Report of the First Common Review Mission Of National Rural Health Mission

Orissa State

14th – 21st November, 2007

Mission Members:

- Shri K B Saxena: Former Secretary, Health and Family Welfare, Government of India.
- Dr S K Satpathy: Director-Training, Public Health Foundation of India, New Delhi.
- Dr P K Mohapatra: Sr. Regional Director, Regional Directorate, Bhubaneshwar, Government of India.
- Dr K S Sachdeva: Chief Medical Officer, Central TB Division, Government of India.

Contents: Page

1. **National, State and District level briefings and organization of field visits - 3**
2. **Institutions visited and methodology adopted for progamme review - 4**
3. **Observations 7 - 25**
    - **3.1 Assessment of case load**
    - **3.2 Preparedness of health facility for inpatient care**
    - **3.3 Quality of services**
    - **3.4 Immunization**
    - **3.5 Diagnostic facilities**
    - **3.6 Manpower position**
    - **3.7 Rogi Kalyan Samiti(RKS)**
    - **3.8 Panchayat Raj Institutions(PRI)**
    - **3.9 District Health Action Plan**
    - **3.10Financial Management**
    - **3.11 Health Management Information System(HMIS)**
    - **3.12 Rationale Use of Manpower**
    - **3.13 Difficult areas and vulnerable Groups**
    - **3.14 Performance of Health providers**
    - **3.15 Disease Surveillance**
    - **3.16 Preventive and Public Health**
    - **3.17 Disease Control Programmes**
    - **3.18 Maternal and Child Health**
    - **3.19 Mobile Medical Units**
    - **3.20 Infrastructure Development**
    - **3.21 Procurement System**
    - **3.22 Non-governmental Partnership**
    - **3.23 Addressing Manpower Shortage**
    - **3.24 ANM Training Schools**
    - **3.25 Programme Management Structure**

4 Recommendations 25 - 38

5 Conclusion - 38

6 Acknowledgements - 38

NATIONAL RURAL HEALTH MISSION
FIRST COMMON REVIEW MISSION
ORRISA STATE

1. The members of first common review mission to review the status of implementation of National Rural Health Mission in Orrisa state visited the state from 15th November 2007 to 21st November 2007. The following were the members of first common review mission.

- Shri K B Saxena: Former Secretary, Health and Family Welfare, Government of India.
- Dr S K Satpathy: Director-Training, Public Health Foundation of India, New Delhi.
- Dr P K Mohapatra: Sr. Regional Director, Regional Directorate, Bhubaneshwar, Government of India.
- Dr K S Sachdeva: Chief Medical Officer, Central TB Division, Government of India.

The team members were briefed about the key issues before the common review mission and the mission schedule at a meeting held at Committee Room, Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi on 14th November 2007.

The members visited and reviewed the programme activities in the state as per the schedule:

- 15th November 2007: Visit to State Headquarters followed by a meeting with Secretary-Health and presentation by programme officers. Review method included presentation by state team, probing by mission members followed by discussion with key functionaries.

- The review mission members decided to visit the District Sundargarh and District Bolangir selected by State.. All team members decided to visit both the districts, however within the district two teams were be formed to evaluate the district independent of the other team. Each team decided to visit tribal, difficult to reach and easily accessible areas and cover all levels of health care from sub center to district hospitals. Besides evaluation of health service delivery outlets both teams decided to interact with community, ASHA, village Panchayat, Rogi Kalyan Samiti members and opinion leaders.

  The review mission members specifically decided to focus on following areas while evaluating districts for progress in implementation of NRHM.
  - Infrastructure
  - Human Resource

- ASHA
- Maternal Health:
- JSY:
- Family Planning:
- Immunization:
- Revised National Tuberculosis Control Programme
- National Leprosy Elimination Programme
- National Vector Borne Disease Control Programme
- Integrated Disease Surveillance Programme
- HMIS
- Rogi Kalyan Samiti
- Untied funds
- Village Health and Sanitation Committee
- Logistics Management
- Mainstreaming AYUSH
- Mobile Medical Units
- Capacity Building

- 16th and 17th November 2007: Visit to Sundargarh District. The programme was reviewed in the following manner:
    - Meeting with District Collector followed by presentation by key programme staff.
    - Discussion with District Collector, Chief District Medical Officer and key staff involved in programme implementation.
    - Visit to District Hospital, Sub Divisional Hospital, Community Health Centre (CHC), Primary Health Centre (PHC), Sub Center (SC), and NGOs Centres. The following methodology was adopted for programme review:
        - Review of records.
        - Observation of working methods.
        - Interview with key functionaries.
        - Interviews with patients.
        - Discussions with members of Rogi Kalyan Samiti.
        - Discussion with Village Sarpanch and other members of Panchayat Raj Institutions.
        - Interviews and discussions with ASHA (Accredited Social Health Activist).
        - Interviews and discussions with NGO representatives.
    - Debriefing and discussion with District Collector and Key functionaries on observations of mission members.

Institutions visited in District Sundargarh

- Urban Slum Health Centre – Tillea Nagar, Rourkela (PPP model)
- District level Hospital - Rourkela Government Hospital, Rourkela
- Sub-divisional Hospital – SDH, Bonai
- Community Health Centres (CHC)

1. CHC - Kinjerkela (Balisankara Block)
2. CHC - Bisra, Rourkela
3. Block PHC - Gurundia

- Primary Health Centres:

1. PHC(New) - Sikajore
2. PHC(New) - Senpatrapali
3. PHC(New) - Tangarpalli

- Sub-Centres:

1. Sub-centre - Tileikani,
2. Sub-Centre - Ujjalpur
3. Sub-centre- Kopatomundla
4. Tamra Subcentre

- 18th to 20th November 2007: Visit to Bolangir District. The programme was reviewed in the following manner:
    - Meeting with Chief District Medical Officer followed by presentation by key programme staff. (District Collector was not able to interact with mission members due to certain pressing exigencies)
    - Discussion with Chief District Medical Officer and key staff involved in programme implementation.
    - Visit to District Hospital, Sub Divisional Hospital, Community Health Centre (CHC), Primary Health Centre (PHC), Sub Center (SC), and NGOs Centres. The following methodology was adopted for programme review:
        - Review of records.
        - Observation of working methods.
        - Interview with key functionaries.
        - Interviews with patients.
        - Discussions with members of Rogi Kalyan Samiti.
        - Discussion with Village Sarpanch and other members of Panchayat Raj Institutions.
        - Interviews and discussions with ASHA (Accredited Social Health Activist).

- Interviews and discussions with NGO representatives.

- Debriefing and discussion with District Chief Medical Officer and Key functionaries on observations of mission members.

Institutions visited in District Bolangir

- District Hospital - Bolangir
- Sub-divisional Hospital - Patnagarh
- Community Health Centres:

1. CHC - Kantabanji
2. CHC – Luisinga
3. CHC - Saintala

- Primary Health Centres

1. Block PHC - Tureikela
2. PHC (New) – Kushang
3. PHC – Khaprakhol
4. PHC (New) – Lathore
5. PHC - Gudvela

- Sub-Centre:

1. Sub-Centre - Ghunesh
2. Sub-Centre - Badabanki
3. Sub-Centre - Kandajuri
4. Sub-Centre - Sargad
5. Sub-Centre - Kushang
6. Sub-Centre – Ghunson
7. Sub-Centre – Rengali
8. Sub-Centre – Telanpali
9. Sub-Centre – Orriyapali
10. Sub-Centre – Gambhriguda
11. Sub-Centre - Ghuna

- 21st November 2007: The state was apprised of the observations made by the first common review mission members after their visit to selective samples of health institutions and their interaction with health staff and community as under:

1. District Hospitals: 2
2. Sub-Divisional Hospitals: 2
3. CHCs: 6
4. PHCs 8
5. Sub-Centres: 15
6. Interview/discussion with Anganwadi Workers: 10
7. Interview/discussion with ANMs 7
8. Interview/discussion with Sarpanch/PRI members: 6

9. Interview/discussion with members RKSs: 3
10. Interview/discussion with ASHAs: 28
11. Community interactions: 14

Debriefing session at state headquarters was followed by discussion with Mission Director and open dialogue session with key functionaries, Non Government Organizations.

3. OBSERVATIONS

Orrisa state administratively has 3 revenue divisions, 30 districts, 58 subdivisions, 171 tehsils and 314 community development blocks. As per 2001 census Orrisa has a population of 368.05 lakhs (Urban 14.99%, Rural 85.01%, SC 16.53% and ST 22.13%).

