It requires constant hand holding and technical problem solving as applied at the level of every facility and every village and every district. It requires capacity building – both of individual capacities and of institutional capacities and of systemic capacities. It requires internal advocacy and negotiation to hold firm on many processes that may not give immediate visible benefits but which are essential for eventually generating the desired outcomes. It requires engaging with and empowering weaker stakeholders who have greater interest in successful outcomes. It requires champions for pro-equity solutions to engage in working with the government. Identifying and stating the problems and designing innovative schemes would not by themselves overcome the many structural constraints in our path. Building the necessary institutional capacity and mobilizing the technical talent and administrative will and applying these to the task of facilitation is critical for a successful outcome for the NRHM.

19.8. Historically, the NRHM represents a return to the spirit of the Alma Ata declaration with a much better understanding gained from the intervening period of the costs of not doing so. But the challenge is to be able to convert this opportunity into an occasion for building partnerships and forging a unity across different stakeholders and political sections that gives it the time and space and guidance to do so.

RECOMMENDATIONS OF THE COMMON REVIEW MISSION

Reviewing the findings of the Mission and putting together the recommendations in from the different mission teams the Common Review Mission to the NRHM for early implementation.

1. **Awareness of NRHM:**

A systematic effort is needed at disseminating NRHM guidelines and practices. There is currently insufficient understanding in the public and even amongst many sections charged with implementing various aspects of the programme.

2. **Governance Issues:**

The poor state of utilization of funds in many states must be seen in relationship to this aspect. The senior levels of programme management are often beset with the problems related to deciding the chain of command, a lack of transparent and participatory decision making, frequent changes of key senior officers, needless delays in disbursements and accounting, and also a reluctance to engage in some of the longer term structural changes that are required. A systematic effort must be undertaken to identify issues of “Governance of NRHM” which are critical and need immediate attention of the state authority to address. Once such problems are recognized and admitted some common plan of reform in health sector governance should be worked for. One key area of governance reform would be decentralization and increasing the role of *panchayats*.

3. Decentralisation and the role of Panchayati Raj Institutions:

For effecting this a set of measurable steps are described below with a gradation from the relatively simple measures with widespread consensus, to the more difficult more contentious issues of decentralization.

- i. Ensuring adequate representation for PRIs in the district health committees and the Rogi kalyan Samitis or equivalent bodies.
- ii. Ensuring necessary consultation with PRIs before submission and approval of district health plans.
- iii. Information about district health plans in print given to all three tiers of panchayats.
- iv. Fund transfers to village health and sanitation committees and untied funds in sub-center where necessarily the panchayat members is one of the signatories or key decision makers.
- v. Transfer of powers of recruitment of contractual staff to block or district panchayats especially for specialists, nurses, doctors, and some technical categories. This could be limited to areas which are facing “willing”-staff shortages or made a general rule. To perform this function effectively, the panchayat would be enabled by a suitable agency/NGO whose costs for successful recruitments and assistance in negotiating the contract could be paid for by the state from NRHM funds. This could be on a continuous basis
- vi. Allow states to include in their PIPs a plan to provide funds to block or district panchayats for incentives to pay for difficulty allowance or to pay incentives to staff who are resident there and performing their duties well. The untied funds to each panchayat would vary according to difficulty criteria. This along with the earlier clause of recruitment would help.

- vii. Transfer of Ownership at least of sub-centers and PHCs by the panchayats along with adequate resources and administrative support once village health planning this may be phased over a few years.

4. Decentralised Planning and Local Area Health Planning:

This aspect of decentralization relates to capacity building related to decentralization and needs to proceed in parallel with the administrative and political changes described earlier.

- a. Ensuring that resource envelope for the district plan is known well in advance for each year.
- b. Ensuring that the previous year's district plan is shared extensively during the year and is updated and resubmitted by the February of each year.
- c. Developing a team of five to seven persons, other than the CHMO to act as the district planning center. This should include at least two or three officers of the deputy CMO seniority, and one or two public health specialists. This center should act as the institutional memory of the planning process. If needed agencies may be contracted in to assist, but the core planning team should be from the health department with the district. There is an important role for non official members/public health experts to be included in this process.
- d. Developing criteria and institutional mechanisms of appraisal and technical support and facilitation to improve the quality of district plans at the state level.
- e. Developing a national cell to facilitate and follow up throughout the year with states to ensure that the states are in schedule and all four above steps are in place.

5. Strengthening the ASHA programme.

- i. Ensure there is a state-specific conceptual and role clarity of the ASHA with respect to programme outcomes expected from her and with respect to the roles of other peripheral government functionaries. Also clarify that she should not evolve as a link worker, a last leg of the government functionaries' pyramid, but as a representative of the community, providing leadership and guidance to the community and partnership to the health system. This clarity should inform the process of monitoring and support.
- ii. Strengthen the payments mechanisms so that the ASHA is paid promptly and with dignity and does not have to spend more than a few hours on one day every month to get her payments for all the incentives due. Revise payment guidelines from the center and the states. The center to maintain a constant observatory of the state level guidelines so that timely problem identification and corrections could be facilitated.
- iii. Ensure that states have developed appropriate training modules and strategies to continue training after the first set of modules are completed and the mechanisms of training M&E through which quality of training is maintained. States that need materials more appropriate to less educated ASHAs would also need facilitation to develop the same. A minimum of 12 days per subsequent year should be mandatory with 20 days in the first year. Identify reasons for delay and organize active facilitation to see that delays due to capacity constraints or failure to develop appropriate state support systems are overcome.
- iv. Ensure that the first ASHA drug kits are procured and distributed in every state within a 6 month target, and then that every state has subsequently put in place a system of refilling the kits every two months.

- v. Ensure that the ASHA is supported by on the job training and facilitation by facilitators and that the ASHA support mechanisms envisaged are initiated. Also developing her role as community mobiliser and developing social mobilization and recognition processes from the panchayats is essential. Support and recognition from the department staff in different forms would also need to be organized.
- vi. The funds for the entire above are in place and in most states disbursed to districts as well. But in the absence of developing programme management and support structures much of this money remains unspent and there are pressures to divert these funds. The critical step therefore is to create the ASHA resource center and with NHSRC support and the support of state and national ASHA mentoring groups build up its capacity in such a way that the state can implement all these recommendations in the spirit intended.

6. On Village Health and Sanitation Committees:

- i. Developing systems in the states for the department to be able to track and guide the content of activities transacted by these committees.
- ii. Developing systems for the states to be able to facilitate the making of village health plans and the utilization and accounting of the funds made available to it. This mechanism of facilitation would most likely be the same as that for ASHA so to avoid duplication and build synergy.
- iii. Ensuring that both panchayats and ASHAs are fully involved and provide leadership and coordination to these committees.
- iv. Center to have a detailed knowledge of the guidelines as issued in every state and the experiences of different approaches. From this to draw lessons and share these between the states so as to maximize the outcomes of this strategy.

7. On role of NGOs:

- i. Insist that all dealings with NGOs be done on the basis of MOUs so that there is accountability on both sides.
- ii. Each state to develop a clear understanding of where it would seek NGO participation and share it with the NGO partners. Each state to develop a grant in aid committee or transparent process of NGO selection.
- iii. In all processes that relate to community participation in any form to try to ensure that NGO partnership in some form or other is secured. In the ASHA programme in particular not only should at least a percentage of block programmes be supported through NGOs, their role in training and social mobilization and support must be taken advantage of.
- iv. Review the reasons why the MNGO scheme has not taken off in many states and undertake correctives.
- v. Accelerate the implementation of the community monitoring programme.

8. On the Rogi Kalyan Samitis:

- i. Reiteration of RKS under the NRHM as meaning better public participation for better accountability and as a vehicle of flexible funding by the government to help raise the quality of care provided without any detriment to equity of access. There is no goal of cost recovery. Moreover there is concern that RKS funding should not reduce/substitute state government expenditure on regular essentials like drugs and human resource.
- ii. Training of RKS functionaries and key officials so as to be able to plan for the expenditure in such a way as to improve quality of care and equity of access.
- iii. Monitoring to ensure that equity in access is not being limited by user fees. It is adequate to monitor exemptions in different services in the hospital to correlate this.

- iv. Ensuring minimum standards in decision making and accounting.
- v. Ensuring that untied funds given by NRHM are linked not only to facility development plans, but also to performance based on measures of quality improvement and total consumption of different services. Further untied fund allocation also needs to look at equity consideration, relatively more backward areas getting more funds. collection amount
- vi. If user fees are charged their main use may lie in optimization of expenditure patterns and better allocation between facilities and within facilities.

9. On untied funds to sub-centers and PHCs and CHCs:

- i. Many of issues are the same as discussed for RKS.
- ii. In the sub-center there is no RKS but the village health and sanitation committee should play this role. Most states have preferred a local sub-center support committee. This too is acceptable.

10. On Janini Suraksha Yojana:

The increase in institutional deliveries potentially assists the reduction of maternal mortality and it also puts pressures on the public health facilities to be revived/ strengthened and functions with quality. However there are concerns. One concern is the huge and growing financial implications. The other was the way on the field the JSY programme tends to marginalize all other elements of RCH and how it could narrow the focus of facility improvement. Yet another issue was the usually delayed and some times denied payments to ASHAs and the mothers. And finally there was the concern that without a corresponding increase in the skills and logistic support of the nurses and without at least 24 to 48 hour post partum care, and without sufficient quality in delivery and access to referrals even the impact on maternal mortality would be illusory. To address these concerns without losing the advantages of the JSY, the need is to

- i. Build up and monitor quality assurance systems for ensuring that the level of care provided leads to decreased maternal mortality.
 - ii. Build up adequate awareness of the NRHM and the entire IPHS package of services so that the pressures for institutional delivery lead to development of the facility as a whole, instead of a possible trend where all other programmes get compromised in the process of meeting JSY targets.
 - iii. Build up ASHA grievance redressal mechanisms and streamline payment systems with the use of external appraisals to identify leakages and glitches in the rules. One key rule that needs to change is to demarcate the ASHA motivation fee from the transport support – but there are many other similar glitches in the details of rules in each state that need to be examined and corrected.
- 11.** A related areas of concern is the increase in compensation for sterilization and the motivation fee. We need to examine in sufficient detail whether given the high demand for these services, such money given as compensation and given as motivation adds value to programme outcomes or merely corrupts the system. Whereas there is consensus on the priority being ensuring quality and access to these services, the role that the compensation and motivation fee is paying would need to be studied further.
- 12. On PPPs:**
- a. Viable PPP approaches have been established for the provision of emergency ambulance services, where such services are largely an extension of the public health system itself. These models have already been picked up by many states for replication and there is a need to replicate this approach widely.
 - b. In the contracting out of PHCs and CHCs and in many other options of PPP the differences between public sector provision and private sector provisioning with public funding, there is no model that is generally replicable and cost effective. Some efforts have

either not taken off or have done poorly or been difficult to replicate. There are others like Chiranjeevi scheme that are promising and appropriate to their contexts but whose replicability and longer term issues need to be understood further. These models are in the stage where an active and analytic observatory and learning from the ongoing work would be the main form of advance for now.

13. On Improving Programme management:

- a. There is a need to strengthen the state level institutional framework at the state level. Past programmes have tried to add consultants to the directorate to achieve the necessary capacity. But this has seldom worked. What is needed is an institutional framework that has at the following institutional capacities:
 - i. A functional strengthened directorate with at least some of the officers trained in health administration. The directorate has divisions that provide technical assistance for each of the national and state health programmes. One recommendation is to build guidelines for the minimum strengths and skills that such a directorate would need.
 - ii. A state programme management unit made up of a mix of contractual staff and regular staff that leads programme management. The SPMU has several sub-components of which two essential ones are the HMIS unit and also the financial management unit.
 - iii. A state institute of health and family welfare or equivalent body, which in partnership with regional and district training institutions, whose core competence is that every health facility(sub-center, PHC, CHC, district hospital etc) in the state has the skills needed for its optimal functioning given the human resources that each facility has available.
 - iv. A state level institution (the SHSRC or equivalent body) that acts as an autonomous additional technical capacity for

planning and building district capacities for planning, evidence based strategy development, for programme appraisals and programme innovation and for guiding health sector reform. Also as single window for channelising technical assistance and creating an institutional memory of such reports and work. (The SHSRC)

- v. a state level institution for guiding, building and strengthening community processes.(ASHA resource centers and equivalents, as part of SHSRC or separately)
 - vi. A state level institution for supporting procurement and guiding logistics in the district.
 - vii. A state level institution for guiding civil works in the districts and where needed undertaking larger projects itself.
- a. In large states a separate institutional arrangement for each is probably essential for reasons for sheer volume of work. But in all states each of these seven tasks requires a different core competence, a different leadership, a different set of skills and therefore different recruitment and career prospects. There is therefore a need for both good coordination amongst them but also some autonomy or at least delegation of powers for each of these institutional arrangements to develop their own capacities and deliver. Also each of them needs to be placed within an accountability and good governance framework. Given these principles the state may decide whether the institution is achieved by contracting in an agency, or by creating a registered society or just creating a division with sufficient powers and autonomy. If a local situation allows it may combine or more of these functions into a single institution, provided that each year the expected deliverable is obtained.
- b. Active facilitation would be needed to create these. More important once these seven teams are identified each of these need to be

supported and capacities need to be built up to deliver their outcomes. Each of these institutions would need annual reports and reviews to ensure that they are delivering as per their MOU and slack in performance prevented.

