NRHM Common Review Mission: Uttar Pradesh, November 2007

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Team Members:

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Program Schedule: Annexure 1

Key Findings at the District Level

The over all impressions from both districts is of a functional public health system which is delivering a considerable quality and quantity of services despite considerable constraints by which it is shackled. It is also – if we may be permitted to say so – a 'surprisingly' clean and well maintained infrastructure even where the patient load was high, an impression that flies in the face of the usual impression about public health facilities in the north Indian context. The team finds most individual staff members that were interacted with as responsive and as having considerable potential to do much more, given a more enabling environment and better support systems.

There are however issues of systems design and systems functioning that constrain the performance and this report tends to examine and highlight these, even as it acknowledges and appreciates the tremendous work being done by so many health functionaries under difficult circumstances.

We note that the NRHM has awakened a live debate at every level about the potentials and the constraints of the system- and very often the response was even of detractors – that 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 harbringers and potential triggers of change. However the challenges are formidable and though many of them are easy to resolve there is much skepticism about whether there would be enough seriousness amongst decision makers to overcoming these bottlenecks. 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.

The District Planning Process and Integration:

In Jhansi and in Jhalon, the district team is aware that the district planning effort had been undertaken and that there is a document available but not of the details as such. In Rae Bareilli the district plan has not been shared at any level- even the CMO. However they

had attended one planning workshop which was an early and interim stage of the process. In all the districts the district plan does not serve as the reference document in use for planning or implementation. JSY is the major component of NRHM and is seen as synonymous with it. Laboratory technicians at the CHC level handle all two programme functions – TB and malaria and are seen as doing RCH work also -but are not called on much for routine CHC work or even RCH work.
Integration of vertical programmes has begun but still remains a challenge. In disease control programs it is happening mainly in terms of sub accounts for each program under one Common Account. In other words there are now as many sub-accounts as there are programs but not necessarily financial integration and integration in terms of activities. Laboratories and lab technicians for TB and Malaria continue to be separate at all levels in Rae Bareilli though in Jhansi they see both programmes.

Human Resources

The numeric adequacy of Staffing and the skill mix:
Medical officers and specialists:
The availability of specialists is better at the district level though even here there are critical gaps. In Urai the gaps may be there in terms of specialists by qualification but the medical officers have the necessary specialist skills and the gaps in service delivery are therefore less.

Specialists posts are vacant at many facilities in Rae Bareilli, especially posts of Gyn & Obs, Anesthetists, and surgeons are lying vacant. There are only two surgeons posted in the entire district. The available specialists, for example, Gyn & Obs, and Anesthetists, are being shared across facilities. Specialist staffing gaps are being filled in some places by posting couples with needed specilisations at a Centre and by sharing available personnel against a post in demand at more than one Centre. For example, at one CHC a female gynecologist and her pediatrician husband have been posted to fill the gap of a gynecologist. At other facilities a lady doctor serves the need by attending to patients on different days. Similar practice has been put in place for meeting the demand of Anesthetist and surgeon. However, there is little evidence of attempts at developing multiskilled competencies among available staff. In the CHC visited at Jhansi specialists are inadequate though medical officers are adequate.

Some staffing problems in specialists appear to be created due to the promotion and transfer system. In some instances transfers have been done without considering their impact on the facilities and their functioning. In the district hospital, pediatricians have been posted to the female hospital where they are expected to conduct deliveries. In terms of deploying staff, the tendency seems to be to divide the specialists according to sex and assign them posts in the female hospital regardless of their specialization.

There is attention being paid to the staffing with medical officers and recent contractual appointments have been made to close gaps in block PHCs. The approach to have one MOCH and one MOIC is they are called (an ayush medical officer and a modern

medicine medical officer) is a good approach but has not been pursued consistently and indeed may have been stopped now even though it is working.