Health infrastructure

	Required (as per GOI norm)	Existing	Gap
Medical Colleges	--	3	--
District Hospitals	--	32	--
Sub Divisional Hospitals	--	22	--
CHC	348	231	117
PHC (single doctor)	1362	1282	80
Sub Centre	7753	5927	1826
Health and Family Welfare Training Centres	--	2	--
ANM Training Schools	--	16	--

Though there are gaps in physical infrastructure vis a vis the requirements, even the existing physical infrastructure suffers form serious deficiencies. Patients are unable to access the existing centers for a variety of reasons, notable among them being either no staff is available or the existing staff frequently absents from duty or the non-availability of drugs.

The overall observations point wise have been structured as per the headings below:

3.1 Assessment of case load being handled by the Public System at all levels:

There is an overall increase in out patient attendance. However this increase in case load seems to further increase distortions in health care delivery system as most of this increase has been observed at secondary care institutions. There is still gross under utilization/ non availability of services at primary care levels as is substantiated by following observations of mission members:

- Many primary health centers are still plagued with shortages of medical officers/ frequent absenteeism of M.Os. Most of the PHCs reviewed by the team had OPD attendance from a low of 5-10 patients per day to a maximum of 50 patients in a day.

- The similar observations hold true at sub-centre level. Sub-centre is infact, the weakest link in the chain.
- OPD attendance in sub-district and district hospitals has increased by an average of 10-15%. (This may be due to poor utilization of services at PHC/SC level).
- The In Patient Department admissions have increased by 5-10% in the district hospital and sub divisional hospitals. A majority of this increase is attributable to increase in institutional deliveries. (The increase in institutional deliveries appears to be driven by financial incentives under JSY scheme to pregnant mothers and ASHA). The benefits of increased attendance at tertiary hospitals have not been translated in better in patient care or better performance of other disease control programmes but an opportunity for intervention has certainly been created which needs to be exploited by health administrators.
- There is no increase in in-patient admissions (Other than the institutional delivery) at the level of CHCs and PHCs.
- Substantial increase in institutional deliveries has been observed across all levels of health care. For the State overall, it has gone up by 18% in the district hospitals, by 25% in Sub-divisional hospitals, by 44% in CHCs/upgraded PHCs and by 69% in PHC (new). The number of deliveries in PHCs is very small. It appeared that some of the PHC (new) have started conducting institutional deliveries after introduction of JSY and ASHA, which they were not doing before.
- In Bolangir district institutional deliveries have gone up from 32% in 2005-06 to 43% in 2006-07. In the first six months of 2007-08, the number of institutional deliveries (10045) is already nearing the annual figure of 2005-06. Registrations of ANC cases also have gone up by 5.5%.
- In Sundergarh District the increase in institutional deliveries has gone up by 11% in district hospitals, 36% in Sub-divisional hospitals and only 6% in PHC/CHCs. However the PHCs (New) are hardly conducting any delivery mainly because the staff is not staying in the premises and coming to the PHC only for some time of the day. Facilities for conducting delivery at PHCs however do exist. Villagers complained about the non-availability of staff in the PHC.

3.2 Preparedness of health facilities for inpatient care and the utilization of beds for such care:

The nomenclatures of the CHC and PHCs and the bed strengths are not akin to the GOI guidelines. Institutions with 16 beds are called CHCs and some of the upgraded PHCs are having 30 beds. PHCs with 20,000 – 30,000 population are known as PHC (New). The rationale for the variance is not clear. It also confuses people regarding the level of expectations from a given centre.

These institutions are still to meet IPH (Indian Public Health) standards though there is some progress in this regard. Considering the present status of the health

centres, the Mission members feel that bringing them up to Indian Public Health Standards should be done in a phased manner. First of all the health centres should be strengthened to provide 24X7 services. Secondly, the CHCs/SDH should be strengthened to function as FRUs as per FRU guidelines of GOI. Thereafter, these FRUs may be strengthened further to IPHS. As regards up-gradation of district and sub-district hospitals to IPHS standards, funds have been made available and facility survey has been completed in some. Money allotted for IPHS is not being spent.

Staff shortages and non-availability of staff during odd hours present a major constraint. Further, retention of staff in rural areas and tribal areas pose a formidable challenge. The state has offered financial incentives for contractual doctors willing to serve in rural and tribal areas (KBK areas). There are only three medical colleges in the state, which are presently insufficient to meet the demand of the state. Presently, about 700 posts of doctors are lying vacant. Shortage of anesthetists at hospitals is a major concern.

The systems of logistics management are not streamlined and there are shortages or stock outs of key drugs and consumables. There is poor utilization and maintenance of existing equipments and shortages of trained paramedical staff to handle them. To maintain these equipments in working order is another area of concern.

Diagnostic support, lack of quality assurance in laboratories, severe shortage of paramedical staff to ensure smooth functioning of laboratories commensurate with increase in anticipated in patient care are still to be addressed. So also there is a need to optimally utilize existing resources- manpower and facilities.

3.3 Quality of services provided for institutional deliveries:

With the operationalization Janani Suraksha Yojana (JSS), there has been a quantum increase in institutional deliveries. However, this quantum increase has further compromised the quality as majority of institutional deliveries are being handled at district/sub-district level. This inequitable utilization of institutions is due to:

- Very few deliveries being conducted at sub-centre level/PHC because:
  i. Many PHCs (New) do not have labour rooms.
  ii. Many sub-centres are running from rented buildings where there is no provision for ANM to stay. Therefore, deliveries at odd hours need to be referred to higher center/conducted at home.
  iii. No provision for referral transport thus necessitating a private transport which is not always available especially in interior and difficult to reach areas.

iv. Virtually/no usage of equipments and their upkeep. Equipments out of order at the sub-centr have not been repaired. There has been lack of proper material planning and physical infrastructure. Few sub centres were being used totally as residential premises by the staff, while most sub centers were partly being used to dump personal belongings of staff. House keeping is bad with little attention on cleanliness, removal of dust from registers and equipment boxes. It was observed that old papers and junk material were crowding the shelves.

v. Some of the existing sub centers had damaged buildings with leaking rooms, total lack of sanitation and are unfit for conducting deliveries.

vi. In many sub centers despite residential premises being available, ANMs are not staying there and commuting daily to place of work. Even in other centres ANMs are not available for one reason or another. Premises remain closed with no information displayed about the absence of ANM.

vii. The sanitary conditions in the labour rooms and toilet facilities in hospitals/centres are in a very poor condition.

viii. Poor attendance at PHCs due to frequent absence/non availability of staff.

ix. Staff motivation is very low due to callous attitude of authorities to their personal problems. In Bolangir district, doctors were allotted residential quarters without electricity and water connection.

x. Poor logistics management. In one of the CHC (16 bedded) in Bolangir district there were no gloves, sutures, needle, Inj. Oxytocin, Inj. Methargine available. (How deliveries were being conducted?)

xi. No provision for stay/waiting area/facilities for attendants across all levels of care.

xii. Many sub center buildings constructed by rural development department, though ready, were awaiting electricity and water connection for a long time and therefore could not be made functional.

xiii. Frequent stock out of key drugs and surgical consumables.

xiv. Release of salary of ANMs after a gap of 6-8 months is a routine feature across districts.

At the district/sub district level:

- Inadequate human resource capacity to handle additional load.
- Staff not ready to assume additional responsibility due disabling work environment and lack of motivation for extra work.
- Poor sanitation in most hospitals. In one of the district hospitals the toilets even did not have bulbs and were completely dark.

- Each patient had a large number of attendants crowding the wards. There is no privacy for female patients. In all the hospitals even in general wards, male and female patients were clubbed together.
- Monitoring, supervision and evaluation of different categories of officers, supervisors and health workers seems to be lacking at all levels including Sub- centres, PHCs and CHCs. The supervising officials are not utilizing their field visits to provide necessary guidance and technical support to the staff.

3.4 Systems in place for immunization and visible changes at the field level:

As per NFHS-3 data full immunization coverage in Orrisa was 52% and no immunization is 9%. Evaluated coverage by UNICEF in last three years indicates that there is decline in coverage for all immunizing agents. Mission review members observed that though there are gaps in immunization coverage as revealed by probing interviews with parents, the reported coverage shows full immunization. Review of records at various levels of health care did not show any increase in number of children vaccinated. Even in institutions where institutional deliveries have increased by 20-60%, vaccination figures do not match this increase. (even for BCG vaccine which is administered at birth). There is wide gap between reported and evaluated coverage.

Sundergarh district is a pilot district for Hepatitis-B vaccination. Despite being a pilot district for Hepatitis B vaccinations, frequent stock out were observed. (Such a situation is likely to erode credibility of system).About other immunization, the general feeling is that because of ASHA the defaulting cases are quickly contacted and brought to the clinic/nearby clinic for immunization. Supply position of vaccines, AD syringes and other logistics were found to be satisfactory.