- c. Within this context the importance of proper recruitment and support and training and coordination of the contractual staff of the programme management unit should be discussed. Often the discussion on the contractual staff of the PMU overshadows all other questions of state and district programme management and this is not useful as it places an unrealistic set of expectations on their shoulders. However the PMU is a key additional programme implementation capacity and the current emphasis on their selection and training needs to continue along with longer term career plans for this workforce. There is also a need to integrate their functioning with the other structures outlined above and this could be done by joint training and team building efforts.
- d. Adequate financial Management capacity and HMIS capacity needs to be built into the programme management unit.
- e. The system of concurrent audit as put in place in Madhya Pradesh is unique and very effective in ensuring timely reports, and should be replicated by other states.

14. Monitoring against norms & Fully Functional facilities:

- a. The nomenclatures of CHCs and PHCs and their bed strengths do not follow a standard pattern, even within states. This is causing considerable confusions in understanding the plans and sometimes even leading to wastage of resources. It confuses people regarding the level of expectations from a given centre besides creating difficulties in monitoring/ comparative performance. State Governments should seriously consider reorganizing nomenclature of all institutions in consultation with the NRHM so as to come to an agreed to consensus that can be used for calculating

fund allocations and for designing road maps to achieve IPHS norms and the fully functional status.

- b. We also need a uniform decision on having a sub-center embedded in every PHC and a PHC embedded in every CHC, and a CHC embedded in every to look after the services of that section, sector or block where the higher facility is situated. This would alter calculations of requirements and increase staff and fund available in the higher facility. (This also relates to the earlier nomenclature issue).
- c. The IPHS norms should be increasingly popularized as a set of service guarantees that each institution has to deliver. With all the IPHS specified inputs (infrastructure, manpower, equipment and drugs) the service would be of a certain quality level, but there is an understanding that even without that targeted level of inputs, an improvement in service delivery can be recorded. This would imply a focus on those inputs that are critical to achieve the service guarantee, some system of grading achievement and a road map to achieving the desired level of services.
- d. Further performance of facilities should also be measured against the available staff and inputs. In addition to the question of how many facilities have reached IPHS standards the other key question should become: “what is the optimum set and volume of services that can be delivered for the existing level of human resource and infrastructure and in how many facilities are we are obtaining that level of services with sufficient quality? Or to put it differently, is failure to move towards a graded IPHS norm, due to infrastructure and human resource gaps which take considerable financial resources and structural changes to achieve or whether gaps in supplies or minor equipment or skills or motivation levels (which are relatively easily remediable within the same year) the main barriers? Measures of quality would help us measure performance in such terms and also give us a more dynamic understanding of the IPHS standards. Issues like improving cleanliness, improving biomedical waste management improved patient amenities would all respond to a system of

monitoring where the key is a flexible notion of quality that is specific for each facility.

- e. The increase in out-patients and in patients should be monitored. But we also need to ensure that this increase is not producing “distortions which militate against equitable utilization of institutions and provision of quality of services.” One example quoted is “the skewed use of institutions has clogged the available bed strength and services with simple delivery cases in FRUs which otherwise would have accommodated patients with serious health problems.” To the extent that the system is alert to the distortion that can creep in these problems can be attended to, but we first need to build a system by which we know what is happening.
- f. For strengthening facilities to reach IPHS norms the critical inputs are of deploying the necessary human resource with the necessary skills. The main inputs from the NRHM for strengthening facilities are the increases in doctors and nursing staff, the effective use of the untied funds to close hardware gaps, the community level support from the ASHA, the referral transport system put in place. There is also the insistence on seeing that the staff in place are well trained with the core skills and many cadre existing with state support like the male MPW are revived and equipped to play a role in many of the services that the sub-center has to deliver.
- g. A state by state decision is needed on the use of sub-center as an institutional delivery site. The state to state variation is too high to have a single policy across states. Some states report no delivery at the sub-center at all, and there are other states, where currently delivery in the PHC is still difficult but a substantial number of deliveries is occurring at the sub-center. The suggestion is that wherever possible, the single ANM sub-center be kept as an optional site for delivery in case of sudden need or where there is no PHC nearby, but the effort is to reach the nearest PHC. Once there are two ANMs, both trained in SBA and provided with referral transport support, mandatory availability of delivery services at the sub-center could be insisted upon. This decision has implications for the

JSY programme where in accordance the institutional benefits would not be available for the sub-center delivery if this is not declared as institutional.

- h. The understanding of IPHS norms as linked to a service guarantee package must be accompanied by the availability in every facility of graded standard treatment protocols, essential drug lists and drug formularies that match the services that are expected. This same service guarantee must inform the drugs procurement and logistics system and the laboratory support system and above all the skill development programme that every district health society would have to ensure.
- i. Technical assistance needs to be made available to each facility to plan for development of quality services – as described under the RKS section earlier.
- j. Drugs and supplies logistics and a matching system or procurement is crucial. The benchmark for this is the Tamil Nadu system . There is a need to develop a comparable system that extend upto sub-centers and to ASHAs. The current drug kit based approach and supply driven distribution has a lot of redundancies and wastages and stock-outs. Facilities can never be fully functional till a TN style logistics management system is put in place. Drugs budgets also need to be indexed to patients attendance and inflationary indices and be revised on an annual norm based system, rather than as response to crisis.

15. Human Resource Management

- a. The availability of health human resources for making facilities fully functional and is the central bottleneck. Each state has to develop road maps or five year plans to show how this can be achieved in the shortest possible time with annual targets for monitoring progress in place. Future funding commitments could also be based on such a projection, as current human resource availability problems leads to a very poor current fund absorption position.

These human resource development plans could be made a separate sub-component of a five year state PIP. Such a road map or five year plan would have to take into account the number of professional education institutions that are functional and those that are coming up.

- b. Dedicated ANM training schools exclusively catering to candidates from areas which perpetually face problems of unwillingness of eligible ANMs to work or their recruited where posted should be considered. This is especially true for tribal areas. Necessary policy decision regarding entry qualification / procedures, selection of women from difficult areas, requisite representation of SC / ST candidates should be taken to facilitate it. Suitable ASHAs/ AWWs could also be sponsored for this training. The plan for vocational stream in higher secondary schools in remote areas could be explored in especially difficult areas.
- c. Similarly initiatives to increase nursing schools and medical education and improve access of weaker sections to such education are also a priority.
- d. For other paramedics, suitable candidates from difficult areas facing deficiency of personnel should be selected and sponsored to training institutions. Necessary changes in rules of eligibility for entry to the courses may be made.
- e. Cadre management of as much staff as possible may be decentralized by transferring the responsibility of recruitment, deployment etc. at the district or even block level to appropriate PRI institutions or empowered committees. Appointment letter should specifically carry the condition that the appointee shall have to work in a defined area.
- f. Task-shifting and multi-skilling – strategies of rationalization of the workforce that refer to skilling one cadre of workers for tasks that normally other cadre would do – is one way of getting the right skill

mix in place. Thus training of MBBS doctors for specialist roles, training nurse practitioners or pharmacists for some curative roles where medical officers are not available, training male workers for laboratory roles and so on could be a general strategy and needs to be built on further.

- g. The AYUSH doctor as medical officer in lieu of an MBBS doctors must become part of an appropriate induction and support programme along with the necessary tools for being effective.
- h. The policy on promotions, transfers, postings, incentives taken together constitute one of the most critical indicators of good governance. An active process of engaging with the states to understand their problems and identify best practices in workforce management and support advocacy efforts for improved governance need to be developed. Appropriate non-monetary incentives, selective promotions for good workers, and favorable postings after a stint of ten or fifteen years etc. should be provided to retain them posted in the area posted.
- i. Examine the issues of private practice of government staff and other conflict of interest situations. Push through an innovative package that engages with this issue. In this context also examines the compensation package for doctors across the states, and estimates the costs one needs to pay to get specialists where they are needed.
- j. Building up the workforce skills level and skill mix is also a key responsibility of the district establishment. There is a huge requirement of training at all levels. The task is so enormous that ad-hoc arrangements would not be sufficient and require an institutional framework. The development of such a capacity in every large district or cluster of districts is a priority and the SIHFWs would have to give guidance to this.

16. Improved Maternal and Child Survival and Population Stabilization issues:

Some of the concerns about whether we would be able to keep to the planning commission and MDG deadlines for improving maternal and child survival and for population stabilization relate to the basic systemic issues of functional facilities and manpower availability. But some of them also relate to the design issues of the RCH programme, especially as regards the horizontal integration of different components and its integration into the district plan. The specific recommendation on issues of the RCH programmes in this regard are not gone into detail here, as there is also another process of review and recommendations for the RCH programme, that need not be duplicated.

17. Preventive and Promotive health

- a. The main thrust of concern is the need for better integration of all the disease control measures into an effective district plan with measurable outcomes. One dimension of such integration is ensuring that the human resource and infrastructure deployed on each programme is fully utilized by rationalization of task allocations between them. The other dimension is being able to address the social determinants and the common factors across such programmes through common strategies. And finally it also includes a critical examination of each of these programmes and the use of the district planning approach to overcome the constraints they are currently facing.
- b. The other set of recommendations flow with regards to strengthening school health programmes, adolescent health programmes, oral hygiene and dental health programmes and the general life style promotion activity as part of the district and state PIPs. In each of these there are some preliminary programmes approaches evolving which would need to be built on, evaluated and then where appropriate replicated.

- c. The effort on control and response to chronic diseases has also been slow. The effort to build a response should be integrated into the development of state and district health systems, without placing undue reliance on a further crop of vertical health programmes.

18. HMIS & Disease surveillance:

Both these programmes, despite several years of work that have gone into evolving them are still evolving in design and very varied in implementation. This work needs to be prioritized so that an effective level of functionality across the states in a year. There is also need to integrate both these aspects in such a way that the infrastructure, equipment and human resource of these two systems are shared even though there are many aspects which are distinct from each other.

19. Social Security Schemes and the cost of care:

Many schemes for health insurance and risk pooling and for reducing the burden of the costs of care are in the pilot stages across different states. These need to be documented and learnt from so as to evolve a better approach to addressing the social security dimension.

Measures of equity in access, and considerations of gender equity and health equity with respect to programme design and programme implementation and health systems development need to be studied further to ensure that we are developing more equitable health systems.

20. Budgetary Outlays:

There needs to be an institution put in place or enabled in every state that can generate annual data on the health expenditure patterns, at least with respect to budgetary outlays and allocations within the health sector. This should be used for monitoring the overall pattern of increase in public expenditure in the health sector.

State-wise Performance on 24 Health Systems Development Parameters

ASSESSMENT OF CASE LOAD BEING HANDLED BY PUBLIC SYSTEMS AT ALL LEVELS

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	Increase in out patient cases and JSY deliveries; JSY deliveries in private clinics as well, even without formal accreditation.
2.	ASSAM	Increase in number of out patient and in patient cases due to JSY, better availability of doctors and medicines; higher increase where human resource gaps, especially Specialists, have been filled; not much change in case load at sub centre level as yet.
3.	BIHAR	Dramatic increase in case load at all Block PHCs, Sub District and District Hospitals; 24X7 Block PHCs offering out patient, emergency and institutional delivery services; substantial increase in institutional deliveries; doctors, drugs, diagnostics, uninterrupted power supply, infrastructure improvement, ambulance leading to improved public demand and expectation from public system.
4.	CHHATISGARH	Improvement in outpatient cases at the sub centre level. At PHC level the number has also increased but less. At CHC the picture was not very encouraging. Load at district hospitals is very heavy and Jeevan Deep Samiti has undertaken hospital improvement efforts. Shortage of specialist at CHC makes improvement of inpatient hospitalized care a little slow.
5.	GUJARAT	There has been an impressive increase in out patient and in patient cases for the State as a whole; often increase is related to the competence and commitment of the doctor posted at PHC which sets of a virtual cycle of all round PHC improvement and patient satisfaction; increase in a district often hides variation within.
6.	JAMMU & KASHMIR	Mixed reports of case load could be seen in all the districts visited; in – patient load in CHC/DH/PHC is not commensurate with inputs of infrastructure and manpower; weak thrust on improving quality and range of service delivery.
7.	MADHYA PRADESH	Significant increase in institutional deliveries; insufficient increase in general utilization of services from health facilities; good gains in specially monitored and selected Dhanavantri Blocks.

STATE	KEY FINDINGS
8. ORISSA	Overall increase in outpatient attendance; however, this increase is primarily in secondary care institutions and largely contributed to by institutional delivery increase; under utilization of services at primary care level often due to non-availability of services at those levels.
9. RAJASTHAN	General increase in the use of government health facilities – signals a positive change in people's perceptions; apart from institutional deliveries where increase is dramatic, there is increase in out-patient, in-patient, surgical procedures, diagnostics, lab investigations from public system; increasing trend in bed occupancy. National Health Programmes including RNTCP, blindness control, vector borne diseases and IMNCI are operated through the health facilities at all levels – Sub Centres, PHC, CHC, and District Hospital; these facilities also offer the Indian System of Medicine, especially Ayurveda, to a limited scale.
10. TAMIL NADU	Case load of patients treated, in patient and out patient, has increased considerably during the last one year in all primary healthcare centres, particularly CEmOCs and PHCs; drop in referrals from PHCs to higher level institutions; possible due to improvement of facilities through Patient Welfare Societies and close monitoring; clear shift in the case load towards public health facilities.
11. TRIPURA	Most facilities showed an increasing trend in out patient load; institutional deliveries showed a significant increase; in in-patient cases the picture is mixed, varying from facility to facility.
12. UTTAR PRADESH	Overall impression of a functional public health system which is delivering a considerable quality and quantity of services despite considerable constraints by which it is shackled; increase in institutional deliveries; high outpatients (not necessarily increase) due to improved availability of drugs.
13. WEST BENGAL	Sustained efforts at strengthening the public system is leading to higher case load; sub-centres doing fixed day clinics and Gram Panchayats authorized to hire doctors for a few days in a week, facilitates higher utilization of services at the Sub Centre level; drug availability is satisfactory; institutional deliveries have gone up. BPHC and Rural Hospitals' up-gradation has also helped in meeting additional case load.