In block PHCs there are only two medical officers posted – but these could be easily remedied if the decision to upgrade them in staff to an intermediate stage of CHC - with about five medical officers is made. In additional PHCs the decision to upgrade to two medical officers – a MOIC and MOCH needs to be pursued. The MOCH could be placed under the AYUSH department and indeed must be placed under it as a permanent staff. But the current more immediate possibility is of taking the second officer on board under the NRHM contractual appointments.

Nurses: Here the gaps in Jhansi district are massive. No facility has anywhere near the nurses needed and even posts have not been created and indeed the problem of lack of nurses may not have been perceived. In the most frank expression of the problem the outputs of district female hospital is largely constrained due to the lack of nurses. CHCs should have nine nurses and barely have two or three. Block PHCs could have asked for nine nurses and as an intermediate stage could have asked for three nurses or ANMs but in fact they have none or at best one ANM. This constrains both quality and quantity of services provided.

In Rae Bareilli in contrast the gap in human resource is filled to some extent in the nursing cadre mainly through hiring contract staff. However, in many facilities vacancies have been created due to hired staff leaving jobs and difficulties persist in hiring fresh staff due to a reported court stay orders against contract jobs.(we were later informed in the state that this stay order does not apply to nurses and for contractual jobs under NRHM. But this information is not there with the district.

The additional PHCs should have aimed for three nurses and today they have only one ANM or not even that- borrowing from the local sub-center to close the gap. Failure to fill even existing vacancies with contractual staff or use the expanded provisions under the NRHM relates to a restrictive clause in selection rules which specifies that even if a suitably qualified nurse is available, she must have done the science option during her schooling. This is completely arbitrary and with no foundation and moreover would not conform to nursing council guidelines. Quite unnecessarily and artificially a shortage of trained nurses has been created. Opening of more nursing schools in this region is also a major necessity.

ANMs: Small gaps exist about 2 out of 34 subcenters have vacancies. However the bigger issue is that in a place like bundelkhand with its vast expanses and difficulties the second contractual ANM would be very effective. Yet no efforts are visible to move towards this at the district level. The main reason attributed is that trained ANMs are not available . Perhaps. This should be tested after the restrictive clause that disqualifies ANMs with arts stream in high school – or even home science which is the most relevant of the school options – is removed. Also a serious effort to open an ANM school in every district of Bundelkhand is called for. The option of a vocational stream for 10^{th} class local girls which gives them a 12 th class plus ANM certificate is now available and in a place like Banda could be tried along with the Mahila Samakhya or some other suitable agency.

Male workers: There is approximately one male worker per sector(additional PHC area) that is available when what is needed is one per section(sub-center area). This is a large gap and there is no clear strategy in place or even a policy commitment to close this gap. Broadly supervisory staff of the male and female workers – the LHV and the health supervisor are present in adequate numbers.

Technical Support Staff: Pharmacists, Laboratory Technicians and Other technicians: There are a critical number of technical staff available to keep most facilities running. But the numbers are often non adequate(much more so if we refer to IPHS standards) and quality can often be constrained because though the available staff perform multiple functions, they are not trained or even officially acknowledged as being multi tasked. Pharmacists where available in particular are playing multiple roles. In Jhansi there are laboratory technician gaps in some block PHCs but in Rae Barelli there are no gaps. At the additional PHC level the post of the laboratory technician does not appear to be sanctioned nor is there any urgency to skill

Transfers and postings affect cadre at this level also. At one place the X-ray technician has been transferred to a Centre without an X-ray machine thus rendering him without a function at his new workplace while making his previous workplace also non-functional.