3.5 Diagnostic facilities at health facilities and their effectiveness:

The strengthening and availability of quality assured diagnostic set up at district hospital and sub divisional hospital is restricted by availability of paramedical laboratory staff, and qualified doctors in the field of laboratory medicine. (There are very few qualified pathologists, microbiologists and biochemists in the state health system).

As far as laboratory technicians are concerned, the staff was available for single disease control programmes like tuberculosis and malaria. However their integration with general health system and their capacity to work for routine diagnostic work showed wide variation from strict compartmentalization to multiskilling. (This appeared to be both directional and managerial issue. Some facility incharges were able to utilize available human resources in a more efficient manner).

3.6 Manpower position in health facilities:

There is a shortage of about 700 medical officers in the state. These shortages assume critical dimensions due to skill mismatch as per the level of facility. Frequent non-availability of medical officers at their place of work. (Generalists posted at tertiary institutions and specialists posted at PHCs.). Manpower needs assessment and long term planning is absent. The situation is more critical in Sundergarh district. (Tangerpali PHC with average OPD attendance of 10-20 patients per day had a qualified surgeon in place, whereas in New PHC Senapatrapali medical officer seldom reported for duty and review of records showed OPD attendance of 8-12 patients per day. Probably patients were seen by a pharmacist).

In Sundergarh district 84 additional ANMs were to be recruited, but only 8 could be recruited. Except district hospitals, no anesthetist exists in any other hospital/CHC). Manpower support sanctioned under NRHM such as 50 staff Nurse, 3 Lab Technician has been filled up. But out of 84 additional ANM posts sanctioned under NRHM, only 8 could be filled up. There is an ANM training school in the district but mostly girls from urban areas get admitted to this institution. Retention of staff in backward districts poses a formidable challenge to district administration.

District Bolangir, although little better has problems with posting of specialists. Out of 177 posts of doctors/specialists, 47(27 MOs and 20 specialists) are vacant (27%). Many posts especially the specialists are yet to be sanctioned. In paramedical and nursing group 11 posts of Staff Nurse, 1 PHN, one sister tutor, 7 Laboratory Technicians, 15 Multi purpose Worker (Male), 7 Female MPW Supervisor (LHV), 49 Male Multi Purpose Supervisor and 3 MPW Female(ANM), 3 Block Extension Educator are vacant. Out of 40 Additional ANM posts sanctioned under NRHM only 18 ANMs have been filled.

The State has taken several steps to overcome the health manpower problem such as:

- Additional incentives of Rs.4000 – 8000 for working in KBK (Kalahandi, Bolangir, and Koraput) districts and 3 backward districts (Boudh, Phulbani, &Gajapati),
- Appointment of contractual specialists and Asstt. Surgeons (281)
- Increase in MBBS seats (43 additional seats in each of the 3 medical colleges)
- Doubling the seats of Diploma in Lab. Technology and DMRT (X-ray Tech) in 3 medical colleges
- 33% increase in seats in all the 16 ANM Training Centres
- Started M.Sc nursing Course in Nursing College Berahmpur
- Starting of B.Sc Nursing Course from 2008-09 in SCB Medical college
- Starting of Nurse Practitioner course from 2008-09
- Short term course on Anesthesia and Emergency Obstetric Care for MBBS doctors (12 doctors completed and 11 are currently undergoing training in Anesthesia in medical colleges).Training of 5 Astt. Surgeons in O&G by FOGSI have been completed.

- Posting of 1500 additional staff nurses in the peripheral institutions.

3.7 Utilization of Rogi Kalyan Samiti and untied funds at various levels of the system:

The State claims to have set up Rogi Kalyan Samitis (RKS) in all the District level hospitals (30 districts, Capital Hospital and RGH, Rourkela), all Sub-divisional Hospitals (22), 341 CHCs/Block PHCs out of 348, and in 338 of 1162 PHC (New).

Bolangir district has set up RKS in the District hospital (1), SDH (2), CHC (8) and block level PHCs(7). However only 20 PHC (New) have RKS as the remaining PHC (New) do not have a MO I/C in position (16). The district claims to have had at least one meeting of each RKS. Major decisions taken are purchase and repair of equipment, minor repair/modification and maintenance of building, wage of sweeper and others, water purifiers, generators, emergency lights/inverters, coolers, out sourcing of cleaning and laundry services, security services etc. Out of Rs. 22 lakhs released, Rs. 5.49 lakhs have been spent.

Sundergarh district claims to have set-up RKS in all its Institutions (District Hospitals/RGH-2, SDH-2, CHC/Block level PHC-18, Area Hospitals -6, & PHC (New)-54. The number of meeting taken place is 84 and major activities done are purchase of water purifier/facility, desert coolers, engagement of contractual ambulances, Driver and sweeper, repair of equipments etc. Although Rs. 54 lakhs have been released, only 3.41 lakhs has been spent at the time of reporting.

The team reviewed the functioning of RKS in the CHC, Kinjirikela, CHC Bonai, RGH, Rourkela in Sundergarh district and CHC, Kantabanji, and PHC Turekela of Bolangir District. The constitution of the RKS is more or less as per the guideline. For example RKS of Tureikala PHC has the chairman of the Tureikela Panchayat Samiti as the Chairman of RKS, and CDPO (ICDS), Sahaya India Service-the NGO, one PRI member, the block Programme officer etc are members. MO I/c of the PHC is the member secretary. The 2nd Governing body meeting was held on 25/09/07. The decisions taken were to buy two inverters to take care of the power cuts, purchase of Aquaguard to ensure safe drinking water for the patients and staff, engaging a sweeper to ensure cleanliness of PHC premises on daily wage basis, fund generation through opening of a medicine store and accepting donation from others (proposal deferred for the next meeting). The minutes of the meeting had been signed jointly by the Chairman and the Member secretary and had been sent to the Additional District Medical Officer (FW & Immunization) on 8/10/07. The RKS of CHC Bisra in Rourkela was more proactive and had three meetings in last six months. Similar activities have been undertaken in the two CHCs in which the team had a chance to meet the members of RKS (namely CHC, Kantabanji and Luisinga). RKS of Rourkela Government Hospital also seems to be very active and is undertaking several expansion activities. However, the RKS of in CHC kinjirikela (Sundergarh

district) has failed to meet for last 6 months and the telephone is lying dead for more than 6 months due to non-payment of the bills.

RKS although constituted are not fully aware of their responsibility and accountability. They also lack fund management ability, resource mobilization, guidance and monitoring skills. RKSs are not paying adequate attention to issues of biomedical waste management, empowerment of community through "Citizens Charter".

The team had a chance to interact with participants of the TOT for RKS. The initiative of the State in this regard is commendable. However, the training appeared to be very theoretical and passive. The module just tells the participants about their responsibility as given in GOI guidelines.

3.8 Involvement of Panchayati Raj Institutions in the functioning of health system:

NRHM has envisaged specific roles for the PRIs relating to health and related sectors. But the ground reality does not suggest any role the PRIs have assumed at the present juncture other than attending some of the meetings and some involvement in the management of untied fund. There is lack of awareness and clarity about their role. The Village Health and Sanitation Committees are not in place in the state as yet. The real communitization process under NRHM has not been visible except positioning of ASHA. The PRIs along with ASHAs, AWWs, ANMs need appropriate orientation jointly to enhance their capacity. They should be given the knowledge and skills on how to assess their own health needs, how to prepare a village health plan, how to mobilize resources for implementing the village health plan, how to conduct a village health and nutrition day, how to coordinate with related non-health sector, how to monitor the activities under NRHM, how to evaluate in simple way etc. Without this empowerment, communitization process will be incomplete. The State is aware of the need but has initiated the orientation training for the PRIs alone. It should be done jointly for PRI, ASHA, AWW, ANM and functionaries of related other sectors. It is better to get this done through credible NGOs.

The village Health Day, although conducted at AWW Centres needs innovation to make it interesting and acceptable to the villagers. Otherwise it would become routine and boring for the mothers and children. Indonesian experience of "Posiyandu" (similar to the concept of village health day and services provided through counters handled by volunteers)) may be used to provide a range of services.

3.9 Process of preparedness of District Health Action Plans and quality of District Health Mission meetings:

The process of preparation of district health plans is yet to be streamlined. The district mission is in place in most districts for less than a year and DPMU is in the process of preparation of plans for next year and trying to incorporate feedback from block level. No institutional mechanism is in place as of now for decentralized and focused planning as per needs of the individual blocks/villages/difficult areas/vulnerable populations.

3.10 Systems of financial management:

Fund flow to districts:
A single society for various progammes is in place in the state. Separate accounting is done for various disease control programmes (separate sub-accounts for each programme). There is no delay in release of funds for various programmes and E-banking ensures speedy and hassle free transfer of funds to district societies. However there are still few problems like submission of audited statements in time. Further dedicated accounting personnel are not available at block level.