PREPAREDNESS OF HEALTH FACILITIES FOR INPATIENT CARE AND UTILIZATION OF BEDS FOR SUCH CARE

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	Lab facilities adequate at PHC/CHC levels; improvement in infrastructure; blood storage units coming up; need for adequate staffing at selected CHCs/PHCs; case for Mandal level pooling of in-patient services; private practice of doctors interferes with higher utilization of hospitalized services from public facilities; government doctor is also the private practitioner.
2.	ASSAM	While bed occupancy and emergency care is steadily improving, availability of nurses and doctors is still a pressing issue; District Hospitals still catering to main in patient load; deliveries are now happening at many more places as is surgical procedures; constraint of Specialists is the major issue.
3.	BIHAR	Human resources, especially nurses, is a constraint; physical infrastructure is improving steadily; Operation Labour Room to improve services at Block PHCs; Rs. 23 lakhs worth of repair and new buildings in all Block PHCs from Finance Commission funds is nearing completion; PPP for 24X7 power supply by generator and ambulance is working well; PPP for cleanliness needs to be decentralized to facility level from the district level.
4.	CHHATISGARH	While physical infrastructure improvement has taken place, provision of adequate doctors and nurses need to be emphasized. Blood storage at CHC also needs to be prioritized. Up-gradation of CHCs behind schedule.
5.	GUJARAT	Significant improvement in infrastructure; commensurate addition of Staff Nurses must be a priority for sustained improvement in utilization of facilities; wherever qualified medical officers and related facilities exist, the bed occupancy seems to be better; availability of drugs was found to be uniformly satisfactory everywhere.
6.	JAMMU & KASHMIR	Infrastructure and manpower is adequate in many places; in spite of it, service guarantees are few, especially for hospitalized treatment and surgeries; need to provide more service guarantees; no CS in

STATE	KEY FINDINGS
	many places despite appropriate specialists posted there.
7. MADHYA PRADESH	The improvement in facilities for in patient care is not commensurate with the increased load due to JSY; needs priority attention; need to streamline systems of diagnostics and availability of medicines;
8. ORISSA	Nomenclature differences of PHC/CHC; there is progress in facilities though yet to reach Indian Public health Standards; staff shortages and non-availability of staff during odd hours present a major constraint; diagnostic facilities and logistics of drugs and consumables need improvement.
9. RAJASTHAN	Increasing utilization of services putting pressures for better preparedness; infrastructure is much better at many places because of conjunctive use of NRHM and RHSDP funds; but still needs more inputs and a better hygiene and sanitation, upgraded institutions with human resources doing much better.
10. TAMIL NADU	Available bed strength being utilized quite satisfactorily; facility improvement is under way.
11. TRIPURA	Health functionaries are a very committed team, but shortages of trained professionals like specialists, doctors, para medics, Nurses and Lab Technicians; Improvement of physical infrastructure also needs to be on a faster track as PWD is not able to cope with the additional load; availability of drugs is satisfactory; TB and Malaria tests are in public facility; lot of other tests are from private providers.
12. UTTAR PRADESH	Nursing staff is a major constraint; shortage of specialists also a constraint, good level of improvement in hospital cleanliness and demand for services; untied funds and RKS helping tide over problems.
13. WEST BENGAL	128 PHCs and 93 Block PHCs have been upgraded; another 82 BPHCs being up graded; Doctors, Specialists and Nurses have been appointed; Lab Technician appointments are held up due to a court case; PPP for diagnostic services have been started in some BPHCs and Rural Hospitals; there is a demand for more such facilities.



QUALITY OF SERVICES PROVIDED FOR INSTITUTIONAL DELIVERIES

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	Institutional deliveries in public and private facilities; BPL paid on the basis of certificate; 26 percent institutional deliveries in public sector in the districts visited. .
2.	ASSAM	Mixed picture, depending on human resource availability; signs of improvement in CHCs/ FRUs in many places; need to improve cleanliness and waste disposal; community perceives improvement in services due to improved infrastructure and availability of drugs, doctors, nurses and para-medics at health facilities.
3.	BIHAR	Quality of services compromised due to large scale shortage of Nurses; State is recruiting 8000 ANMs/Nurses; need to focus on cleanliness, waste disposal, etc.
4.	CHHATISGARH	While JSY coverage has increased, payments are not timely. More attention needs to be paid to quality of service.
5.	GUJARAT	Qualified medical officers for conducting deliveries was found in most of the institutions; in particular, district and sub district hospitals showed brisk activity and interest from doctors to patient needs; RKS filling gaps in infrastructure; problem of shortages of doctors and specialists and staff nurses remains everywhere and more glaringly so in un served and under served areas specially in the tribal tracts; there are no short term solutions for such shortage except to increase intake in Nursing Schools.
6.	JAMMU & KASHMIR	Very poor condition of labour rooms and lack of privacy in many places; inadequate new born care; improvement in institutional deliveries after JSY recorded in all institutions but quality of care needs to improve.
7.	MADHYA PRADESH	Quality of services needs improvement; RKS must have greater patient welfare focus; early discharge after deliveries is a problem; need to prepare facilities for in patient care; cases of misuse of JSY as well.

8.	ORISSA	Quantum increase in institutional deliveries putting further load on secondary care institutions – Block PHC, CHC, Sub District and District Hospitals; very few deliveries at Sub Centre / Mini PHC level.
9.	RAJASTHAN	Sharp increase in institutional deliveries; 62 percent jump over 2006; quality of care improving; hospital stay needs to be longer; need for more cleanliness in some institutions; improved performance and maintenance due to RMRS and untied funds in many institutions.
10.	TAMIL NADU	Availability of medical and para medical and nursing personnel in the Block PHCs and other PHCs was found to be satisfactory; infection management and cleanliness found to be satisfactory; patients satisfied with the quality of services.
11.	TRIPURA	Increase in institutional deliveries is noticeable; still a large number of home deliveries due to distance factor from facilities; preparedness for complicated deliveries compromised with shortage of trained professionals; One New Medical College through PPP and Nursing College through PPP recently set up – may ease situation in a few years.
12.	UTTAR PRADESH	Gaps in quality of care at all levels; Sub Centre deliveries suffer in the absence of physical infrastructure and referral transport linkages; women returning after 3-4 hours after delivery from facilities is a problem; delivery cases have tripled at District Hospital level. Insistence on replacement donors even in case of life saving transfusion under JSY is a problem.
13.	WEST BENGAL	Institutional deliveries have increased; Many Sub Centres are far better equipped now with untied funds to carry out deliveries; Up gradation of PHCs and BPHCs along with the untied funds have also helped in improving the infrastructure; Panchayats are fully involved in this process of improving quality of services.

IV

SYSTEMS IN PLACE FOR IMMUNIZATION AND CHANGES IN THE FIELD

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	Performance of the State is satisfactory.
2.	ASSAM	Impressive progress in immunization coverage; increased awareness is palpably visible at all facilities; cold chain and vaccine availability well maintained; major role of ASHAs and ANMs in enhancing awareness and in organizing immunization rounds; improved monitoring of performance at State level.
3.	BIHAR	Cold chain well maintained; Facility improvement of Block PHCs and PPP for Generators at Block PHCs helps; alternate delivery of vaccines is working well; polio rounds taking too much time, adversely impacting on other health programmes.
4.	CHHATISGARH	Mitanins has completed list of hamlets where children were not immunized. List has been acted upon by district authority enhancing immunization coverage.
5.	GUJARAT	Following measures for effective immunization initiated – mapping of poor performing Blocks followed by area specific strategies; immunization through mobile unit in difficult and remote areas; monitoring through RIMS; appointment of State Routine Immunization Monitors; measles surveillance.
6.	JAMMU & KASHMIR	System of routine immunization at facilities on fixed date and out reach in villages could be recorded; increase in coverage and usage of AD Syringes; regular immunization sessions being held at village level and in Sub Centres as per records. System of waste disposal needs to be put in place.
7.	MADHYA PRADESH	Report has not commented on immunization separately; more improvements in the selected Dhanavantri Blocks that re being monitored closely; some thrust on maternal and child health, including immunization.

STATE	KEY FINDINGS
8. ORISSA	No confirmation of increase in immunization coverage; even where institutional deliveries have significantly increased, there is no matching increase in immunization coverage,
9. RAJASTHAN	Very good progress in covering under one age children for full immunization; strong monitoring; functional sub centres improves outreach.
10. TAMIL NADU	State has adopted 'fixed day fixed place system for immunization; every Wednesday, 8683 Village Health Nurses visit villages and around 1500 workers in urban areas to carry out immunization activities; has ensured timely immunization and quality coverage.
11. TRIPURA	Immunization coverage is high; Village Health Days are popular; system of following up on immunization of children; helicopter used for health camps in remote areas.
12. UTTAR PRADESH	Alternate vaccine delivery and untied funds to Sub Centres has helped in improving the sessions for immunization.
13. WEST BENGAL	Some stock outs for OPV and hepatitis B vaccine has been reported; otherwise immunization levels in West Bengal continue to be satisfactory.



DIAGNOSTIC FACILITIES AT HEALTH FACILITIES AND THEIR EFFECTIVENESS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory quality of diagnostic facilities available at all levels.
2.	ASSAM	Lab Technicians have been deployed PHC onwards; further vacancies being filled up; ANM providing basic services; need to multi skill and break separate vertical systems for diagnostics; gaps in equipment and maintenance in some places; new equipment are with three year AMC.
3.	BIHAR	Diagnostic services up to Block PHCs through PPP working very well; basic services available at reasonable cost; x-rays in 136 institutions by outsourcing.
4.	CHHATISGARH	Not commented upon.
5.	GUJARAT	Satisfactory availability of diagnostic facilities and their utilization at all levels.
6.	JAMMU & KASHMIR	Diagnostic facilities of x-ray,, ultra sound, ECG, lab , were available in all Sub Divisional Hospitals and one PHC visited; facilities being poorly utilized in many places.
7.	MADHYA PRADESH	Improvements in a few places; key Lab Technician shortages hamper diagnostic services;
8.	ORISSA	Diagnostic facilities weak; compartmentalized system of TB and Malaria needs to move towards multi-skilling; happening in a few places.
9.	RAJASTHAN	Basic diagnostic facility available every where; free for BPL, pensioner, and senior citizen; user charges for others through RMRSS (equivalent of RKS).
10.	TAMIL NADU	All PHCs are provided with lab providing basic facilities; special services like ECG, X – Ray in upgraded PHCs; semi-auto analyzers in Block PHCs; District Hospitals have ECG, X-Ray, Ultra sound with CT Scan.

11. TRIPURA	TB and Malaria diagnostic facilities in PHCs; other tests in private in many places; need for integration and multi-skilling of Lab Technicians and other para-medics to improve availability of diagnostic services.
12. UTTAR PRADESH	Though under staffed, basic diagnostic facilities were available at most places; staff shortages are a key issue. Multi-skilling offers potential for closing gaps.
13. WEST BENGAL	PPP for diagnostics seem to be working well in Bengal as well; Lab Technician for TB and Malaria are there but they do not seem to be doing TLC/DLC/ etc. The inability to fill up vacancies of Lab Technicians due to court cases is also posing problems; there is demand for PPP for diagnostics.

STATE	KEY FINDINGS
1. ANDHRA PRADESH	There are manpower mismatches; need to focus on a few institutions rather than all institutions at the same time, for in patient, hospitalized treatment; satisfactory Lab Facilities; satisfactory position of Nurses; over 2500 2 nd ANM already appointed.
2. ASSAM	NRHM has increased/improved availability of MBBS Doctors, AYUSH Doctors, Nurses, ANMs; Lab Technicians and Pharmacists being recruited; ASHAs are very enthusiastic and are helping in putting community pressure on public facilities.
3. BIHAR	Improving, but not fast enough; Sub Centres and Additional PHCs to be fully operational shortly; present focus on Block PHCs; Appointments of ANMs, Nurses, Lab Technicians, OT Assistants near completion; need to plan for additional manpower more effectively, especially nurses.
4. CHHATISGARH	There are shortages of staff at various levels. State needs to plan nursing and doctor needs more effectively. Quality of ANMs is reasonably good. Mitani programme very strong, is more than 60000 Mitanis creating an environment for state health institutions to provide services. Mitanis very effective in the field. They have drug kits as well.
5. GUJARAT	Major shortages in most cadres, AYUSH doctors being posted to fill vacancies of medical officers in PHCs; lack of specialists; urgent need for nursing staff to provide actual 24X7 services; ANM deputation reduces availability of ANMs where they are needed; Lab Technicians have been provided in most of the PHCs.
6. JAMMU & KASHMIR	Good availability of Specialists and other professionals; Specialist services during day time; need to provide more quarters for staff to enable resident health workers; need for rationalization and clear service guarantees from professionals.
7. MADHYA PRADESH	Large scale shortages at all levels including specialists, PHC doctors, MPW (Male), Pharmacists and Lab technicians. Employment of doctors is only on contract basis since several years. Some manpower shortages being met in innovative ways;

	PPP training sponsorship for nurses from vulnerable social groups and remote areas; large scale shortages.
8. ORISSA	Shortage of 700 Medical Officers; need for manpower needs assessment and long term planning; shortage of Nurses and ANMs; State has taken many steps – additional incentives for KBK area, appointment of contractual specialists, increase in MBBS seats, doubling Diploma in Lab Technology seats, 33% increase in intake of ANM Training schools, starting B.Sc. and M. Sc. Nursing courses, short term course on Anaesthesia and Emergency Obstetric Care, and posting of 1500 additional staff nurses in the peripheral institutions.
9. RAJASTHAN	Shortage of Specialists, especially Gynaecologists, Anaesthetists, and in public health; MPW(M) not filled up and training institution languishing; ASHA Sahyogini doing TB, Malaria, JSY and immunization work, besides coordination with ICDS.
10. TAMIL NADU	3 years compulsory rural service helps in filling vacancies; 740 VHN posts and 2400 Medical Officer posts filled up; 2258 Nurses recruited under NRHM to provide 24 hour service at PHCs. Second ANM not being considered as PHCs are able to close the gap.
11. TRIPURA	Doctors' Association playing very important role in reducing absenteeism by promoting rotational posting for remote areas; there is a shortage of adequate number of trained and skilled doctors, nurses and para medics. Need for more ANM Schools as well as two districts do not have any institution.
12. UTTAR PRADESH	Human resource is the challenge in UP; large unmet need for nurses, doctors and para-medics; need for more rational deployment as well; Key Specialist shortages alongside incidence of irrational deployment as well. AYUSH doctor being added at PHCs. 2 nd ANM not in place. Large gap in male workers.
13. WEST BENGAL	West Bengal has taken major steps to meet its need for ANMs; training capacity has been raised from 600 to 3500 by involving higher order Nursing Institutions in ANM Training and by involving Non Governmental organizations; difficulties in getting Specialists; strong Nursing cadre and Directorate is helpful in further strengthening the system.