Adequacy of Skills:

From Both districts:
The available staff interviewed are competent persons who are trying to deliver services. However none of the new skill based trainings – like SBA training, IMNCI, multi-skilling for specialist skills etc have reached these districts and even on institutional delivery or new born care the skill levels of the nurses and ANMs who are actually conducting them needs considerable strengthening to achieve a quality that would impact on indicators. There could be much progress made in reaching the levels of IPHS specified service provision through closing skill gaps in existing staff. Sector supervisor skills are also in need of upgradation. In this context it is worth noting that all training activity is almost invisible at the district level and only two persons who are not currently involved in service provision reported having received any training. In contrast at the state level a lot of training activity is reported. The problem is the scale of operation and the need to build an over all training strategy where many more regional and district level training institutions are all functional for at least 300 days every year.

Workforce Issues:
From both districts:
The usual problems of transfers and postings are also found here. Promotions have been behind schedule. Nurses and ANMs in particular have no career progression paths.

There is a lot of animated discussion when it comes to the cadre policy for doctors. The state has created four cadres – a specialist cadre and a generalist cadre and within each of these a male cadre and a female cadre and each cadre has four levels based on years of

experience with a time bound promotion. Above this they can rise to be additional directors of each cadre and then directors where the cadres merge. There are seems to be many strengths in this arrangement as it prevents many arbitrary and unfair postings and builds in some space for respecting seniority. However there are many problems that were brought to our attention. One reported problem is that the creation of a female cadre works against women specialists by lumping them together as women and compulsorily therefore posting them in gynecology irrespective of whether they are trained pediatricians or ophthalmologists. It should give them faster avenues of promotion but as all promotions are time bound there is no such advantage either. Another reported problem is that once there in the district hospitals the faculty are all of level 4 and therefore no clear chain of command can be established making administration difficult. Yet another problem reported is that the district hospitals get occupied exclusively by senior persons but there is a heavy case load which needs young enthusiastic surgeons who can do many repeat night duties and operate on heavy schedules. In some specialties there are no level 3 or 4 available but level 1 specialists are denied to district hospitals because they have to be posted at the peripheri first- and when we do that for example with a cardiologist or neurosurgeon we would be squandering valuable skills and de-skilling them. Still looking across states this system still seems to have great merits and one needs to tinker with it to overcome anomalies rather than do away with it all together. The most exciting possibility about this system is that all the generalists could be systematically trained in public health(diploma and masters programmes both distance education and residential courses) and one would have achieved a qualified capable administrative cadre. A problem that has defied solution in most states almost stands solved here. However this review mission makes no recommendations recognizing the complexities of the cadre policy. Its observations are only to guide local reflection on these possibilities.

ASHA

The visit to Rae Bareilli suggests that about 95 percent of the expected ASHA Bahus have been selected and nearly all have received first module training. However, from the account of various PHCs and CHCs only 60 – 70 per cent ASHAs are active with some not even showing up for training. The indication is that some ASHAs are inactive after learning that it is not an employment but is linked to performance.

In Jhansi it was even more difficult to quantify functionality but the impressions were the same as in Rae Bareilli.

Issues with ASHA:

Selection: Selection has been varied. In most cases the health department functionary in consultation with the pradhan has made a considered choice – often allotting the work to some needy woman who could do the task or selecting the most literate woman. In such cases the outcome is good. In many cases it has been made by this same combination with undue considerations including a promise of a regular job and the collection of money against such a promise. Here the outcome is either an ASHA dropout or a poorly functional ASHA or sometimes despite all this a functional ASHA. Unfortunately there has been no understanding of the concept of social or community mobilization or of community processes and even in the better scenarios there has been no such input. We

note that despite this the ASHAs we met were eager and of great potential. The dropouts also are not a problem but an opportunity and the best programmes world wide also go through such a turn over initially. The programme cannot be dismissed therefore even where the selection is poor.

Training: only one round of training of 6 to 7 days have been completed. The training programme has been welcomed. 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.

Support: There are no regular meetings of ASHAs at the local level being organized. There is no programme of on the job support or training. There are no efforts at social mobilization. The village health and sanitation committees have been constituted but 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. This need is felt by organizers for organizing support but there is little clarity of how exactly this can be initiated and done.