Untied Fund for Sub-centres:
The State has utilized 82% of the funds received for this purpose in 2005 -06 and 45% of the fund received in 2006-07. Bolangir District has spent 81.4% of the fund received in 2006-07 and 36.65% as of October, 2007 of the available fund. The pattern of expenditure has been on account of minor repair of sub-centre, payment for cleanliness, transport of emergencies to appropriate referral centre, purchase of consumables, daily wageworker, and supplies for environmental sanitation and other expenditures. In Sundergarh District, 28.2 lakhs and 34.50 lakhs have spent from this fund. The pattern of expenditure has been procurement of furniture for sub-centres, drinking water storage facility, environmental cleanliness etc. Difficulties about the operation of funds and taking decisions for their utilization could not be probed.

Rogi Kalyan Samitis:
An amount of Rs. 520.00 lakhs has been released to RKS this year out which an expenditure of Rs. 199.55 lakhs has been booked. Major activities taken by RKS are purchase and repair of equipment, minor repair/medication, maintenance, wage for sweeper and others water purifier, generator, emergency light, security services etc.

The capacity to utilize untied funds at sub-centre level, PHC and CHC level varied and still many institutions are not comfortable to handle funds and need assistance in developing procedures for efficient utilization of funds. The District Collector of Sundergarh district felt that there should be provision for untied funds at district headquarter level so as to initiate some interventions at district level in the interest of community.

3.11 HMIS and its effectiveness:

Health management information system is one weak area in the state. Data collection and maintenance of records at field level was found to be faulty. In many of the sub-centres reviewed by the team the records were not up-to-date. In one sub-centre registers were not completed since February/March this year. Similar deficiencies in record keeping were observed in other sub-centres.

The sub-centre reports that are submitted monthly to PHC were not being analyzed by MO I/Cs in the PHCs visited by the team. Many sub-centres reported Stillbirths/ neonatal deaths but no pro active efforts were visible by MO I/Cs to find out the cause/take corrective action for prevention of such deaths in future. Many PHCs/CHCs in Bolangir districts did not have formats for reporting surveillance activities. Hence no reports were being prepared. In the absence of quality data capture at field level, no credible management information system can be built.

The state is conscious of these ground realities and is planning to train all levels of staff in the collection and use of database on programme indicators. The state claims that HMIS is already implemented in 30 districts. State has still to fill vacancies of statisticians at block level. Several IT initiatives are being taken by the state. Data entry operators and computers have been provided to all blocks. The state has conducted GIS based mapping of malaria endemic areas for targeted interventions. SMS based daily monitoring of key parameters at all block level and district level health institutions is being developed.

3.12 Rational use of manpower at various levels to ensure appropriate skill mix for better outcomes:

Lack of rational use of manpower emerged as a main area of concern during the review. While on one hand there is shortage of all categories of staff, on the other hand posting them in PHCs is wasting skills of a large of doctors with specialist qualification. Many general duty doctors are being used as specialists in district and sub-divisional hospitals. Further, many categories of staff are not residing within the premises of PHCs/CHCs/Hospitals despite availability of residential premises. Non-resident staff posted in difficult and hard to reach/backward areas frequently absent themselves from duties resulting very poor utilization of services and infrastructure.

State does not follow any system of postings and transfers. As a result people who do not have any clout are posted in difficult areas and it is seen as punishment posting bringing down motivation levels and morale.

Though there is shortage of allopathic doctors in state, many AYUSH doctors in the state are not properly utilized. The state has engaged 259 AYUSH doctors in block PHC/CHC. In Sundergarh district AYUSH Doctors have been posted in all the 17 Block PHC/CHCs and 15 days orientation training is going on for them. However, no AYUSH drug has been provided to them so far. The district has received the job chart for them from the state.

In Bolangir District, 14 AYUSH Doctor (7 Aurvedic and 7 Homeopathic Doctors have been posted to work in block PHCs/CHCs. Training is on but drugs not received.

3.13 Thrust on difficult areas and vulnerable social groups:

Orissa occupies a unique place in the tribal map of the country having the largest number of tribal communities with a population of 81.50 lakhs (22.3% of states population). The health indices of tribal population in Orissa are worse than national average. The state has initiated few measures for difficult areas and vulnerable social groups. Several Swasthya Melas in villages of tribal blocks, camps by hiring vehicles in selected pockets of remote tribal blocks and TBA trainings have been organized. However provision of referral transport for maternal care has yet not materialized in these areas.

The state has also sanctioned additional incentives for regular doctors in KBK (Kalahandi, Bolangir and Koraput) districts and 3 back ward districts (Boudh, Phulbani & Gajapati). Mobile Health Units in these districts are functioning with a chalked out visit plan.

The districts have just started collecting disaggregated data on utilization of services by SCs/STs from April 2007 and a clear picture will emerge by next year.

3.14 Assessment of performance of Accredited Social Health Activists, ANM's, Lab Technicians, Medical Doctors, etc.:

ASHAs

- ASHAs are visible everywhere, be it in the village or in the labour wards of the hospitals. They are known to the villagers especially to the women as the one who takes care of the pregnant women and take them for delivery to the hospitals.
- The State has nearly achieved (99.7%) its target of selection of ASHA (34231 out of the target of 34324 and 93 more only will be selected) of whom 12437(36.3 %) have received advanced training and 30207 (88.2 %) have received only the induction training. Similar pattern has been observed in the two districts.
- District Sundergarh has selected all the 1884 ASHAs, given advanced training to 680(36%). 191(16%) of the ASHAs selected in PhaseII are yet to be given induction training. District Bolangir has selected 1256 ASHAs out of the target of 1269. Selection of remaining 13 ASHAs is disputed. 506 ASHAs of the 1st phase have been given 23 (7+16) days training and 634 of the II phase have been given only induction training of 5 days. Immediately after the induction training the ASHAs have started taking pregnant women to the hospitals for institutional delivery.

- The role of PRI in selection of ASHA was not uniform. Most of the ASHAs were selected by involving self-help groups, ANMs and AWWs in village meetings. Incase of more number of candidates, the selection was made on the basis of lottery. The process of selection does not help her emerge as a representative of the community. Most of the ASHAs we interacted with had 8-10 years of schooling. Some of the ASHAs may be eligible to undergo ANM training.
- All trained ASHAs have the identity badge. ASHAs of the 1st phase have been given the ASHA bag. In the field it was observed that some ASHAs have not been given the drug kit.
- Knowledge of the ASHAs about MCH care was found to be of acceptable standard though only on issues of Reproductive and child health. However there is little knowledge about the other health programmes such as RNTCP, Leprosy, IDD, Blindness control programme, Malaria, Diarrhoea and IDSP. Most of the ASHAs are yet to be trained in these programmes.
- ASHAs have benefited from taking pregnant women to hospitals/health centres for delivery, immunization sessions, motivation of and follow-up of cases for sterilization and as a DOTS provider.
- On an average each ASHA in Bolangir and Sundergarh districts have accompanied 1-2 pregnant mothers to hospitals/health centres for delivery in the month of August, 2007.
- The team observed that ASHA scheme is largely incentive driven and whatever progress in the service delivery has happened is because of the financial incentives given to the ASHAs and the pregnant mothers. Sustainability mechanism of the scheme in the long run is to be seriously thought of and should be built in to the scheme.
- The ASHAs immediately after induction training have started earning for themselves. One of the ASHA of the 1st phase even has received Rs, 25,000 during a period of about 1½ years mostly from the JSY and some amount from Immunization, FP (Sterilization) and as a DOTS provider. She was covering larger area initially. But of late her earning has come down because more ASHAs have been inducted in to the area. The team had also come across ASHAs earning Rs.10, 000 and above in a year. Almost every ASHA after induction has earned at least Rs.600/-. The team also came across disputes between ASHAs on geographical coverage, one case of caste barrier and non-acceptance by a section of the community (Only one case). There have been complaints about delayed payment both to the pregnant mothers and the ASHAs. There is a need for financial monitoring and grievance redressal mechanism.
- In all the centres, the AWWs and ANMs have expressed that induction of ASHA has been very helpful. Contacting, motivating and bringing the mothers and children to antenatal, immunization clinics and to the village health day have been very productive and useful. In fact, they have found a good assistant in every village to contact the beneficiaries and bringing them to the clinics, the job they used to do earlier with difficulty. There is lack of clarity on the role of ASHA vis-à-vis AWWs.

ANMs

- The performance of ANMs in the field is far from being satisfactory. Many ANMs are not staying in peripheral remote institutions and are traveling to these centers on working days. This has compromised their availability and reduced their contact and rapport with the community.
- Most ANMs complained about their salary being released after a delay of 6-8 months. This appeared to be statewide phenomena. This may be partly responsible for lack of motivation and drive.
- Some of ANMs had no updated /knowledgeable about common health practices and may require capacity building.
- Healthy work dynamics has developed between ANMs and ASHAs as ASHAs have assumed a subordinate role and giving a helping hand to ANMs.