VII

UTILIZATION OF ROGI KALYAN SAMITIS AND UNTIED FUNDS AT VARIOUS LEVELS

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	Large scale use of untied funds at all levels; VH&SC, Sub Centres, Hospital Development Societies have received funds and utilized it; Sub Centre needs not taken care of as resources are given village wise; sanitation and cleanliness is the focus; wider public health activity likely to be taken up
2.	ASSAM	RKS and untied funds have worked as enablers at all the places visited; used for improvement of amenities; elected representatives involved; funds being used for emergency referrals as well.
3.	BIHAR	Funds have reached and utilization has just started up to Block PHCs; need to speed up utilization to improve cleanliness and basic standards; need for stepping up of activity at Sub Centre and Additional PHC level; RKS guidelines prepared and disseminated; institutions need confidence to spend; electricity, ambulance, diet, and cleanliness through PPP.
4.	CHHATISGARH	Untied funds utilized at all levels from sub centre, PHC, CHC etc. Jeevan Deep Societies playing positive role in hospital improvement need to give more confidence to these Societies for utilizing untied funds.
5.	GUJARAT	RKS at the level of hospitals and sub hospitals are well set; RKS at CHC level is one year old and teething problems are over; RKS at PHC not registered as yet in many places; funds used for face lift of facilities; need to do more patient oriented services as well.
6.	JAMMU & KASHMIR	Hospital Development Boards from before, charging user fees; RKS formed at PHCs and funds received; process being completed in CHCs and District Hospitals; few facilities were yet to receive funds.
7.	MADHYA PRADESH	RKS are fully functional; evidence of substitution of State Government resources by RKS resources; needs immediate rectification; user fee

	collections form large part of RKS Budget; infrastructure maintenance, salary and medicine purchase are few items of expenditure; need to provision medicines from general hospital budgets; need to ensure that poor are not denied health care because of user charge.
8. ORISSA	RKS set up everywhere but not effective everywhere as yet; works taken up to improve facilities; needs to make RKS realize their role and function.
9. RAJASTHAN	RMRs established everywhere up to PHCs; raising revenues and also receiving untied grants; reasonable sums of discretionary funds are now available at institutions; while some have made good use, fear of incurring expenditure in others; Sub Centres have improved with untied funds; cashless hospitalization of BPL – a focus in RMRs.
10. TAMIL NADU	Patient Welfare Society funds has led to marked improvement in the facility appearance and has considerably improved the look of the facility; development of gardens, gas stove connections, repair, RO system for drinking water, inverter in labour room etc. done with untied funds.
11. TRIPURA	RKS funds and untied funds very well utilized with complete involvement of Panchayati Raj Institutions.
12. UTTAR PRADESH	Untied funds well utilized at Sub Centre level, improving the performance of the institution; RKS set up and beginning to use resources. Delayed utilization of RKS/untied funds due to delays in guidelines. State already had system of user charges which has been modified; need to ensure that resources remain with the institution.
13. WEST BENGAL	RKS formed in each and every institution up to PHC level; Panchayats fully involved; untied funds used very effectively to improve the quality of services; physical infrastructure handed over to Panchayats for maintenance; Panchayat Samiti involved in decision making;

VIII

INVOLVEMENT OF PANCHAYATI RAJ INSTITUTIONS IN THE FUNCTIONING OF THE HEALTH SYSTEM

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	PRIs involved in VH&SC, Sub Centre level activities; as members of Hospital Development Societies.
2.	ASSAM	VH&SC not set up as yet as fresh PRI election is to be held; willingness to involve PRIs, village opinion leaders, local NGOs and Mahila Samitis; PRIs participating in RKSs and at Sub Centre level.
3.	BIHAR	VH&SC to be set up under the umbrella of PRI very soon; Panchayats involved in RKS; need to orient PRIs for better management of health institutions and for inter sectoral convergence.
4.	CHHATISGARH	Mitanin programme works very closely with Panchayati Raj Institutions. Innovative Swasthya Panchayat Yojana in Chhattisgarh. Indicators have been developed for measuring health status and delivery of health services at the village level. Panchayat fully involved in this exercise. State is now setting up VH&SC under umbrella of PRI.
5.	GUJARAT	Need to involve PRIs more directly; DHS meets but the District Health Mission under the Zila Parishad Adhyaksha does not meet often; VH&SC accounts managed by ANM and teacher and not by PRI representative; need for capacity building in PRI members for better management of the health system.
6.	JAMMU & KASHMIR	No PRI in J&K; however, community members are fully involved.
7.	MADHYA PRADESH	Not commented upon separately; need to step up involvement of Panchayati Raj Institutions; joint accounts have been opened;
8.	ORISSA	PRI role limited to attending meetings and management of untied funds; VH&SC not in place as yet; ASHA has been positioned; Village Health Days are being conducted.
9.	RAJASTHAN	Panchayats involved in the health system; partnership at Sub Centre level is working well; Village Health Committee meeting regular; Village Health Committee and water and sanitation committee to merge under the umbrella of

Panchayati Raj.	
10. TAMIL NADU	12619 Village Health and Sanitation Committees are fully functional; untied grants used for cleanliness; has helped in community involvement; involvement of PRI at village and Sub Centre level is very good; Panchayats providing free meals for patients in a few places.
11. TRIPURA	Very high and effective involvement of <i>Panchayati Raj</i> Institutions in health institutions; very active in Rogi Kalyan Samitis and Sub Centre Committees; Village Health Committees being constituted along with water and sanitation committees;
12. UTTAR PRADESH	PRIs are involved in the Village Health and Sanitation Committees and the Sub Centre level Committee, as also the RKS; need to enhance their involvement in the management of the health system.
13. WEST BENGAL	Panchayats are actively involved in the management of the health system; RKS and untied funds available with them; <i>Gram Unnayan Samitis</i> working as VH&SCs;

IX

PROCESS OF PREPARATION OF DISTRICT HEALTH ACTION PLANS AND QUALITY OF DISTRICT HEALTH MISSION MEETINGS

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	District Plans prepared in 2007-08. District Teams are involved; involvement will increase with earmarked DPMUs and SPMU for the purpose, which is in the process of being set up.
2.	ASSAM	24 districts prepared plans in 07-08; regular district level review meetings; review by CM/Minister regularly improves performance; need to improve record keeping of District Health Mission meetings.
3.	BIHAR	District Plans by unicef in 2 districts; rest of the district through technical consultants; data collected but matter went into litigation; still being resolved; low local involvement.
4.	CHHATISGARH	All districts have prepared their plans in the previous year. Need for more intensive discussion on the district plans. Need to link it up with Swasthya Panchayat programmes.
5.	GUJARAT	Plans prepared for all the districts; approved by the Executive Committee; need to seek approval of the District Health Mission.
6.	JAMMU & KASHMIR	District Plans nearing completion; done by contracting out; while planning is participatory, district level health functionaries needed to be more fully involved in the process; District Health Society meetings being held; need more focus on NRHM.
7.	MADHYA PRADESH	Good system of District Health Action Plans and their appraisal; District Plans as basis for monitoring and review as well; village plans being developed. <i>Need more participatory processes at community level.</i>
8.	ORISSA	District Health Action Plans prepared for 2007-08; being prepared for 2008-09; District Health Mission involved but process needs more decentralization to be able to capture needs.
9.	RAJASTHAN	26 of the 32 districts have prepared integrated plans; 23 plans already appraised; remaining plans being prepared; District Missions active.

10.	TAMIL NADU	2007-08 plans complete; Plans for 2008-09 are under way; will be completed by January 2008; Facility Surveys nearing completion for PHCs and Sub-Centres; Household surveys are in progress.
11.	TRIPURA	Village Plans are prepared based on household health data and with involvement of PRIs; facility surveys were conducted but without involvement of community/PRI; Planning and Monitoring Committees have to be established; District Plans prepared for all the four districts.
12.	UTTAR PRADESH	District Health Action Plans have been prepared but the involvement of district teams is weak; need to improve involvement of local stakeholders.
13.	WEST BENGAL	2007-08 Plans made by all 23 districts; process for 2008-09 under way; likely to be completed in January 2008; Panchayats fully involved at each level; Chairman of <i>Zila Parishad</i> heads the District Health Mission that meets regularly;

X SYSTEMS OF FINANCIAL MANAGEMENT

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	Quality of accounts in Area Hospitals and project Hospitals is satisfactory; need for improvement in untied fund accounts at PHC/CHC/Sub Centre and VH&SC level; need for more capacity building.
2.	ASSAM	Very good accounting system with proper account books, payment and receipt records, referral details, etc. being maintained; well performing system for flow of funds.
3.	BIHAR	SPMU, DPMU, Block Managers are all in place; SPMU needs to improve supervision; Monthly district audit proposed;
4.	CHHATISGARH	SPMU and DPMU have been set up. Need to improve their acceptance within main stream health system. Clarity of role required.
5.	GUJARAT	The overall financial management system seemed to be properly streamlined; District Accounts Managers managing accounts at the district level; delegation of administrative and financial powers needed.
6.	JAMMU & KASHMIR	Need to improve financial management system; SPMU/DPMU in place since April 2007; need for orientation and training of functionaries; need to follow financial procedures as laid down in NRHM system; need to ensure timeliness of fund releases.
7.	MADHYA PRADESH	Excellent system of monthly district audit; SPMU/DPMU fully functional; timely audit of accounts; governance issues regarding procurement need attention.
8.	ORISSA	Need for dedicated accounting personnel at Block level; SPMU and DPMU is in place; no delay in release of funds to districts.
9.	RAJASTHAN	Societies have merged; SPMU/DPMU are functional; Block Management structure being put in place; fund flow is smooth; very good use and accounting of untied funds.
10.	TAMIL NADU	System of record keeping right from the village and

sub health centre levels to PHC/Taluk hospitals and District Societies is extremely good; system of financial reporting is very good.

11. TRIPURA	Untied funds have increased the need for better financial management as there are many more details needed; strengthening of the system is going on; needs some more attention.
12. UTTAR PRADESH	SPMU/DPMU not set up as yet; however systems; mainstream health functionaries are satisfactorily managing the financial system including of JSY.
13. WEST BENGAL	Accounts Managers provided in Districts and Blocks; Financial management system is very effective; PRIs involved in decision making at all levels;

XI HMIS AND ITS EFFECTIVENESS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Effective reporting system for surveillance; ANMs reporting weekly; data being acted upon.
2.	ASSAM	The availability of information and its use at the State level is very good; district level needs to do more data analysis rather than mere mechanical data collection.
3.	BIHAR	Data Centre at State level collecting Block PHC data regularly; data being used for effective monitoring; district level needs to be activated;
4.	CHHATISGARH	System of reported through sub-centres. Needs further strengthening.
5.	GUJARAT	Useful institution specific data being generated and regularly monitored; helps in focusing on under performing institutions;
6.	JAMMU & KASHMIR	HMIS being collected by facilities and submitted to district/State; however, analysis of data collected not happening at facility and district level; need for facility specific monitoring to ensure full utilization of professionals at institutions.
7.	MADHYA PRADESH	Useful MIS work; reporting systems getting streamlined;
8.	ORISSA	A weak area in the State; Monthly Sub Centre reports submitted to PHC; needs more local level analysis. State is proposing training of staff for better data management.
9.	RAJASTHAN	Report has not commented on HMIS.
10.	TAMIL NADU	Excellent reporting system is in place; All districts are reporting on the new MIES format on time.
11.	TRIPURA	Integrated MIES data formats found at lowest levels; Multiple reporting still in vogue; contractual staff reporting on NRHM; needs more support of regular staff; community monitoring is not in place as yet but PRIs are involved in sanction and expenditure of untied funds across all facilities.
12.	UTTAR	

PRADESH

Need to improve system of HMIS and quality of data. Facility specific data has been devised for monitoring service guarantees. More effective use of the data is possible for district planning.