Payments: Reports made by doctors at District Hospital and at some of the PHCs and CHCs suggest that the husbands of some of the ASHAs are accompanying the pregnant women to the health facility and getting paid in the name of ASHA. For example, at one SC , the ANM reported paying money to the husband of ASHA who had brought a woman for delivery to her Centre. At some facilities it was reported that sometimes ASHAs claim to have brought a woman when in reality the patient denied having been brought by her. It was also reported that ASHAs insist on getting payment even when funds have not reached the facility. Some ASHAs reportedly also insist on staying with 'their' patients in the labour room.

Functionality and outputs: Based on interviews with available ASHAs at various facilities the general profile of ASHAs appears to be of women in age group 25- 45 from the poorer sections of the OBC and upper castes.

The major functions of ASHA seem to be mobilizing women and children for immunization and for institutional delivery under JSY and helping out in the pulse polio campaign. Assisting with sterilization motivation is one marginal activity but in areas like the two districts visited, it does not offer much scope as families are already motivated. (We are told that this would be different in eastern uttar Pradesh districts like Gorakhpur). Their active participation in JSY and immunization has kept them in touch with the programme and with the health system. However systematic use of this workforce for health education is not ongoing and essential newborn care or first contact care for the sick child have also not happened. The lack of drug kits makes the latter even more difficult to achieve. Despite these constraints ASHAs we met were enthusiastic and looking forward to more training and being more useful and going beyond JSY and immunization. While it may be true that they would tend to do what they are incentivised to do – the current limitation in their going beyond JSY and immunization is the lack of skills and support and drugs – and if these are provided incentive or no incentive they are likely to go far beyond the very limited link worker role being rolled out for this social activist. ASHAs are easily one of the most vibrant dimensions of the NRHM roll out and 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. An external catalyst in the form of an activist drawn from an NGO or an academic with a equity focus or even a fresh postgraduate working on a fellowship could make a big difference.

Janani Suraksha yojana – safe motherhood

The program has started in April, 2007 and a significant shift in deliveries from home to facilities is occurring. Table 1 shows a higher proportion of reported deliveries taking place in institutions post April 2007 as against home based deliveries, and Table 3 shows the increase against the same months in 2006. Based on interviews with ANMs and their registers, it is evident that there is only a marginal increase in the number of deliveries being conducted by them since the JSY started but there is a clear shift in the location where they are now conducting them. There is a numerical reversal in the proportion delivered by them at home and at SCs. For example, earlier records showed one third occuring in the SC and two-thirds at home while records post April 2007 indicate one third at home and two- thirds at institutions. This reversal is also evident at the PHC and CHC levels. At the District hospital (Female), almost three times more deliveries are now taking place as compared to pre JSY period. There is also a doubling of caesarian sections in the DH post April 2007, suggesting that a greater number of high risk cases are now coming to the DH.

In terms of quality of care some gaps are observed at all levels. At the SC level the lack of government owned buildings and lack of electric connections raise issues of quality. Facilities in rented places lack adequate infrastucture for safe delivery. From all rural facilities women were reported/ observed to be returning home within 3- 4 hours of delivery. At some facilities this was reportedly against medical advice/ at the women's insistence. The mode of transport for women in labor coming to the SC and returning after delivery raises concerns about ensuring safe motherhood when shifting the delivery location by ANM from home to SC. With tripling of delivery cases at DH, women were being discharged post delivery earlier than the usual practice due to shortage of personnel and beds required to meet the additional demand of JSY. A major cause of maternal deaths in the past month was reported to be lack of blood for cases of severe anemia due to non availability of replacement donor blood raising the need for reviewing the blood bank policy in the context of JSY. See Table 2.

There does not appear to be a corresponding increase in utilisation of indoor or outdoor services in facilities for other health problems. See Table 3.