Paramedical Staff

- There is shortage of trained paramedical staff in the state. State has already initiated measures to improve their availability in future.
- RNTCP and Malaria lab technicians do other laboratory work only in those centers where MO I/Cs assume role of a leader and motivator. Their integration with general health staff is still low.
- Only basic investigations are available in most institutions and strengthening and improvement of laboratory services will necessitate capacity building and multiskilling of paramedical personnel.

Doctors

- The performance of doctors at PHCs and CHCs is far from satisfactory. Most PHCs/CHCs are running at sub optimal capacity and MOs have not been able to generate confidence of the community in the system.
- At the level of sub divisional hospital and district hospital the doctors seem to be overburdened compromising quality of service delivery.
- Many MOs were having other interests that had a bearing on their ability to give their optimum potential to the community.

3.15 System of disease surveillance and reporting:

A state surveillance committee has been set up under the Chairmanship of Principal Secretary Health to oversee all the surveillance activities in the state. State surveillance officer, State epidemiologist, and surveillance medical officer are in place. There are 3 data entry officers, one administrative assistant and one helper in position at state level.

At the district level though there are designated officers and assistance is available from NRHM cell, the system is still not functioning efficiently. Laboratories are still to be upgraded and computerization is yet to be initiated at sub-district level. Training

of district and state surveillance team members has been completed. However other category of staff is still to be trained (MOs, Health workers, Supervisors, DEOs).

Data collection and maintenance of records at field level was not satisfactory. In many of the sub-centres reviewed by the team the records were not up-to-date. In the absence credible system of data capture, surveillance and reporting system may not yield intended results. Bolangir districts did not have formats for reporting surveillance activities; hence no reports were being prepared. In the absence of quality data capture at field level, no credible management information system can be built.

4. 16 The preventive and public health measures for vector control and efforts at inter-sectoral convergence:

Malaria continues to be a major vector borne disease in Orrisa state. Chikungunya also reported in the year 2006. The state initiated several new measures for vector control such as:

- Involvement of NGOs in indoor residual spray.
- Proposed epidemic response team in each district.
- Sensitization of PRI members.
- Sensitization of traditional healers and their involvement in the programme.
- Message transmission through school students and SHGs.
- ASHAs trained on a pilot basis in 50 blocks in 21 districts.
- Training of more than 4000 ASHAs in process.
- Tribal districts of Mayurbhanja and Sundargarh selected as model districts.
- GIS mapping with village wise epi-data is being prepared for microplan.
- Regarding distribution of impregnated bednets to BPL families the review mission members noted discrepancy in classification of BPL families and in the distribution of bed nets. The impact of the measures could not be assessed. However, epidemiologically, it requires that all irrespective of the socio-economic status need to be protected with insecticide treated bed nets otherwise it wont have any effect in blocking the transmission of Malaria. NVBDCP need to look in to the ways and means to ensure that all are protected against Malaria and take appropriate policy and strategic decisions for this purpose.

3.17 Effectiveness of the disease control programmes:

National Vector Borne Disease Control Programme(NVBDCP):

- Malaria and Filariasis are the two main diseases that are very much of concern to Orissa State.
- In both the districts, the percentage of falciparum malaria cases is as high as 85%.

- Sectoral Microscopy centre is not working in many places due to shortage of Lab. Technicians. Blood slide examination is taking 10 – 15 days creating hurdle in ensuring timely complete and effective treatment.
- ASHAs may be trained as FTDs and also in the use of Rapid Diagnostic Tests in Malaria so that treatment is given immediately for Pf cases.
- RDT is available in plenty in the district and has been supplied to the Sub-centres.

National Leprosy Eradication Programme:

- The prevalence rate of leprosy has come down to 0.91 per 10,000 populations at state level.
- 21 districts and 227 blocks have achieved the goal of leprosy elimination.
- About 2728 persons are waiting for re-constructive surgery (RCS). 235 cases have already undergone RCS till date. 235 cases have already undergone RCS in 2006 and 209 cases have undergone such surgery till October, 2007. It is a big challenge to complete number of RCS with huge backlog of such patients.
- Bolangir district has PR 0.98 and Sundergarh district has 0.96.
- There has been an overall increase in prevalence rate in the compared to lowest level of 0.65 recorded in the month of March 2007.
- At present there is complacency at every level.
- There is lack of leadership and monitoring at district level.

National Programme for Control of Blindness:

- The state achieved a cataract surgery rate of 286 per 100,000 populations in 2006-07. But this has been mostly contributed by NGOs. The capacity of Public Health Centres remains sub-optimally utilized due to non-availability of experts.
- The programme unit has not submitted audited accounts to center for the previous year resulting non release of funds this year. This is affecting programme performance.

Revised National Tuberculosis Control Programme:

- The overall performance of programme in 3rd quarter 2007 in state shows a case detection rate still below target level of 70%.
- In Bolangir district both new sputum positive case detection rate and treatment success rate are below target levels.
- The review team observed several deficiencies in record keeping. Treatment cards were not updated in many institutions. In Bolangir district poor supervision was noted as many patients were initiated on treatment without proper verification of address of patient and contact person details.

3.18 Performance of Maternal Health, Child Health and Family Planning Activities seen in terms of availability of quality services at various levels:

Maternal Health

- Maternal mortality ratio as per SRS-2003 in the state is 358/100,000
- To achieve a target MMR of 100/100,000 by the year 2015 state has planned several activities such as:
    - State specific implementation guidelines developed for JSY in English and Oriya.
    - Accreditation of 18 private institutions completed.
    - Training of district nodal officers on JSY undertaken.
    - Collection of disagregated data on JSY performance started.
    - Institutional deliveries in the state increased by 33% over previous year figures.
    - Multiskilling of MBBS doctors in Obstetrics and Gynecology and Anesthesia is in progress.
    - Skilled birth attendance training has commenced.
- However there are still numerous areas of concern such as:
    - Referral transport for pregnant mothers especially in remote areas still not available. No transport is provided to serious patients when transported to higher level referral units. RKS, fund is not utilized for this purpose.
    - Only marginal increase in overall antenatal registration and tetanus toxoid immunization. Antenatal care is incomplete in the absence of required investigations. Little is done on postnatal care.
    - Most FRUs still to be operationalized.

Child Health

- In Orrisa state more than 22% children are low birth weight and 54% of children below 3 years of age suffer from moderate to severe malnutrition.
- Immunization coverage in the state is very low (52% complete immunization).
- Even rates of breast-feeding are very low. (Only 37% of mothers practice exclusive breast-feeding for first 6 months).

Family Planning

- Trends in use of contraceptive over years have shown a steady increase but even the current use of contraceptive by any method in the state is 50.7%
- Hardly any health worker in the field had been given contraception devices to eligible couples as a priority area.
- Male sterilization rates are very low and it may not be feasible for ASHAs and AWWs to mobilize men to adopt family planning methods. In most sub-centres Male Health Worker is not available. Available vacancies are not being filled.

3.19 Performance of Mobile Medical Units/ systems of ambulances:

One mobile medical unit (MMU) for each district as envisaged Under NRHM is not in place so far. Design and procurement process is being finalized. However, there are 15 Mobile Health Units have been working in Bolangir District and in other KBK

districts prior to NRHM. The potential of these mobile units even in KBK districts is not fully exploited. Many villagers interviewed by the review team did not know the advance programme and timing of these MMUs. In CHC Saintala where one MMU was available, one AYUSH doctor was posted at MMU but he was not provided with either a stethoscope or a BP instrument. He did not even carry AYUSH drugs with him as the state has not made them available as yet, nor he had received orientation training for common disease control programmes. In PHC Khaprakhol, one AYUSH doctor was hardly seeing 2-3 patients per day but her services were not being utilized in MMU attached to PHC.

3.20 Progress of infrastructure development and systems for improvement of civil works:

There are 5927 sub-centres in the state out of which 2539 sub-centres have their own buildings and the rest have either no residential facility or are managed from rented buildings. Out of buildings available, around 1500 sub-centre buildings need repair. Out of 1166 single doctor PHCs in the state, hardly 100 of them are functioning in government buildings. Most of the block PHCs/CHCs/PHC (N) are in a dilapidated condition. There does not appear to be any prioritization on improving infrastructure in difficult areas. In Bolangir district, in many places residential quarters for MOs did not have regular electricity and water supply and they have to depend upon nearby hand pump for water and use candles in the evening/night for light.