13. WEST BENGAL

Not commented upon in the CRM Report; Good data collected as part of planning for Health System Reform in West Bengal; need for integrating data sets effectively.

XII RATIONAL USE OF MANPOWER AT VARIOUS LEVELS TO ENSURE APPROPRIATE SKILLS FOR BETTER OUTCOMES

STATE	KEY FINDINGS
1. ANDHRA PRADESH	Rationalization calls for pooling of hospitalized, in patient services; Sub Centre, PHC, CHC Nursing needs provided for; shortage of Specialist; need to ensure assured services.
2. ASSAM	Though manpower is being used optimally, there is room for some further rationalization; shortage of Specialists; under utilization of 2 nd ANM due to non residence – need for corrective action; ASHAs helping put pressure on public system.
3. BIHAR	Serious efforts at rationalization by Block pooling of doctors at Block PHC, Sub Divisional and District Hospital; more service guarantees, especially with regard to surgery and in patient care possible with this rationalization, but not happening as yet; shortage of nurses/ANMs.
4. CHHATISGARH	Governance reforms needed to ensure rationale deployment of specialists, doctors and nurses. System of incentives introduced to encourage doctors and nurses to work in remote areas. Better governance and cadre management needed.
5. GUJARAT	Since large vacancies will continue to occur at all staff and professional levels, the skill mix would have to be constantly evolving and shortages will have to be met by trying many innovations; one third of the PHCs in a district had staff shortages.
6. JAMMU & KASHMIR	Need for rationalization from large pool of manpower available to the State to guarantee services; need to carefully look at facility and service mix; need for orientation and training of staff nurses.
7. MADHYA PRADESH	Report has not commented on this separately; while staff availability has improved, more work needed to ensure better rationalization of services in remote areas; need for improved promotional avenues and regularised (not contractual) employment for PHC and CHC doctors to attract more medical human-power to the rural public health system.
8. ORISSA	Lack of rational use of manpower is an area of

concern; Specialists posted in PHC is wasting of skill; need for system of posting and transfers. State has engaged 259 AYUSH doctors.

9. RAJASTHAN	Deployment is rational but shortages persist, especially for Specialists; GNMs being appointed as ANM but MPW (M) vacant.
10. TAMIL NADU	'Counselling' an integral part of the posting system; Human resource shortages made up by hiring of services whenever required.
11. TRIPURA	State is rationally using manpower; ANMs from outside the district poses problems in remote areas, of non – residence since malaria is a problem, State has filled up posts of MPW (Male) on contract.
12. UTTAR PRADESH	Lot more rationalization needed in the management of cadre of Specialists and Doctors; need for rational use of Nurses, Paramedics as well, based on case load.
13. WEST BENGAL	Efforts have been made to rationalize manpower and make the system efficient and effective; few key vacancies (Specialists, Lab Technicians) posing problems; decentralization of contractual recruitments at local level, even by Gram Panchayats for fixed day services;

XIII THRUST ON DIFFICULT AREAS AND VULNERABLE SOCIAL GROUPS

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	More in patient treatment in public facilities will improve access of vulnerable groups; out patient facilities and availability of drugs is useful.
2.	ASSAM	District PIPs reflect special thrust on SC/ST, and minorities; separate record of OPD cases of SC/ST/Minorities, available for inspection; coverage of Char areas by camps; demand for health services in Char areas.
3.	BIHAR	Poor flocking government hospitals for drugs, doctors and diagnostics; operationalizing Sub Centres and Additional PHCs will further help in attending to needs of vulnerable groups.
4.	CHHATISGARH	Mitnian programme very pro poor. Provides communities an opportunity to seek health services. Need to improve health services faster.
5.	GUJARAT	Data on SC/ST being generated by HMIS; closer monitoring of data driven monitoring required;
6.	JAMMU & KASHMIR	Special action on remote areas through RCH camps/sessions.
7.	MADHYA PRADESH	Mobile units for remote areas; more camps needed in remote areas. In tribal areas ASHAs are required at hamlet or cluster of hamlets level (may be below 1000 population) to ensure adequate coverage of remote and far-flung households.
8.	ORISSA	State has initiated a large number of activities for tribal areas; <i>Swasthya Melas</i> , incentives for posting in difficult areas, etc.
9.	RAJASTHAN	Clear BPL focus in RMRSs for cashless hospitalized treatment of BPL; provision for generic drugs for poor.
10.	TAMIL NADU	Ambulance services and RCH camps take care of many needs; Specialist camps are also being organized; thrust is on vulnerable groups.
11.	TRIPURA	Helicopter service health camps in remote, inaccessible tribal villages; State needs to analyze

STATE	KEY FINDINGS
	disaggregated data on health parameters.
12. UTTAR PRADESH	Activation of Sub Centres though untied grants and presence of ASHAs helps households to connect with health facilities; almost two third of deliveries at the PHC/CHC were of SC and OBC, but coverage still low; need to further increase focus on marginal groups.
13. WEST BENGAL	Vulnerable groups are a focus; ASHA only for tribal areas and minority concentration areas with unsatisfactory indicators; ANMs from difficult areas from such communities;

XIV ASSESSMENT OF PERFORMANCE OF ASHAs, LAB TECHNICIANS, MEDICAL DOCTORS, ETC.

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	ASHAs selected and completing 23 day training; very high quality of training by NGOs; likely to make a difference in the demand for public services.
2.	ASSAM	ASHA enthusiastic and enjoys confidence of community; ASHAs given radios; ASHA radio programme well received; 2 nd training going on; Non resident 2 nd ANM is a concern; ASHAs demanding services for communities.
3.	BIHAR	ASHAs are local and very enthusiastic; well trained for basic activities; handling JSY, Immunization, DOTS; playing social mobilization role; very active; payments not timely; need for facilitation and resource support.
4.	CHHATISGARH	Mitanins are an outstanding success. ANMs in the field working very well. More Lab Technician, Doctors, Specialists required with better governance and incentive system.
5.	GUJARAT	ASHA/Gram Arogya Sathi selected; first round training nearing completion; drug kit must be provided to ASHAs immediately on completion of training.
6.	JAMMU & KASHMIR	ASHA selection completed; first round training complete; second round in a few districts; ASHAs found to be quite knowledgeable; non payment against activities is an issue. Need to record output of all functionaries in institutions.
7.	MADHYA PRADESH	Most ASHAs selected and first round training completed; lack of role clarity between ASHAs and AWWs/ TBAs; creating conflicts regarding compensation money.
8.	ORISSA	ASHAs are visible everywhere; selection complete; 36% have advanced training and 88% had done induction training; Trained ASHAs have badges; induction training has been found to be very helpful.

STATE	KEY FINDINGS
	.Performance of ANM is not satisfactory; delay in release of ANM salaries; shortage of para medical staff; performance of doctors not satisfactory at PHC/CHC level; overburden on doctors at Sub Divisional and District Hospital level.
9. RAJASTHAN	ASHA Sahayoginis are doing very well; handling malaria, TB, immunization, JSY and family planning; well integrated with ICDS; blended payment of stipend and performance based payment is a good model; ANMs are doing well.
10. TAMIL NADU	The patients, the community, and all stake holders have a very high opinion of health personnel in the State; known for their devotion to work; ASHAs not provided for Tamil Nadu.
11. TRIPURA	Health staff are generally motivated, committed and enthusiastic; ASHAs selected by transparent process involving the PRIs; trained in first module and provided drug kits; training included training on use of Rapid Diagnostic Kits for malaria; bright red coats and blue kit bags have given a unique sense of pride and identity to the ASHAs; ASHAs working as drug dispensers and JSY motivators. Doctors playing important role in remote areas;
12. UTTAR PRADESH	ASHAS have had one round of training; there is drop out especially of those who were looking for government employment; immunization, JSY work focus; payments are not timely; need to ensure drug kits and involvement in more public health activities. Almost two third of deliveries at the PHC/CHC were of SC and OBC, but coverage still low; need to further increase focus on marginal groups.
13. WEST BENGAL	ASHAs not in position as yet; ANMs doing very well at Sub Centres; Doctors and Nurses meeting additional load at PHCs, Block PHCs and Rural Hospitals.

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory system of disease surveillance in place; regularity of report by Sub Centres; good quality labs at PHC/CHC level; IDSP getting well established. 108 and 104 emergency and Counseling services to be used for surveillance as well.
2.	ASSAM	Surveillance limited to TB and Malaria; District Surveillance Unit not fully functional; new computers supplied but not installed.
3.	BIHAR	Weak system; Disease Surveillance Team not effective; ASHA is active but not reporting to the surveillance team; need to activate below Block PHC for effective surveillance and reporting systems.
4.	CHHATISGARH	Disease surveillance through Mitans and ANMs need to improve receptivity of PHCs, CHCs to information from below. Labs at PHCs level were found to be satisfactory with trained technicians. Mitans visiting household regularly for fever survey. Mitans having drug kits.
5.	GUJARAT	The system is working satisfactorily and the time taken for reporting surveillance data is within stipulated time frame; IDSP central monitoring cell has been established; District surveillance Officers placed and manpower trained.
6.	JAMMU & KASHMIR	Reporting of IDSP has started in selected districts.
7.	MADHYA PRADESH	Not commented upon separately. Needs attention; disease surveillance units need to be made active and functional; current focus is much more on maternal and child health alone;
8.	ORISSA	Surveillance system not functioning very effectively, though cell has been constituted.
9.	RAJASTHAN	No comment in the Report.
10.	TAMIL NADU	IDSP trying to integrate communicable and non communicable diseases; 28 District Surveillance Units fully functional; Lab facility modernized under

STATE	KEY FINDINGS
	IDSP.
11. TRIPURA	IDSP Centres are operating at all levels and registers are being maintained; Supervisors and ANMs/MPWs have been trained under IDSP and are sending reports; PHCs have received computers but software is not installed yet; data operators being shortly placed at PHCs.
12. UTTAR PRADESH	Not reported on.
13. WEST BENGAL	ANM doing disease surveillance work as well; involved in leprosy, TB, Malaria and blindness control programmes; malaria a focus;

XVI PREVENTIVE AND PUBLIC HEALTH MEASURES FOR VECTOR CONTROL AND EFFORTS AT INTER SECTORAL CONVERGENCE

STATE	KEY FINDINGS
1. ANDHRA PRADESH	Untied funds of VH&SCs and Sub Centres have been used for sanitation and water purification activities; wider public health focus will emerge.
2. ASSAM	VH&SC Not set up as yet – waiting for Panchayat elections; spray of DDT, etc. reported but specific efforts for inter-sectoral convergence were not visible.
3. BIHAR	Community involvement in select Kalar districts in DDT spray; new initiative of 'Muskaan' for 100 % immunization and 100% institutional delivery involves ICDS Centres, AWWs and ASHAs together as a team; Constitution of VH&SC in partnership with the water and sanitation committee (as proposed) under the umbrella of PRI will be helpful in inter sectoral convergence.
4. CHHATISGARH	Mitanins playing critical role in the behaviour change communication and community activities.
5. GUJARAT	The measures for control of vector borne diseases under NVBDCP guidelines are in position and working satisfactorily; involvement of PRIs has been there; inter sectoral convergence for vector control in position through institutions.
6. JAMMU & KASHMIR	Inter sectoral convergence not started as yet.
7. MADHYA PRADESH	Nutrition Resource Centres have been established in 60 places; effective in handling extreme forms of malnutrition; a pilot initiative; more inter-sectoral convergence required.
8. ORISSA	Malaria major vector borne disease; New measures – involvement of NGOs in spray, epidemic response team in each district, sensitization of traditional healers, message transmission through school students and SHGs, ASHA trained on a pilot basis in 50 Blocks, GIS mapping, etc.
9. RAJASTHAN	Good partnership with ICDS through ASHA Sahayogini; Sub Centres have improved

STATE	KEY FINDINGS
	performance though untied funds and are better placed for convergence; Maternal, child and nutrition days being organized in every village; Village health and Sanitation Committees have been constituted at Gram Panchayat level but are not fully functional as yet.
10. TAMIL NADU	Health Inspectors (MPWM) at PHC level doing malaria surveillance; VHNs trained in various diseases; Lab Technician available at every PHC; Regular system of monitoring and review besides availability of trained personnel with earmarked responsibilities.
11. TRIPURA	Village Health Committees to be constituted by merging with the water and sanitation committee; PRIs fully involved;
12. UTTAR PRADESH	RNTCP and malaria programmes in place, case detection in RNTCP poor due to lack of staff in some key facilities and poor coordination with private sector; more integration with district planning needed.
13. WEST BENGAL	VH&SC constituted in 16770 villages as <i>Gram Unnayan Samiti</i> , under the umbrella of PRI; PRIs involved at all levels; provides useful platform for inter-sectoral convergence.