Total population of District Rae Bareilly (2001 census)- 28,72,000

Birth rate- 32/1000

Expected deliveries/year- 91,904
Estimated April to Oct. (7months)- 53,610

Table 1
Janani Suraksha Yojana: Institutional and Home Deliveries
District Rae Bareilly, April-Oct. 2007

Place of Delivery	**No. of Reported Deliveries**	**% of total reported deliveries**		**No. brought by ASHA**	**% brought by ASHA**
Dist . Hosp. (F)	992			288	29%
CHC	2413			610	25%
PHC	1487			1110	75%
SC	1898			331	17%
Total Rural Institutional	5798	62%		2051	35%
Total Institutional	**6780**	**73%**		**2339**	**35%**
Home	2513	27%		??	
Total	**9303 (17.4% of total expected)**	**100%**		**2339**	**25%**
Total expected in district in 7 months	**53,610**				

Table 2
Institutional and Home Deliveries Month-wise April-Oct. 2007:
Data from one PHC in District Rae Bareilly

Month	**Total No. of Reported Deliveries**	**No. of Home deliveries**	**% of Home deliveries**		**No. of Institutional deliveries**	**% of Institutional deliveries**
April	107	77	**72**		30	**28**
May	132	110	**83**		22	**17**

June	82	58	**71**		24	**29**
July	127	73	**57.5**		54	**42.5**
August	227	90	**40**		137	**60**
September	241	83	**34.5**		158	**65.5**
October	243	77	**31.5**		166	**68.5**
Total (7 months)	1159	568			591	

Table 3
District Hospital (F) Rae Bareilly: Comparative Data on Patient Load, 2006and 2007 for April and October

	April		**October**	
	2006	**2007**	**2006**	**2007**
OPD	3601	4882	5345	7460
IPD	444	497	561	1108
Deliveries	109	129	173	419
Operations (mainly CS)	11	22	18	61
Deaths		3		**5 (4 due to severe anemia with lack of donor for blood transfusion)**
Bed Occupancy		53%		154%

Functionality of SCs/ PHCs and CHCs.

All rural facilities appear to be providing services for delivery and emergency cases 24 x 7. At two SCs surprise checks at night done in Rae Bareilli indicated that ANMs are generally available at the Centres. This is the same impression from Jhansi also. The functioning of SCs is focused on pulse polio, routine immunization, family planning, ANC and deliveries. The identification of symptomatic cases for detection of TB, and making slides for fever cases for identification of Malaria is inadequate at the SC level. The latter is organized from the block level though supervisors and a depleted male worker workforce without any clear link to the sector/additional PHC who may not even have an awareness of these and may not even contribute passive surveillance cases to the pool. At all other levels services as expected in terms of labs, DOTS treatment, ICTC, curative care and FP, RI were `being given. We note however that the norm being used in

practice is one microscopy center per block and thus the microscopy is available only at the block PHC. However the blocks are large with over 1.75 lakh population as a rule and in Bundelkhand they are highly dispersed as well and if we stick to the one per lakh norm at least one more microscopy center should have been operational. X- ray services were not uniformly available either due to non availability of machine and technician or due to malfunctioning machine. The alternative vaccine delivery scheme operational in Bundelkhand appears to be working well and has made a large difference.
At some places it appeared that sector MOs were not familiar with the community they are serving and the lower level facility under them and the outreach activity and community processes by pass them.

Electricity is a surprisingly widespread problem for all sub-centers and even for a number of additional PHCs visited in both districts. Water supply is also a problem in some of the facilities in Jhansi. Otherwise as a rule infrastructure is adequate and very well maintained and very spick and span. There is a large emphasis given on health facility cleanliness by the present governments with surprise visits and suspensions being linked to this dimension and perhaps due to this – every facility visited was really clean and the pan spit marks, so common in many states, conspicuous by their absence.