138 CHC, Block level PHCs and 32 District and Sub-district hospitals have been identified by the State for their up gradation to IPHS but till date only 3 CHC have achieved IPHS standards. Six public sector and government agencies have been entrusted the civil construction work. Considering the present status of these institutions, it would take a long time to bring them up to IPHS.

3.21 Systems of procurement and logistics for equipment and drugs and its effectiveness:

There is a State level procurement system and drugs are procured at the State level. The State is planning to strengthen the State Drug Management Unit (SDMU) for more efficient procurement and online monitoring of inventory in the field. Though the state claims that there are no shortages of drugs and other essential consumables, the following observations at field level reveals the deficiencies in the present system.

- Key drugs (Paracetamol, ORS, Chloroquine, Oxytocin etc.) were in short supply or there were frequent stock outs at all levels.
- CHC, Saintala in district Bolangir did not have sutures, gloves, stitching needle, Inj Oxytocin, Inj Methargin, I/V fluids and yet they claimed to be conducting 2-3 deliveries per day.

- In one of the PHC where Tab Paracetamol was out of stock for more than three months, MO I/C apprised the team that one government order restricts the maximum budget on drugs for one PHC at Rs. 16,000/- per month.
- In district Sundergarh where a pilot was being done for Hepatitis B Vaccine, the vaccine was out of stock at least 4 times in last six months. (How does one completes the course of vaccination??).
- There did not appear to be a scientific system of inventory management in place in both the districts and the MO I/Cs were not trained in good store management practices.

3.22 Assessment of non-governmental partnership for public health goals:

The state has made some progress in this regard. An NGO/PP cell has been established with a full time NGO coordinator in place. The state has decided to hand over management of public health institutions in blocks and sub-blocks to NGOs in identified unserved/ underserved areas. The review mission members visited one such facility (Urban Slum Health Centre – Tillea Nagar, Rourkela). There was heavy load of patients in this center. However at present this center is only offering curative services and package of preventive and promotive measures for health is yet to be introduced. District Sundergarh has further plan to handover 4 PHCs to NGOs. In Bolangir district, one private and one defense hospital has been accredited to provide services under JSY.

State has involved 21 Mother NGOs (MNGOs) and 119 Field NGOs (FNGOs) under RCH scheme. The performance of these NGOs is being evaluated on a continuous basis and state has recommended to stop funding of 1 MNGOs based on these reviews. There are only 2 Service NGOs (SNGOs) funded by the state, which could actually provide service in hard to reach and inaccessible areas. MNGOs and SNGOs are active in both the districts. NGOs are involved in indoor residual Spray and distribution of insecticide treated mosquito nets.

NGO (MY – HEART), a MNGO under RCH-II programme has developed an educational booklet on “Reproduction Process” to be used as a resource material by Trainers, Educators, Counselors and Health Workers.

3.23 Preparation for meeting manpower needs specially with regard to nursing and Para-medical staff:

The state is conscious of the fact that there is shortage of qualified Nursing and Para-Medical staff in the state and certain long-range measures need to taken at this stage to increase availability of these staff in Orrisa state particularly in rural and tribal areas. While long-term plans are yet to be formalized, the state has already initiated certain measures to increase the availability of these technical personnel’s. Some of measures already initiated at state level are:

- Doubling of seats in lab. Technicians and X-ray technicians courses in 3 medical colleges.
- 33% increase in seats in all the 16 ANM training centers.
- M.Sc. Nursing course in Nursing College, Berahmpur.
- B.Sc. Nursing course in SCB medical college from 208-09 is under active consideration.
- State is examining the possibility of starting a Nurse Practitioner and mid-wifery course from 2008-09 to meet the shortfall of Gynecologists in PHC/CHC.
- Skilled birth attendant (SBA) training to handle complicated obstetric cases started.

Despite above measures the state has still not drawn plans to deal with problem of retention of Nursing and Paramedical staff to work in backward, rural, tribal and hard to access areas or ensuring that suitable candidates from these areas are sponsored for training and thereafter recruited.

3.24 Functioning of ANM Training Schools and other Nursing Institutions:

Bolangir and Sundergarh districts have one ANM tainting school each. But the admission is open for all the districts. As a result, there are more admissions from coastal and other districts resulting non-availability of ANMs passing out from these training school to them. This is a problem in respect of all level of health providers.

Sundergarh district administration is planning to open one more ANM training school exclusively for locals, which would encourage and support local girls to take up nursing as a career option. District administration is also exploring possibility of giving suitable and deserving ASHA and AWW an opportunity to enroll in the proposed Nursing Training School to improve career prospects.

3.25 Assessment of programme management structure at district and state level:

Orrisa State Health Mission has a Mission Steering Group and an Empowered Committee. The Mission Steering Group is chaired by Chief Minister and has Principal Secretary to health and Family Welfare Department as Member Convener. The Empowered Committee is chaired by Principal Secretary to health and Family Welfare Department and includes Government Officials of Health and Family Welfare Department. An IAS Officer has been posted as a Mission Director. A separate Mission Directorate has been constituted and the State Programme Management Unit provides technical support to State Health Mission.

All the districts have also set up the DPMU with the district programme manager, district accounts manager, district health information officer and computer assistant in position but not all blocks have a Block Programme Management Unit (PMU) in place. Sundergarh district has only 2 out of 17 Block Programme Organizers (BPO)

and 8 block Accountants cum data Assistants. In Bolangir district, 7 out of 14 BPO are in position, but not a single block accountant cum data assistant has been recruited so far.

The state PMU has developed timeline for various NRHM activities and also developed performance indicators. In both the districts reviewed, the District Progamme Managers were active. Some tension between the PMU officials and the line programme Officer was observed in Sundergarh district. Sundergarh district administration appeared to be more involved in NRHM than the CDMO and other line Programme officers where as the situation is reverse in Bolangir district. (In Bolangir district despite best efforts the First Common Review Mission members could not seek an appointment with the District Collector).

4. Recommendations:

1. National Rural Health Mission is conceived as a major initiative to improve the primary health care system in rural areas in terms of availability of facilities, access to people, quality of services, efficient management and accountability of the community so as to enhance its utilization from its current low levels. In the perception of the Mission team, there is no visible trend that a decisive beginning has been made in this direction. It is therefore necessary to strengthen effort in all areas of the public health care system to generate confidence in people towards its optimum use. This would require a range of interventions some of which have been briefly indicated in this note.
2. There are gaps in physical infrastructure vis-à-vis the normative requirements per unit of population. The existing infrastructure of primary health care is deficient in all respects – availability of health personnel, drugs, functioning equipments, resources, accountability of providers- internal and external, linkage with and involvement of the user community. Priority should be given to make existing health care units fully functional by measures sharply focused to meet the deficiencies and bring them to the level of IPH Standards before expanding the available physical infrastructure to meet GOI norms.
3. The nomenclatures of CHCs and PHCs and their bed strengths do not follow GOI guidelines and the national pattern. The rationale for variance is not clear. It confuses people regarding the level of expectations from a given centre besides creating difficulties in monitoring/ comparative performance. The State Government should seriously consider reorganizing health centres so as to bring them at par with GoI guidelines.
4. The increase in institutional deliveries despite a low OP case load at various primary care levels has produced distortions which militate against equitable utilization of institutions and provision of quality of services. 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. A time bound programme should be chalked out to ensure that PHCs handle simple deliveries by ensuring 24X7 presence of requisite health personnel, supportive facilities, improving sanitary conditions in labour

rooms, provision of proper toilets, and mobilizing ANMs and ASHAs to approach the nearest facility.

5. District and Sub-district level health facilities need strengthening of human resource capacity and motivation of existing personnel at all levels to handle additional responsibility, substantial improvement in sanitation, upkeep of hospital premises, lighting, cleanliness, bed linen/mattresses, shelter for attendants, segregation of female wards, streamlining of equipment maintenance system and timely replenishment of drugs and consumables.
6. Sub-centres are the weakest link in the chain of primary health care system. The following aspects need immediate attention:
    - Where a Sub-centre building exists, the sanctity of official premises must be maintained and should not function both as a house and a health centre. The part of the building used as centre should be strictly separated and should not be combined as a living room or used to dump personal belongings.
    - ANMs need training in house keeping for maintaining cleanliness, removing waste and junk, properly stacking registers and necessary papers and keeping equipments in working condition.
    - They also need training in use of equipments and motivated to use them.
    - They also need "Hands on Training" for conducting deliveries, ante-natal care, record keeping, interpretation of information collected, follow up action required, material planning for timely replenishment of drugs and vaccines.
    - Sub-centres should display the list of services and drugs /vaccination facilities available and convenient timings when ANM is available and when she is out on field visit or to attend official meetings.
    - It should be ensured that ANM is available at the centre and, where accommodation is available, lives there rather than commuting daily to place of work from the residence.
    - Sub-centre buildings, where damaged, need to be urgently repaired and made fit to conduct deliveries. Difficult and hard to access areas should be prioritized for renovation, repair and reconstruction.
    - Referral transport arrangements should be firmed up and alternatives worked out, where regular public transport is not available. Panchayat president should be mobilized to sort out this problem.
    - Streamlining of tours and official meetings of ANMs to ensure that ANM is able to stay at the centre on specific days atleast.
    - Timely release of salaries by the state government by streamlining financial procedures.
    - Prioritization of construction of Sub-centres in deficient areas where even a proper building is not available.
    - District Collector should liaise with the Works Departments to ensure that completed sub-centres are handed over for use by time bound provision of electricity, water connection etc. Where state level coordination required to effect it, this should be undertaken without delay.