STATE	KEY FINDINGS
1. ANDHRA PRADESH	Satisfactory performance of disease control programmes; apprehension in RNTCP that integration of Labs could affect DOTS performance; need for integration of services.
2. ASSAM	Satisfactory within the limitation of resources available in health institutions; PHCs have facilities for sputum examination for TB and blood smear for malarial parasite; Rapid diagnostic kits are available; consumables are available; Malaria Surveillance Workers and MPW(M) are being engaged; need to break verticality in diagnostic activities.
3. BIHAR	Thrust on Kala azar treatment visible in Block PHCs and District Hospital; Loss of wage payments from RKS for Kala Azar; Improved case detection for TB and Malaria due to improved diagnostic facilities and functional Block PHCs; Health system strengthening has positive impact on disease control programmes.
4. CHHATISGARH	Malaria, Leprosy, TB programmes need better follow up. Better monitoring required by sector medical officers.
5. GUJARAT	Merger of programmes has taken place under the Mission Director; supervisory cadre vacancies; contractual Lab Technicians help;
6. JAMMU & KASHMIR	RNTCP has done well; Lab services at PHC are integrated; technician doing routine and TB work; case detection is satisfactory.
7. MADHYA PRADESH	It has not been commented upon. Report does say that the focus in MP seems to be on JSY and other family welfare programmes; need for a public health approach covering all sectors has been reported.
8. ORISSA	Sectoral Microscopy Centre not working in some places due to shortage of Lab Technicians; RDT available in plenty; ASHA may be trained as FTD; use of RDT Kits. Leprosy needs more attention; Blindness Control programme audited statements are pending; Need for improvement in record keeping of RNTCP.

STATE	KEY FINDINGS
9. RAJASTHAN	TB programme doing well; ASHA sahyogini involved in DOTS; 1978 treatment centres in the State; ASHA Sahyogini involved in bringing cataract patient in camp; ASHA Sahyoginin involved in distribution of anti – malaria drugs; high incidence of malaria in State.
10. TAMIL NADU	Very effective implementation with clear responsibilities at each level; Human resources and effective monitoring makes the difference.
11. TRIPURA	Malaria prone are with drug resistance as well; RDKs are being used by peripheral level health workers; slide examination at PHC level; RNTCP staff positions filled up and satisfactory cure rate; teleophthalmology being tried out; good IEC;
12. UTTAR PRADESH	
13. WEST BENGAL	Satisfactory performance of all disease control programmes; ANMs and Sub Centres fully involved; shortage of Lab Technicians; need for integrating TB and Malaria Lab Technicians.

XVIII PERFORMANCE OF MATERNAL HEALTH, CHILD HEALTH AND FAMILY PLANNING

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	More attention needed for child health; satisfactory performance of family planning; maternal health facilities being up graded.
2.	ASSAM	Remarkable increase in institutional deliveries; need to keep women in facility longer; Family Planning services need improvement; erratic distribution of condoms and pills; IUD services not provided by ANMs.
3.	BIHAR	Family planning picking up; useful PPP with Janani; need to improve quality of institutional delivery and hospital stay; basic availability of equipments in Labour Rooms needed immediately.
4.	CHHATISGARH	Need to improve quality of maternal and child health.
5.	GUJARAT	Appreciable new initiatives for maternal and child health; blood storage facilities need attention; Lab technicians have helped JSY; Chiranjeevi Scheme of PP for BPL women in institutional deliveries has contributed in a big way;
6.	JAMMU & KASHMIR	Compromise of quality seen at many places; low performance on family planning; need to improve quality of services.
7.	MADHYA PRADESH	RCH activities have received thrust resulting in significant increase in institutional deliveries; family planning services have also picked up;
8.	ORISSA	Significant increase in institutional delivery; multi skilling for Anaesthesia and Emergency Obstetric Care being tried out; 33% increase in institutional deliveries; need to improve referral transport system.
9.	RAJASTHAN	Dramatic increase in institutional deliveries; PPP for JSY and sterilization programmes; additional posts created to meet large demand for maternal health services; IMNCI being implemented in 9 districts;

STATE	KEY FINDINGS
	immunization performance is satisfactory; improvement in sterilization after decline over the last two years.
10. TAMIL NADU	High quality maternal health, child health and family planning services being provided at institutions; quality of labour rooms and wards is very good; shift from private sector to government sector in the last one year.
11. TRIPURA	Strategies need to be developed to reach out to remote areas; arrangements tackling neo natal mortality need to be strengthened;
12. UTTAR PRADESH	Health facilities are clean even where there is over crowding; shortage of nurses is a limiting factor in quality of care. With only one ANM at SC and many hamlets to cover, absence of ANM limiting care; ASHA not yet given second round training. Neonatal unit being opened in the district hospital, but difficulties of transport.
13. WEST BENGAL	Excellent Sick and New Born Care Units established; increasing institutional deliveries along with strengthening of the system; family planning picking up with more functional health system at all levels.

XIX PERFORMANCE OF MOBILE MEDICAL UNITS/ SYSTEMS OF AMBULANCES

STATE	KEY FINDINGS
1. ANDHRA PRADESH	Outstanding system of emergency medical service throughout the State; excellent example of PPP; provides opportunity for Mandal pooling as transport system ensures timely referrals.
2. ASSAM	Ambulances available in all PHCs with drivers; log books provide details of referrals and other use; MMUs established in 8 districts; Boat clinics in four districts.
3. BIHAR	Ambulances by PPP in every Block PHC working very well; PPP experiment in MMU did not work well – has been discontinued.
4. CHHATISGARH	Not set up as yet.
5. GUJARAT	85 GPS enabled Mobile units working in the State; more strengthening of the Mobile Health unit will improve access in difficult areas; Ambulance service also started on EMRS pattern.
6. JAMMU & KASHMIR	Ambulance services available in each health facility visited; MMUs not procured as yet.
7. MADHYA PRADESH	<i>Deendayal Chalit Aspatal</i> (Mobile Health Clinics) for remote tribal pockets, providing all services; Janani Express Yojana by PPP for meeting referral transport need; improved availability of ambulances in most areas.
8. ORISSA	NRHM Mobile Units not procured as yet; State's own Mobile Health Units are functional; need to improve planning and monitoring of Mobile unit.
9. RAJASTHAN	Orders have been placed for 52 Mobile Medical Units; tenders for 52 diagnostic vans and 100 ambulances have been floated;
10. TAMIL NADU	100 mobile outreach units working; another 146 units proposed in 2008-09; successful mobile health camps; ambulances available on call.
11. TRIPURA	Ambulances are available at PHCs; Referral

STATE		KEY FINDINGS
		transport funds are also spent through the RKS; demand for ambulances to bring patients from villages;
12.	UTTAR PRADESH	Not functional in the districts visited.
13.	WEST BENGAL	Ambulances at all Block PHCs with the involvement of NGOs working well.



PROGRESS OF INFRASTRUCTURE AND SYSTEMS FOR IMPROVEMENT OF CIVIL WORKS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory progress in infrastructure development;
2.	ASSAM	Community perceives improvement in health infrastructure; need for improvement in design of civil works; demolish unusable old buildings; waste management needs attention.
3.	BIHAR	Excellent use of Finance Commission funds to improve Block PHCs; Sub Centres being constructed with in built ANM residence; low utilization of NRHM funds for infrastructure so far due to Finance Commission works; 24X7 generator and ambulance at Block PHCs working very well.
4.	CHHATISGARH	Civil construction completed. Over all improvement needs more attention.
5.	GUJARAT	Project Implementation Unit is the nodal agency for infrastructure; has done commendable job in construction and repair; need to delegate minor repairs to districts and institutions;
6.	JAMMU & KASHMIR	Need to plan the entire health facility in a systematic way; current approach is piecemeal; need for detailed facility survey and institutional plan; three different agencies are doing construction work in J&K.
7.	MADHYA PRADESH	Not commented upon.
8.	ORISSA	6 public sector agencies have been entrusted the civil works task for up gradation of infrastructure in Hospitals.
9.	RAJASTHAN	Civil works planned very systematically in conjunction with RHSDP; Facility Survey completed in 290 out of 352 CHCs; planned up gradation of facilities with a focus of NRHM on residential quarters; work complete in 42 CHCs and under progress in 232.
10.	TAMIL NADU	

STATE	KEY FINDINGS
	Funds for up-gradation of 75 PHCs has been given to PWD.
11. TRIPURA	PWD doing the infrastructure up gradation; progress is slow; PWD note able to cope with work load; need to explore possibility of central construction agencies for infrastructure up gradation.
12. UTTAR PRADESH	Sub Centre buildings needed on a priority; up gradation work has been taken up in many places; need to speed up infrastructure development, electricity connections and provision of quarters.
13. WEST BENGAL	Civil works development through the PWD; progress is satisfactory; need to further improve the pace of infrastructure development.

XXI SYSTEMS OF PROCUREMENT AND LOGISTICS FOR EQUIPMENT AND DRUGS AND ITS EFFECTIVENESS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory system of procurement and logistics; drugs available every where;
2.	ASSAM	Procurement from TNMSC and by State Government; improved drug availability everywhere; needs to be made need based; logistics and demand for drugs needs to be incorporated with procurement system (as in TNMSC); need based system being put in place.
3.	BIHAR	Remarkable improvement in drug availability; rate contract with manufacturers at State level and resources with District Health Societies; cash and carry system working well; wants to do TNMSC like procurement and logistics system.
4.	CHHATISGARH	Availability of drugs is satisfactory. Quality of procurement needs more attention.
5.	GUJARAT	Efficient system of drug and equipment procurement in place; system is working well.
6.	JAMMU & KASHMIR	Mixed picture regarding drug availability and its management; need for improvement; storage facility available in health facilities; need to monitor drug availability.
7.	MADHYA PRADESH	Non-availability of medicines to certain patients reported; significant portion of RKS expenditure on medicines, logistics support to peripheral facilities needs strengthening.
8.	ORISSA	State Drug Management Unit in place; has improved system but there are shortages in the field. Inventory management needs to be improved.
9.	RAJASTHAN	Very good availability of medicines at all levels;
10.	TAMIL NADU	TNMSC doing a remarkable job of procurement and logistics not only of drugs but also of equipments.

STATE	KEY FINDINGS
11. TRIPURA	Adequate availability and off take of drugs in facilities; need to sensitize doctors to prescribe generic drugs. Equipment/ drug procurement is also being done through the RKS and Sub Centre committees.
12. UTTAR PRADESH	Drugs are available everywhere. But prescription for buying from outside also high. The procurement and disbursement system needs to be rationalized to prevent delays in procurement by the central store and make distribution responsive to demands.
13. WEST BENGAL	Good system of procurement of drugs by districts based on rate contract; further refinement attempted to make it need based, like TNMSC. Availability of drugs is satisfactory.

XXII ASSESSMENT OF NON GOVERNMENTAL PARTNERSHIPS FOR PUBLIC HEALTH GOALS

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	EMRI – excellent example of PPP that helps professional emergency ambulance services in the entire State.
2.	ASSAM	Very few partnerships other than the MNGO programme.
3.	BIHAR	A few PPPs working well – diagnostics, ambulance, generator; NGO partnership for running Additional PHCs has been discontinued as payments are not timely; lack of trust; need for clear responsibilities and time lines for payment and assessment by both sides; another attempt to give Additional PHCs to NGOs and Panchayats.
4.	CHHATISGARH	NGOs involved in Mitani programme on a large scale.
5.	GUJARAT	Strong tradition of partnerships; Chiranjeev scheme; many small partnerships with NGOs for specific tasks;
6.	JAMMU & KASHMIR	Not seen in any of the institutions visited.
7.	MADHYA PRADESH	Useful innovations in Janani Express and Deendayal Chaiti Aspal (Mobile Health Clinic); supporting SC/ST trainees from remote villages for nursing in private institutions;
8.	ORISSA	MNGO scheme is working well; very few other PPPs.
9.	RAJASTHAN	Private institutions accredited for JSY, sterilization and IUD insertion.
10.	TAMIL NADU	NGOs helping in operationalizing the toll free ambulance system.
11.	TRIPURA	Telemedicine partnership established for eye care; PPP Medical College and Nursing College recently started.
12.	UTTAR PRADESH	Several NGOs evidently working in the health field

STATE	KEY FINDINGS
	but public health services not yet develop partnerships.
13. WEST BENGAL	Large number of partnerships in ANM training, ambulance services and mobile clinics, diagnostic services, etc.

XXIII

PREPARATION FOR MEETING HUMAN RESOURCE NEEDS, SPECIALLY WITH REGARD TO NURSING AND PARA MEDIC STAFF AND FUNCTIONING OF ANM TRAINING SCHOOLS AND OTHER NURSING INSTITUTIONS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	State needs to focus on multi-skilling of doctors for anaesthesia and obstetrics; no shortage of nursing training institutions; quality needs attention.
2.	ASSAM	ANM Training Schools are functional but need to improve quality of their infrastructure and training; repair work funds provided under NRHM and plans approved but work yet to begin; more practical orientation required in ANM curriculum – hands on!!!
3.	BIHAR	Highest focus needed on Nursing institutions as that is the most important and critical constraint; mopping up of trained ANMs and Nurses not enough; 12 ANM schools have started again but they are not in a satisfactory state; much faster improvement of infrastructure, equipment and trained human resources needed to make ANM Training Schools vibrant; funds are already available under NRHM.
4.	CHHATISGARH	State needs to develop long term and short term plan for enhancing health human resource in the State. Three year programme started in Chhattisgarh some years ago.
5.	GUJARAT	State needs to plan its nursing staff needs; ANM vacancies; Staff Nurse vacancies; thrust needed on strengthening ANM/Nurse training Schools.
6.	JAMMU & KASHMIR	While manpower availability is good, need to guard against over deployment without service guarantees; ANMs and Staff Nurses being recruited;; Staff Nurses need.
7.	MADHYA PRADESH	SPMUs and DPMUs in place and functional; DPMUs may need more synergy with district officials and block level staff..
8.	ORISSA	State is aware of the long term needs of human resources; many actions already initiated; further

STATE	KEY FINDINGS
	long term strategy to be firmed up.
9. RAJASTHAN	State has tried to strengthen ANM Training Schools; faster implementation required; MPW (M) is neglected;
10. TAMIL NADU	No ANM School needed; 6000 Nurses completing from Nursing Institutions are adequate to meet State's needs. More thrust on Staff Nurses.
11. TRIPURA	State has drawn up a plan for human resources; new institutions will help;
12. UTTAR PRADESH	Need to prioritize human resource thrust, especially nursing personnel. ANM TCs reopening and MPW (M) need a priority thrust.
13. WEST BENGAL	Exemplary focus on selecting local ANMs and creating additional capacity to train them; high vulnerable group representation; thrust on under performing areas.