All facilities did not have an idea of the services that they are expected to deliver- the gap in perception being most in the additional and block PHC. 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. There is an urgent need to expand the range of services offered in each of these facilities. Closely linked to this is 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 so 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 earler the state circulates standard treatment guidelines the better. Both Maharashtra and Chhattisgarh have graded guidelines that could be easily borrowed from and built upon.

As a rule the supplies of drugs and essential consumables is good at the district hospital, CHC block PHC and to some extent at additional PHCs. Common essential drugs are available and at least one antibiotic is in place. The range of drugs in additional PHCs is poor. Logistics support is a supply driven system and not responsive to demand leading to considerable stock outs and gaps in supply. In one additional PHC when drugs run out the doctor travels to the district stores , gets the needed drugs and transports it by public bus , loading and unloading it himself. May be exceptional – but clearly an extreme manifestation of not having a modern logistics system in place. The Tamilnadu type pass book system has proven its worth and it would make life much easier for health care providers and improve quality of services if this is improved. Drug supplies to ANMs is however poor and public health drugs like iron and folic acid and albendazole is just not available. We need to understand the dependence on the kit based supply system which is

do difficult to organize and which has so many operational problems. Is it not simpler to make sub-center and ASHA drug kit part of the general drug logistics of the district – using the drug kit only as the starting up device to be followed by regular drug refills of the kit – rather than by replacement drug kits!!!

AYUSH

Mainstreaming of AYUSH under NRHM is a non- starter in the District as is evident from the absence of any linkage of the Ayurvedic Unani activities with the district health services despite provision of space for Ayurvedic and Unani facilities in the medical institutions. The Office of the CMO and the Divisional Ayurvedic and Unani office were found to be functioning in complete isolation of each other. This despite the fact that a large number of Ayurvedic and Unani (total 64) facilities are reportedly active in the District. The AYUSH division has no communication about NRHM in the District with no allocation of funds for the same. The infrastructure available to AYUSH institutions is extremely deficient both in terms of buildings and funds for maintenance and rentals. There are wide gaps between sanctioned posts and in-position staff. There are no staff nurses and no residential facilities at Centers. No budgets are available for stationery or for repairs of machines like typewriters etc. The budget for drugs was reported to be Rs. 7000/- per year per hospital. Training of Ayurvedic and homeopathic Officers in NRHM under the District Health servces is being conducted by the CMO without involvement of the respective departments at the State/ district levels.

There are many vacant AYUSH posts in the district health program.

Rogi Kalyan Samitis

RKS have been formed as per guidelines in all institutions visited.

The use of RKS funds collected through User fee/ registration was largely for running of generators and for general upkeep. In the Female hospital over and above the reduction in user fee amount, the reduction has also occurred due to free services under JSY. This has reportedly affected their ability to run generators.

The major issue is that as of date 50% of the funds generated are being deposited in the treasury. This is a significant loss of revenue for the hospital – each district hospital visited loses about Rs 11 lakhs per year due to this. And in would make no difference to the UP state revenue collection. Also it is violative of the guidelines of the NRHM . Conformity to these guidelines would bring in large degree of central funds for RKS. Curiously there is complete unanimity at all levels on this recommendation – but it just needs doing.

RKS meetings have not as yet started happening. The RKS as a platform for decentralized facility level management and as a platform for public participation and accountability for improved hospital services and as a vehicle to improve quality of care and improve equity of care are four key dimensions of the RKS that is going to require a

lot of facilitation to achieve. Currently these perceptions are either minimal or completely absent. Indeed the RKS is just seen as a bank account for receiving user fees earlier and untied funds now. There is a long way to go on this front.