- State heath secretary should look in to the wide gap between reported and evaluated coverage of immunization and issue necessary directions for verification followed by necessary interventions.
- Younger ANMs should be posted at the Sub-centres to ensure requisite mobility
- Human Resource Management requires following interventions
    i. Recruitment
        a. ANMs
            i. 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. 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/ AWW could also be sponsored for this training.
            ii. The cadre management of ANMs has already been decentralized by transferring the responsibility of recruitment, deployment etc. at the district level. Appointment letter should specifically carry the condition that the appointee shall have to work in a defined area.
            iii. Appropriate non-monetary incentives, selective promotions for good workers, favorable postings after a stint of ten or fifteen years etc. should be provided to retain them posted in the area posted.
            iv. 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.
            v. For both paramedics and doctors, the state department of health and family welfare should make use of existing government schemes (particularly for SC/ST/ OBC/minorities) to select and groom bright students with scholarships, bridge courses, teaching aids etc. to enable them to fulfill the eligibility qualifications for entry into that these courses. The provision of this assistance should carry the condition that they would have to work in a defined area for a specified period.
            vi. If Government of India's attempt to enforce compulsory deployment for a year in public rural health care facilities before getting a graduate degree does not succeed, they should progressively increase

the level of re-training of Ayush doctors to fill in these positions.

ii.Deployment

i. The mismatch in postings of medical professionals particularly specialists should be corrected to optimally utilize the existing talent. Necessary changes in cadre management should be made for this purpose.
ii. Short term courses for GDMOs to perform the role of specialist should be pursued vigorously.
iii. The incentive of sponsoring graduates for PG courses in requisite specialties should be considered if the concerned officers give an undertaking to work in a specified areas for a specified period of time.
iv. Specialists who choose to function as GDMOs for pursuing their "other" interests should be severely discouraged by compulsorily notifying them as specialists against the vacancy in the facility where they are posted.
v. Promotion policy should be suitably altered to facilitate postings of specialists in positions of their specialty in deficient areas.
vi. Available specialists should be optimally utilized by making available necessary supportive facilities where lacking.

iii. Logistics

i. Procurement and distribution system of drugs needs serious overhauling to remove serious bottlenecks in supply chain and to ensure timely availability of drugs in health facilities at all levels. Placing of timely requisition and monitoring system for this purpose at all levels should be streamlined through training in store management and system reform.
ii. There is a need to have annual maintenance rate contract for upkeep and repair of equipments with concerned suppliers and devise arrangements which facilitates speedy placements of complaints by field officials and corrective action by suppliers.
iii. The existing system of identifying non-functional and irreparable equipments and their timely replacement needs urgent review. The system of disposal of condemned equipments and vehicles needs to be decentralized to remove the junk clogging health facilities.
iv. Where trained paramedics are not available to operate equipments, existing staff should be trained to operate and use them.

v. Priority needs to be given to address other problems responsible for non-utilization of available equipments such as non-availability of suitable building, electricity connection etc.

vi. The state drug management unit requires revamping for efficient procurement distribution and on-line monitoring of inventory to remove large gaps in availability of essential drugs.

vii. The budget allocation for drugs needs to be considerably increased to meet the demand which is bound to increase as a result of activities under NRHM.

viii. MO in-charge needs to be trained in good store management practices at all levels.

iv. Training

i. 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 comprehensive interventions. This effort should encompass identification of diversity of trainees (official/ non-officials) to be trained, training needs, strategy and methodology of training, selection of institutions and devising non- institutional arrangements for catering to the huge load of nonofficial stakeholders, content of training, duration of trainings/ re-training, proper mix of theoretical training with hands on skill development, identification of trainers, levels at which particular categories of trainees would be trained, evaluation of training imparted etc. Government of India could help in selecting an expert to assist the state government in this mammoth task. The expert would also assess the quality of existing training and its suitability to the tasks in hand.

7.Supervision

State should issue detailed guidelines to strengthen and improve them, if already existing, to fix responsibility of carrying out supervision at various levels, devise formats specifying content of work to be supervised, action taken and interventions recommended at different levels.

8.Manpower assessment

The existing arrangements needs to be reviewed to ensure that appropriate action is taken timely for initiating recruitment/ promotion process, training and skilling programmes, rationalization of deployment

etc'. the action initiated needs to be periodically monitored.

9.Financial management

Timely submission of SOE and allocation and release of funds and identification of bottlenecks in utilization needs to be vigorously pursued. The monitoring system devised for this purpose should identify defaulting institutions, reasons thereof followed by immediate corrective measures at appropriate levels.

10. Infrastructure development

i. Top priority should be given to sort out bottlenecks responsible for delays in handing over completed buildings through requisite itersectoral coordination and vigorous monitoring.
ii. Norms and guidelines should be issued by the state government regarding prioritization of new construction / repair and maintenance of damaged buildings in a manner that liberates this process from political pressures and lobbying by powerful sections of society.
iii. Immediate action should be taken to provide electricity and water connections to staff quarters where health providers have already shifted to motivate them for better performance. Guidelines may also be issued on how they can access these facilities pending provisions of these connections to keep them free from the nagging problems.
iv. Provision of toilet facilities, renovation of existing facilities where urgently required in various health institutions should be prioritized within the existing allocation of funds.
v. State government needs to augment allocation for infrastructure development to make all the existing facilities functional. Difficult areas may be identified for prioritisation.

11. ASHAs

i. ASHA is conceived as a community health volunteer. But the process of selection of ASHA adopted by the state Government does not bring 'community' into the picture. The selection of ASHA should emerge from the gram sabha of the village and have its endorsement. She would have to be accountable to the community. This is important also because in a few places selection through the existing process is being contested.

ii. The few ASHAs we came across during our visit are too young to be confident and effective in dealing with more grown up and mature women. It would be desirable to select ASHAs who are middle aged. In some places Angawnwadi workers on account of her age and experience seemed better suited for this role.

iii. There is a need for role clarity between ASHAs and AWWs and division of labour between ASHA and ANMs. Availability of ASHA in the village has further reduced the mobility of ANM and her contact with the people of her area. This is not desirable. ASHA should not substitute for ANM.

iv. It would be necessary to enhance the present level of knowledge on MCP imparted to ASHAs. They certainly need training on disease control programmes. Exposure should be provided not merely about the reproductive side of women's health but also other health problems which women suffer from. Preventive and public health measures, first aid are other areas of knowledge which need to be imparted.

v. ASHAs who have started functioning immediately after their first phase of training should be provided with requisite bags and drugs.

vi. Caste barriers still operate. State Government has to devise appropriate measures to ensure that ASHAs service all sections of the society without any discrimination and bias. Systems have should be put in place to evaluate the impact of these measures

vii. TBAs should not be abandoned and should be taken in the fold of NRHM and given some role. In difficult areas with transport difficulties, TBAs are the only resource available for conducting deliveries. They are also more patient friendly.

viii. Incentive driven arrangement for ASHA needs to be reviewed because of its unsustainability and distortions it produces in utilization of services.

12. Communitization

i. Community involvement has not even begun. There is no comprehensive thinking at the State level on how to go about it. It is being conceived in terms of a training programme for PRI members. A great deal of clarity is required on what it would involve, how to go about it and who could be most suitable to execute this task. It may perhaps help if consultation at the national level with those who have been mobilizing the communities

for various programmes is organized to achieve this clarity. Thereafter, states could be advised on the steps to be taken.

ii. Meanwhile, to start with ASHAs, ANMs, AWWs should be directed to attend the meetings of the gram-sabhas. Efforts should be made to discuss health issues in all such meetings. This would increase awareness in the user community and make the functionaries more accountable.

iii. In place of existing orientation training for PRIs alone, joint sessions with the participation of PRI members, ANMs, ASHAs, AWWs may be organized at the level of village panchayat where necessary knowledge may be provided about health programes, services available and where they should go and get them in addition, the assessment of health needs, preparation of a village health plan, mobilization of resources for its implementation, observation of village health day, coordination with related non-health sector, monitoring activities, social audit of programmes etc.