XXIV ASSESSMENT OF PROGRAMME MANAGEMENT STRUCTURE AT DISTRICT AND STATE LEVEL

STATE		KEY FINDINGS
1.	ANDHRA PRADESH	State is in the process of setting up SPMU and DPMUs; currently being managed by regular Directorate of Health services team; need for administrative re- arrangements that provide a convergent platform; too many Directorates currently managing health services in AP.
2.	ASSAM	SPMU/DPMU/BPMU actively and enthusiastically involved in the field; lack of adequate participation of Directorate staff needs to be consciously addressed; need to push integration of all programme management structures for effectiveness and efficiency.
3.	BIHAR	Enthusiastic Block Managers, DPMU and SPMU; need for better integration with mainstream; enthusiasm for service delivery not internalized by mainstream task leaders;
4.	CHHATISGARH	SPMU & DPMU is in place, but linkage with directorate needs further attention. Role and functions need clearer articulation.
5.	GUJARAT	System is in place and working very well; DPMUs and BPMUs are functional; coordination is effective; need for integration of programmes in spirit – not only in letter.
6.	JAMMU & KASHMIR	SPMU/DPMU in place since April 2007; need for PMU teams to visit facilities more often; capacity building needs should be met on priority.
7.	MADHYA PRADESH	SPMU/DPMU working very effectively.
8.	ORISSA	SPMU/DPMU in place; BPMU in some Blocks; improved monitoring system.
9.	RAJASTHAN	SPMU and DPMUs are fully functional; BPMUs being established; Management systems have greatly improved performance; Directorate staff also involved in implementing NRHM; greater integration will be beneficial.

STATE	KEY FINDINGS
10. TAMIL NADU	Directorate of Public Health staff provides support for programme implementation; efforts to set up SPMU/DPMU; care should be taken to ensure that the involvement of DPH staff remains total.
11. TRIPURA	Coordination of contractual NRHM staff with mainstream staff needs to improve. Staff is in position.
12. UTTAR PRADESH	SPMU/DPMU not in place as yet; need to set them up on a priority basis, or to give management training to the existing CMO/deputy CMOs.
13. WEST BENGAL	Strengthening of accounts system at all levels; mainstream well integrated with implementation of NRHM; need for further convergence of functions at State level.

STATE SUMMARIES OF KEY FINDINGS

1.	ANDHRA PRADESH
2.	ASSAM
3.	BIHAR
4.	CHHATISGARH
5.	GUJARAT
6.	JAMMU AND KASHMIR
7.	MADHYA PRADESH
8.	ORISSA
9.	RAJASTHAN
10.	TAMIL NADU
11.	TRIPURA
12.	UTTAR PRADESH
13.	WEST BENGAL

1. ANDHRA PRADESH

THE REVIEW TEAM:

1. Dr. I.P. Kaur Dy. Commissioner., Maternal Health, MOHFW
2. Manish Kakkar, Public Health Foundation Of India
3. Shri Rajesh Kumar, Consultant Finance, FMG, MOHFW
4. Dr. Kamla Mohan, Regional Director, MOHFW

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Nalgonda:** PHC – Yadagirigutta, Peddakura & Chandampet, Sub-centre - Muthireddy Gudem, Area Hospital – Bhongir, District Hospital – Nalgonda.
2. **District Panchmahal:** PHC – Srisailam & Atmakur, Subsidiary Health Centre - Bairlutely, CHC- Atmakur

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ▶ Excellent Emergency Ambulance Service with a single state wide call number. ▶ well designed Good Quality of ASHA Training ▶ Good drugs availability at all facility levels. ▶ Dedicated and well informed ANMs, ASHAs and Staff Nurses at all the locations where the team went. ▶ Good utilization of untied funds at all levels. RKS not centred on user feed or cost recovery. ▶ Functional disease surveillance system- computerization upto PHCs. 	<ul style="list-style-type: none"> ▶ major staffing gaps especially of specialists at CHCs and hospitals- this can be reduced by multi-skilling, and reducing mismatches and better recruitment policies. ▶ Private practice govt. doctors (as allowed) interfering with utilization of services from public facilities ▶ More capacity building for systems of financial management. ▶ Need to improve/provide institutional care for new-borns. ▶ Laboratory bio-safety and biomedical waste management was lacking generally across all facilities visited by the team in both districts and needs to improve

2. ASSAM

THE REVIEW TEAM

1. Mr Amardeep Singh Bhatia, Deputy Secretary, MOHFW.
2. Dr J N Sahay, Advisor, NHSRC.
3. Dr. Parthajyoti Gogoi, Regional Director, H&FW.
4. Mr. K.K. Kalita, Advisor, RRC, NE, Guwahati.

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Kamrup Rural:** CHC/FRU- Bezara, PHC – Hajo, SDH – Rangia, FRU – Sualkuchi, BPHC – Kamalpur, MPHC - Ramdia, Halugaon, SC - Dora Kuhara, Koilbortapara, Dhupagiri, Borkaboragaon, Kharikhot, Kekenikuchi.
2. **District Darrang:** Civil Hospital – Mongoldoi, CHC - Kharupitia, MPHC - Gorukhuti, CHC/FRU - Sipajhar, PHC – Pathurighat, SC - Kathpati, Dohkhola, Moamari, Hatimura, Maroi Bijuli.

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ► Increased Case load and bed occupancy at most facilities - due to better availability of doctors, and improved infrastructure and due to increased institutional deliveries. ► Commendable role played by ASHAs and ANMs, especially in organizing immunization where good progress is reported. ► RKS and untied funds have worked as enablers for improvement in amenities and over all functioning of CHC/FRUs. ► Perception of community is that there is a good improvement of services. ► Good Ambulance availability along with logbooks and accounting system-good ► 24 districts have completed District health plans. 	<ul style="list-style-type: none"> ► Availability of Nurses is a pressing issue. ► Village Health and Sanitation Committees have not been formed. ► Quality of care is varied with biomedical waste disposal being a problem everywhere. ► Diagnostics provision is very weak. ► Training infrastructure and training systems need improvement – essential skills not in place even where qualified staff is there. ► Logistics of drugs and supplies needs improvement. ► HMIS weak and needs much improvement. ► Delivery of Family planning services weak

3. BIHAR

THE REVIEW TEAM

1. Dr. Thelma Narayan, Public Health Specialist.
2. Dr. D. Thamma Rao, Mission Director, NRHM, Puducherry.
3. Dr. M. S. Jayalakshmi, D.C. Family Planning MOH&FW, GOI.
4. Dr. Dileep Kumar, Nursing Advisor, MOH&FW, GOI.
5. Mr. Amarjeet Sinha, Joint Secretary, MOH&FW, GOI.

THE DISTRICTS/INSTITUTIONS VISITED

Patna District: Patna Medical College
Gaya District: Pilgrim Hospital; Sub-centre-Monara; PHCs-Phanania, Rajgir Makhadumpur, Belajganj, Bodhgaya, Manpur, Vazirganj, Harnaut
Vaishali District: Sub-centre and AWC- Jayanthi Gram PHC's – Lalganj, Garaul, Sarai, Paru, Vaishali
Muzzaffarpur District: S.N. Medical College Nalanda Medical College Distt. Hospital – Sarai, & Hajipur
Jehanabad District: Dist Hospital Jehanabad & Dist Hospital Hajipur

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ► Dramatic increase in case load at BPHC's and district hospitals and increase in institutional deliveries ► Facility improvement of BPHC's, especially in infrastructure and drugs and doctors availability by block pooling. ► PPP for generators and for Diagnostic services and for ambulance services. ► State, dt. and block managers in place. ► Improving disease control programmes especially in kala-azar. ► Promising ASHA programme with links to village health and water & sanitation committee. 	<ul style="list-style-type: none"> ► Huge gap in skilled human resources for health – for almost all cadres. ► Slow pace of expansion of nursing and ANM education. ► Quality of all services especially of institutional delivery inadequate. ► Frequent Polio rounds taking time ► Rate of improvement of peripheral facilities not commensurate ► Timely payments for ASHAs ► Institutional Neonatal care service provision and family planning service provision inadequate and needs to increase.

4. CHATTISGARH

THE REVIEW TEAM

1. Ms Ganga Murthy, Economics Advisor, MOHFW,
2. Ms. Neidino Angami, NGO, Mizoram
3. Dr. K. S. Gill, MOHFW,
4. Manoj Kar, Advisor, NHSRC,

THE DISTRICTS/INSTITUTIONS VISITED

Distict Kanker: CHC/PHC - Charama and Hardula, Sub-centre - Jaiskara and Jaipara Pandhari Pani, Hospitals - Distt. Hospital Kanker and Dhamtari.

Dist Durg: CHC/PHC - Bhilai-3, Ghotia, Dondi, Chikhlakasa Kala and Balod, Sub-centre - Katro, Kusum Kasa, Hospitals - Distt. Civil Hospital, Durg.

District Rajnandgaon: CHC/PHC - Dongergarh, Sub-centre - Khaprikalan and Indamara, Hospitals- Distt. Hospital, Rajnandgaon

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ➤ Successfully put in place community health activists-Mitanins- with high degree of commitment. ➤ District Health Mission established and functional. ➤ Effective involvement of PRIs and Community Processes noticeable. Panchayat health diary introduced for panchayat sarpanches. Village health planning systematic. ➤ Hospital development committees (Jeevan Deep Samities) have focus on quality care and provide for adequate representation of NGOs ➤ State health resource center effective and makes a positive contribution to health planning and community processes. 	<ul style="list-style-type: none"> ➤ Issues of “Governance of NRHM” are critical and need immediate attention. Poor co-ordination at the senior levels. ➤ Health Infrastructure neither properly maintained nor fully utilized, needs immediate action steps for improvement. ➤ Increase in institutional delivery not matched by any quality of care improvement. ➤ Programmes of CHCs into FRUs/IPHS standards doing poorly. ➤ HMIS functioning poor. ➤ Financial Management, especially in some programmes like annual maintenance grants :

5. GUJARAT

THE REVIEW TEAM:

1. K. S. Srinivasan, Consultant and former, Secretary, MOHFW.
2. Madhukar Chaudhury, Mission Director, Maharashtra.
3. Sandhya Ahuja, Senior Consultant, NHSRC.

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Sabarkantha & Panchmahal:** DH- Sabarkantha, DH- Panchmahal, Civil Hospital- Himmatnagar, General Hospital - Gandhinagar CHC - Sivaliya, Halol, Vijaynagar & Samalaji, PHC - Hadiyal, Atarsumba, Viralia&Bhiloda, Sub-centre - Palla & Lalpur

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENTS
<ul style="list-style-type: none">• Overall increase in case loads in public health system.• Effective Programme Implementation Unit for Infrastructure development that serves as national benchmark in this area.• Good Drug supply and distribution system• Diagnostic Facilities in public health facilities improved• Mamta Abhiyan and involvement of voluntary sector provides for better community involvement• Effective PPP model - Chiranjeevi Scheme- for institutional delivery.• Effective disease control and disease surveillance.	<ul style="list-style-type: none">• Sharp decline in deliveries conducted by Public Institutions.• Plans needed for taking care of acute shortage , at almost all levels, of human resources for public health system• Proper utilization of untied and RKS funds and promptness of payments in JSY• Greater involvement of PRIs required.• HMIS system is relatively much better but data reports need to be acted upon.

6. JAMMU & KASHMIR

THE REVIEW TEAM

1. Dr Amarjeet Singh, Mission Director & Commissioner, Health, Gujarat.
2. Dr Tarun Seem, Director, MOHFW, GOI.
3. Dr AC Baishya, RRC, Guwahati.

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Udhampur:** medical aid center at Jhajjar kotli, PHC at Tikri, CHC at Chennai and Batot, and Katra and sub-center at Jakhani
2. **District Jammu and district Samba:** CHCs at Ramgarh, Akhnoor, Vijaypur, PHC at Anandpur, SHC at karalia, District hospital at Samba and Missionary Hospital at Samba.

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ▶ .Good , well maintained infrastructure. ▶ Good availability of equipment and supplies. ▶ RKS at PHCs reported to have started working nd untied funds have worked as enablers for improvement in amenities and over all functioning of CHC/FRUs. ▶ Manpower position is relatively better. 	<ul style="list-style-type: none"> ▶ Poor quality of services, even for institutional delivery. ▶ Poor utilization of available manpower due to skill and motivation and management issues. Village Health and Sanitation Committees have not been formed. ▶ District action plans and facility surveys.contracted out and being done with poor participation and behind schedules. ▶ HMIS almost non functional. ▶ RKS in CHCs and district hospitals and village health and sanitation committees not yet constituted and not yet functional. ▶ Financial management poor.

7. MADHYA PRADESH

THE REVIEW TEAM

1. Mr. Praveer Krishn, Joint Secretary, MOHFW, Government of India
2. Mr. Sushil Kumar Lohani, NRHM Mission Director, Orissa
3. Dr. Abhay Shukla, Senior programme coordinator, SATHI-CEHAT, Pune
4. Ms. Shruti Pandey, Senior Consultant, NHSRC

THE DISTRICTS/INSTITUTIONS VISITED

1. Jabalpur: Office of Collector, District Victoria hospital, Lady Elgin Hospital, Civil Hospital, Tehsil Sinhora, CHCs, Patan, Majhauri; PHCs: Chargaon and Sub Health Centers, Nunsar, Bijori and village Gosampur, Tehsil Sinhora.

2. Barwani: CMHO office; DPM office; District Hospital, Barwani; CHCs at Thikri; Pati and Niwali
PHC at Anjad; Sub Health Centre at Sawariyapani and Village Sawariyapani (Pati Block).

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ► Increased Case load and bed occupancy at most facilities – largely due to impact of increased institutional deliveries. ► system of concurrent audit is unique and very effective in ensuring timely reports ► PPPs in Jananai Express - for emergency services and Deendayal Chalit Aspatal (Mobile Health Clinics are promising ► supporting SC/ST trainees from remote villages for nursing in private institutions ► Nutrition Resource Centres have been established in 60 places; effective in handling extreme forms of malnutrition; ► District health action planning completed in all districts and considerable mechanisms for this are built up. 	<ul style="list-style-type: none"> ► Significant portion of RKS expenditure being spent on medicines and other inputs which substitute state government budgetary expenditures. RKS tends to be perceived as mainly a form of cost recovery. ► Large human resource gaps with more long range planning needed to address these. . ► Serious issues of governance ► Need for greater decentralization and PRI involvement. ► Major gaps in drugs supplies: Logistics of drugs and supplies needs improvement. ► HMIS weak and needs much improvement. ► ASHA programme needs to use flexibilities in sanctioned numbers, in training and selection process as applicable to tribal areas for achieving its goals.

8. ORISSA

THE REVIEW TEAM

1. Shri K. B. Saxena: Former Secretary, Health and Family Welfare, Gol.
2. Dr S. K. Satpathy: Director-Training, Public Health Foundation of India.
3. Dr P. K. Mohapatra: Sr. Regional Director, Bhubaneshwar, Gol.
4. Dr K. S. Sachdeva: CMO, Central TB Division, Gol.

THE DISTRICTS/INSTITUTIONS VISITED

1. Sundergarh District: Rourkela Government Hospital, Sub-divisional Hospital, Bonai; CHCs at Kinjerkela; Bisra, and Gurundia; PHCs at Sikajore; Senpatrapali and Tangarpalli; Sub-Centres at Tileikani, Ujjalpur, Kopatomundla; Tamra, Urban Slum Health Centre – Tillea Nagar, Rourkela (PPP model).

2. Bolangir District: District hospital, Sub-divisional Hospital – Patnagarh, CHCs at Kantabanji; Luisinga. Saintala; PHCs at Block PHC Tureikela; Kushang; Khaprakhol; Lathore; Gudvela; Sub-Centres at Ghunesh; Badabanki; Kandajuri; Sargad; Kushang; Ghunson; Rengali; Telanpali; Orriyapali; Gambhriguda; Ghuna

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ► Overall increase in out patient case load in secondary hospitals. ► RKS have been well constituted and are functional and untied funds have worked as enablers for improvement in amenities and over all functioning. ► . Keeping to time schedules and expected outputs on the ASHA programme. ► NGO support good and is being harnessed. ► Financial Management and financial flows much improved. 	<ul style="list-style-type: none"> ► Primary health centers and sub-centers still remain very weak and no significant increases –due largely to staffing problem. ► logistics management are not streamlined and there are shortages or stock outs of key drugs and consumables ► Human resource planning for public health system needs to improve. Both non availability and lack of adequate performance are issues. . ► training systems need improvement – essential skills not in place even where qualified staff is there. ► HMIS weak and needs much improvement. ► Village health and sanitation committees not in place and weak social mobilization and community participation.

9. RAJASTHAN

THE REVIEW TEAM

1. Mr. Arun Baroka, Director, MOHFW, GOI
2. Dr. T. Bir, Faculty, NIHFW
3. Dr. D. C. Jain, D.C., MOHFW, GOI
4. Dr. Sunil D. Kharpade, Director, MOHFW, GOI
5. Dr. A. K. Shiva Kumar, Consultant, Member MSG, NRHM
6. Dr. H.P. Yadav, Regional Director, GOI.

THE DISTRICTS/INSTITUTIONS VISITED

Alwar District: District Hospital, CHC: Kishengarh; Thangaje, PHC Harore and Sub-centers Dhane

Churu District: One DH and CHCs in Bidasar & Salasar, PHCs in Talchapar and Charawas, Sub-centers and the community in Gulariya, Lodiya Sub Centres/villages.

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ▶ Sharp rise in institutional deliveries ▶ Increased confidence and utilization in government facilities with a noticeable increase in in-patient treatment, out-door care, surgical operations and laboratory investigations. ▶ ASHA-Sahayoginis – positive innovative adjustments- in selection and compensation and support. Functional programme. ▶ Functional hospital development committees with clear guidelines. ▶ Improved integration of national health programmes. 	<ul style="list-style-type: none"> ▶ Poor availability of specialists and poor compensation package for doctors leading to shortages. Human resources planning for paramedicals also needed especially with regards to the MPWs. ▶ Need for better integration of PMUs with regular programme officers at state and district level. ▶ Need for better awareness and understanding of NRHM and its provisions at all levels. ▶ Physical conditions of health facilities, especially hygiene and cleanliness need improvement. ▶ Village Health and Sanitation Committees not adequately functional, and ASHA and JSY payments poor. ▶ Introduction of incentives for JSY and sterilization compensation having deleterious effects.

10. TAMIL NADU

THE REVIEW TEAM

1. Shri Javed Chaudhary, Retd. Secretary, MOHFW.
2. Shri P.K. Agarwal, Consultant Finance, FMG, MOHFW,
3. Ms. Vandana Krishna, Commissioner Family Welfare, Maharashtra.

THE DISTRICTS/INSTITUTIONS VISITED

Thiruvellur District :Taluk hospital-Ponneri, Block PHC- Puzhal ; PHC- Padianallur, Budur, Naravarikuppam, Health Sub-centre- Chinnakavanam,Arani, Nallur, Kummanur, Chinnakavanam
Kancheepuram District :CEmONC Kancheepuram, Taluk hospital- Maduranthagam, Block PHC- Walajabad,PHC- Ayyampettai, Gnanagirisaranapettai, Health Sub-centre- Uthukada
Villupuram District :Block PHC- Mailam, Addl. PHC- Omandur & Avalurpet

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<p>► Good pre-existing services with admirable transparency in postings and procurement, efficiency in logistics; Public health cadre exists as well as three to five year rural posting for all on joining service.</p> <p>Consequent to NRHM:</p> <p>► Untied funds improve ambience of facilities, empower local health providers and motivation of community</p> <p>► Block PHCs now working 24x7 with additional nurses (3 now)</p> <p>► Upgradation of PHCs to B-PHC and CHC undertaken and expedited</p> <p>► Active PRI and community participation, VHSCs functional</p> <p>► NGO partnerships for emergency ambulance network expanded to whole state.</p>	<p>► Janini Suraksha Yojana and Dr. Muthulakshmi Reddy scheme for SC/ST/BPL needs further inputs, poorly known/utilized and delay in payment, and no JSY incentives for taluk and district hospitals</p> <p>► Upgrading Block PHCs to CHCs to be expedited.</p> <p>► District Planning with focus on equity issues slow to take off.</p> <p>► Urban health planning lags behind.</p>

11. TRIPURA

THE REVIEW TEAM

1. Ms. Archana Varma, Deputy Secretary, Ministry of Health & Family Welfare,
2. Mr. Praveen Srivastava, Director M&E, Ministry of Health & Family Welfare,
3. Dr. Charan Singh, Joint Director-NVBDCP, MoHFW, and
4. Mr. Gautam Chakraborty, Senior Consultant - Health Care Financing, NHSRC

THE DISTRICTS/INSTITUTIONS VISITED

INSTITUTIONS/ PLACES VISITED
Dhalai District: Gandachara and Kamalpur Hospital, PHC- Ganganagar, Kulai, Salema, Sub Centres- Harinchara, Durbajoy, East Nalichara, Kolachari, Training Institute- District Health Training Institute, Village- Baligaon
West Tripura District: SDH - Sonamura and Bishalgarh, CHC – Mohanpur, PHC - Narsingharh, Bamutia, Anandapur, Bishramgarh, and Kathalia Sub Centres - Airport, Laxmilunga, Tulabagan, Bishalgarh, Bhabanipur
South Tripura District : Tripura Sundari District Hospital, Udaipur, PHC – Kakraban, Sub Centre - Purba Mirza, Village - Purba Mirza

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> • Institutional deliveries showed a significant increase. • Village Health Days are popular. • Doctors' Association playing very important role in reducing absenteeism by promoting rotational posting for remote areas. • RKS funds and untied funds very well utilized. • Very high and effective involvement of PRIs • Village Plans are prepared. • Helicopter service health camps in remote, inaccessible tribal villages; • ASHAs selected by transparent process involving the PRIs; bright red coats and blue kit bags have given a unique sense of pride and identity to the ASHAs;. • Adequate availability and off take of drugs in facilities; need to sensitize doctors to prescribe generic drugs. Equipment/ drug procurement is also being done through the RKS and Sub Centre committees. • Telemedicine partnership established for eye care; PPP Medical College and Nursing College recently started. 	<ul style="list-style-type: none"> • There are key shortage of trained professionals like Specialists, Doctors, paramedics, Nurses and Lab Technicians. Need for more ANM Schools. • Need for integration and mutli-skilling of Lab Technicians and other paramedics to improve availability of diagnostic services. • Untied funds have increased the need for better financial management as there are many more details needed • State needs to analyze disaggregated data on health parameters. • PHCs have received computers but software is not installed yet; data operators being in short supply. • Village Health Committees are yet to be constituted by merging with the water and sanitation committee; • Malaria prone are with drug resistance as well • PWD not able to cope with work load; need to explore possibility of central construction agencies for infrastructure up gradation. • Arrangements tackling neo natal mortality need to be strengthened

12. Uttar Pradesh

THE REVIEW TEAM

1. Dr. T. Sundararaman, Executive Director NHSRC
2. Dr. Shalini Bharat, Dean, School of Health Systems studies, TISS
3. Dr. Ritu Priya, Advisor, NHSRC
4. Dr. Dinesh Biswal, Asst Commissioner, MOHFW, GOI
5. Dr. Siddharth Choudhury, Regional Director, GOI

THE DISTRICTS/INSTITUTIONS VISITED

District Rae Bareilly: General Hospital - Rae Bareilly, Female Hospital - Rae Bareilly, CHC – Bachraon, Khiron, New PHC - Karahiya Bazar, Sub Centre - Rampur Kasiya, Beni Madhoganj, Village - Singhor Tara, Bheera, Ganagaganj-Sohra, ABR Girija Devi Charitable Hospital, Raalpur

District Jhansi: General Hospital and Female Hospital Urai, General Hospital and Female Hospital Jhansi, CHC Moth, Block PHC Chirgaon & Gorsarai, Addl PHC Baghera, Todi Fatehpur, Raven, Sub-center Baghera, Raven, Gugua

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ► Functional health institutions; Clean and well maintained ► PHCs upgraded, functional 24x7 ► CHC and District Hospital upgradation to IPHS in process ► JSY is being utilized widely, Institutional deliveries increased at all levels. ► Untied funds used for essential infrastructure and has enabled and given confidence to local health care providers. 	<ul style="list-style-type: none"> ► Poor HR planning in all aspects, opening of new institutions,reviving of training centers, recruitment of doctors, nurses,ANMs, lab technicians;Rational deployment/transfers of personnel/facilitating;Multi-skilling needed but not yet started up. ► Objective of each facility reaching a certain level of service provision needs to be put in place. ► ASHA second round training overdue, support and mentoring systems need to be set up. Village health and sanitation committees to be started up. ► Adequate and timely disbursement of JSY funds.

13. West Bengal

THE REVIEW TEAM

1. Mr. S.K. Das, Addl. DG.
2. Dr. P.L. Joshi, DDG-L.
3. Mr. Sunil Pal, Consultant.

THE DISTRICTS/INSTITUTIONS VISITED

1. District Birbhum: BPHC Illambazar, Sub Centre Ruppur, PHC Sattare, RH Labour, ANM Trg Centre Suri, Distt Hospital Suri

2. District Bankura: Bankura Sarmelini Medical College Hospital, Nursing Training Centre – Bankura, RLTRI Gauripur, BPHC Amarkanan, PHC Beliatod, SC-W, Beliatod

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
<ul style="list-style-type: none"> ▶ Sub-centre doing fixed day clinics ▶ GPs authorized to hire doctors for few days in a week ▶ Drug availability increase institutional deliveries ▶ Up-gradation of PHC's & BPHC's ▶ Appointment of doctors, specialists & nurses ▶ Satisfactory immunization ▶ Strong nursing cadre & Directorate ▶ Physical infrastructure handed over to Panchayats maintenance ▶ Active involvement of panchayats in the management of health system 	<ul style="list-style-type: none"> ▶ Demand for PPP for diagnostics ▶ Getting specialists ▶ To integrate data sets effectively ▶ satisfactory indicators for ASHA's in tribal & minority concentration areas (ASHA's not in position) ▶ Shortage of lab technician's ▶ Need for integrating & Malaria lab technician's levels ▶ Need to improve pace for infrastructure development ▶ Refinery of system of procurement of drugs to make it need base, like TNMSC key findings ▶ Further convergence of functions of accounts system at staff level