13. RKS

i. Training of RKS members need to be taken up on a priority basis to make them aware of their powers and responsibity and the dimensions of accountability in this regard. It should build capacity for fund management, resource mobilization, monitoring skills, and ensuring bio-medical waste management and involvement of the community. The training of trainers initiated by the state government for this purpose needs to be reviewed both with regard to its contents and methodology. Hierarchical mode of training should be replaced by an interactive and participatory mode. Government of India may suitably assist the state Government in this matter.

ii. Considering the difficulties experienced by RKS at various levels in exercising their responsibility, reluctance to take financial decisions, the state Government may provide necessary clarity and undertake requisite capacity building of RKS members.

iii. Central government may consider placing some un-tied fund with the district collector for initiating interventions at the district level which do not come within the purview of concerned RKS.

14. HMIS

i. Training needs to be imparted at all levels to remove the discrepancies in the existing system and make it an

effective instrument for necessary intervention, this should cover staff engaged in collection, interpretation and use of data base pertaining to various programme indicators and record keeping.

ii. The post of accountants cum data managers at block level should be filled expeditiously.

iii. Reporting formats should be replenished to the PHCs and CHCs. CDMOs could be authorized to get them locally printed where necessary.

iv. A state level team should be constituted to do quality check on the data captured.

v. Supervisory officers at the district level should during their visits to sub-centres, PHCs, CHCs look into records and give necessary directions where deficiencies are noticed.

15. Mobile units

i. Arrangement should be made to display in bold letters days, time, and venue of the visit of the mobile unit. The programme scheduled should be adhered to so as not to disappoint people who have collected for consultation. The information should also be conveyed to ASHA and village panchayat so that people adequately utilize this facility.

ii. The doctor accompanying mobile unit should be supplied with diagnostic aids such as BP instruments, stethoscope etc and drugs. Arrangement for blood sample collection should also be undertaken in these visits.

iii. AYUSH doctor who are usually deployed on this duty should be provided with AYUSH drugs beside those of allopathy.

iv. They should be given periodical additional training to handle variety of cases reported during these visits.

16. Disease surveillance

i. The up-gradation of laboratories and computer hard-ware at the sub-district / block level should be expedited. State level team should look into reasons of low-efficiency/ non-functionality of disease surveillance system.

ii. Despite officers having been designated and training completed at the district level, there is no progress in analysis of information and its utilization. State level monitoring should identify reasons for taking corrective steps to make system functional

iii. Training of MOs, health workers, supervisors, should be initiated in data collection and maintenance of records, analysis of information and its utilisaion.

17. Disease control programmes

i. Merger of societies

a. Despite separate structures having been merged into a single society, the programme implementation is still segmented on account of separate allocations and fund flow. The laboratories attached to programme at the field level are also investigating programme specific samples only. These deficiencies need to be corrected at the central level first before the culture percolates to the state and districts. Meanwhile, state Governments should issue necessary directions to ensure that laboratories handle the entire range of samples. Where necessary, the lab-technicians should be provided additional skills/ training for this purpose.

b. The complacency regarding leprosy elimination needs to be dispelled through continued vigorous monitoring at the district level. Orientation training of health workers on seeking community involvement in reporting fresh cases, if any and those of incomplete treatment. The periodical publicity y ASHA in gram sabha should also help in this direction.

c. The capacity within the public health systems for cataract cases remains sub-optimally utilized due to the non-availibity of eye specialists at designated facilities. The postings of such specialists need to be prioritized.

d. RNTCP needs greater attention at the state level to improve detection rate and success rate, follow-up, record keeping and quality supervision by filed officers.

e. MCH

i. The non-availability of referral transport for pregnant mothers needs to be sorted out by making appropriate arrangements in consultation with local sarpanch.

ii. Areas of weak referral transport needs to be identified for prioritizing institutional arrangements to handle cases in the village itself instead of risking delivery in transit.

iii. Serious cases coming to FRUs and referred to superior facilities are not provided with

transport. This has serious implications for poorer patients who do not have resources to hire a vehicle. RKS should meet this expenditure which it doesn't do at present.

iv. ASHA and ANM have to be adequately oriented to ensure that the ante-natal registration, investigation and care to remove the mismatch with the increasing numbers of institutional deliveries.

18. child health

i. Child health other than immunization services are not attended by ASHAs who are entirely focused on institutional deliveries. This distortion needs to be corrected.

ii. Reasons for low breast feeding, and incomplete immunization coverage needs to be investigated for initiating corrective interventions.

iii. Reasons for ICDS not making a dent on malnutrition of children need to be identified. States need to take up measures for strengthening of nutritional services in areas of severe deficiency. People migrating for work outside the district and the state are one such group which needs attention in this regard.

19. Family planning

i. Male health workers are necessary for mobilization of men to adopt FP methods. State is not filling these vacancies. Central government may take up the matter with the state government.

20. NGOs

i. Huge NGO involvement would be required to assist the state government in pogrammes of communitization and training of PRIs and RKS members. This aspect of NRHM is better handled by experienced NGOs rather than government officials. The state has therefore to move beyond the current paradigm of NGO involvement to make a dent on this aspect of the programme.

ii. Link between ASHAs and SNGOs, should be established for better performance and orientation.

21. Programme management structure

i. The under current of tensions both at the district and state levels between PMU officials and line programme

officers need to appropriately neutralized to get requisite corporation from concerned health officials.

ii. Block level programme management is weak at present both in terms of manpower resources and management capabilities. This needs to be strengthened.

iii. Block health managers need to be trained in public health management.

iv. Block level accountants should be expeditiously positioned for the submission of SOEs / reports timely.

22. FRUs

i. The FRUs receiving additional load on account of increase in institutional deliveries need be to strengthened so as to maintain quality of services rendered.

ii. PHCs/ CHCs should be made functional to reduce the load on sub-divisional and district hospitals.

iii. Secondary care units should attend to the maintenance and timely repair of equipments and ensure that available equipments are used. Sanitation and hygiene in premises and waste disposal need priority attention to improve the quality of services.

23. District level health plan

i. Institutional mechanism should be put in place expeditiously about decentralized health planning for placing proper focus on area specific, group specific health needs. District health plan would become a meaningful document only when it emerges from the field level plans (e.g. Village health plan, block health plan)

ii. District health plan, which is in the process of preparation, should be discussed at the block level with PRI representative and community organizations before it is submitted so as to have some non- official input and the input from difficult areas until such time the block level/village level health plans are prepared.

24. Thrust on difficult areas

i. The difficulties are experienced by people from areas which are physically cut off due to floods, and non availability of boats to cross the river. District officials should make provision for a boat. Where the boat can not be plied due to strong current, health personnel, drugs and make shift arrangements for conducting delivery should be positioned to prevent avoidable mortality. The cooperation of the concerned panchayat should b enlisted in positioning this arrangement.

25. Preventive and public health measures

1. Joint sessions of ASHAs, AWWs and ANMs and panchayat members should be regularly held to spread awareness about preventive and public health measures and for assigning responsibility of each stakeholder in this regard.

2. Inequitable distribution of impregnated bed-nets has been observed despite the association of local panchayat officials/Village Health and Sanitation Committee where constituted. This needs to be prevented by appropriate official checks and verification and requisite awareness generation about the norms in the gram sabha.

3. The discrepancy in BPL leading to omission of genuine poor and wrong inclusion of better off need to be addressed by a policy decision at the State level in a manner that ensures that health benefits are made available to the deserving irrespective of whether the list is revised or not.

4 Unqualified private practitioners continue to operate and are accessed by villagers due to the non-functional nature of sub-centers. This is happening even in villages which are very close to sub-centres/ PHCs. This would be reduced if the sub – centers and PHCs are made fully functional.

5. Conclusion:

The observations made by the Mission Members are based on their short visit to the two districts which may not represent the reality in respect of the entire State. The observations cited in the report may be already engaging the attention of the State authorities who may be taking steps as suggested. The initiatives worthy of appreciation taken by the State Government include increasing institutional deliveries, addressing manpower shortage, training of officials and non-officials, public-private partnership in the delivery of services, near complete positioning of ASHAs, initiation of posting and short training of AYUSH Doctors, positioning of personnel in SPMU and DPMU. More important is that there is a strong commitment at the top decision making level to improve things.The Mission Members are quite hopeful that substantial improvement will take place by the time the next NRHM Review Mission visit takes place.

6. Acknowledgements:

The Mission Members acknowledge with appreciation the courtesy, hospitality and cooperation extended by the officials of the State of Orissa at all levels during this visit. We also appreciate with thanks the officials of the NRHM at National level for providing the opportunity of visiting Orissa State and getting exposure to the programme with a detailed pre-visit brief. The Mission Members deeply regret the delay in submission of the report due to unavoidable reasons.