Untied Funds

UF have been received at all facilities although the use has not yet started due to lack of guidelines except for at the SC level. At this SC level the use is mainly reported for furnishing and equipping the SC with curtains, chairs, buckets, lights, building repairs, whitewashing,stationery and lanterns, torch lights etc. There were other needs pointed out for example, sign board, gloves and cotton and sometimes essential drugs in short supply. One problem in usage at the SC level in some places was reported to be the demand for a cut made by some Pradhans as prerequisites to signing of checks. This however could not be verified. However where there is a support committee organized and there is discussion of the expenditure the possibilities of such pressures are more limited. In some subcenters such committees are functional – but not in most. However as a rule this fund has been welcomed with great enthusiasm and been used with immediate effect.
In additional PHCs Rs, 75,000 has been received and there is good appreciation of this – but the accounts are not opened and the guidelines are not there for this. It is essential to ensure that all untied fund management is through a committee and that it is transparent. And that going beyond issuing an enabling order a team visits and sits with each RKS at each facility, briefs them fully of the possibilities and then facilitates their operation of this fund. We also note that the ideas of what to do with the second tranche of Rs 10,000 for the sub-center are much less and that even with the first tranche . For PHCs where infrastructures and supplies are adequate the ideas of how to utilize the funds are limited. There is a need therefore to give the untied fund a general direction of " to be used to improve quality and access to services " and build up a menu of ideas and approaches through which publicly recognized levels of quality can be achieved.

Panchayati Raj Involvement

. The Pradhans role is mentioned in relation to the village Health and Sanitation committee, use of untied funds and in the selection of ASHAs. In these three roles there is considerable scope for the pradhans active participation. We could not judge how far this was proceeding in the time available to use.
PRI is evident only in the formal structure of the District Heath Society and the RKS and sometimes not even that. At these levels the efforts to involve them, much less give them a major role need to be discussed and started up.

District Health Management Processes

The district health society has been formed and registered. And it has held executive committee meetings. The district mission and the general body are not functional. Key functions however are not society driven – for example even the district health plan has not have been formally placed on the agenda, discussed and approved by it as yet. In effect therefore it just becomes a device to give a larger say to the district collector – and

given the frequent changes and varied priorities of different officers, such a move in isolation cannot make too much of a difference. The need is to make the decision making more transparent and participatory and relegate specific financial powers to the executive and governing body – like approving the annual budget as a governing body function- to make these more useful.

In both districts visited there appears to be a reasonably effective management both in terms of personnel and finances within the given constraints. There is a lot of additional CMOs and deputy CMOs available with mainly management and administrative and programme functions and with little or no clinical load. This is not the situation in many states and is a strength that could be built upon. The contractual staff based district and state programme management units have not been created and even if created the main strategy in this context may be a fast track capacity building system for these second level district officers and better work definition and monitoring of their functioning.

The supervision at CMO and Dy CMO levels was reasonably effective in terms of ensuring availability of personnel at different facilities, though very slow on recruitment and postings where they either do not have or are unable to exercise their authority. The formats for recording information from various programs have been developed innovatively at peripheral level to facilitate monitoring of JSY and 24x 7 facilities and on disease control programmes and to feed into the information requirements of the state and center. The flow of information/ records from lower level facilities upwards` appeared good and timely on many parameters, but there were frequent complaints about far too much data having been required of them monthly. Similarly, information about new programs and government orders to field staff and all facilities from CMO's office seems good. Bill boards and pamphlets have been developed to dissemnate information about JSY in the public.

The accounting system was examined by the Rae barelli team. The NRHM Accounts are opened and maintained as per guidelines. The entire JSY funds available to date has been disbursed. JSY funds disbursement has been further facilitated by use of Flexi funds for making payments to beneficiaries bringing the total fund utilization to 2 crores. The cash books and ledgers appear to be complete. The peripheral institutions are able to send utilsation certificates for programs such as pulse polio with in six weeks to CMO's office.

NGO participation:

There is limited NGO involvement. Some of it is in NACO and some of it is in monitoring and support for immunization. The mother NGO programme has not received any funds over three years and is therefore at a stand still.

The possibilities of the NGOs for the ASHA programme are also not exploited. And the state ASHA mentoring group is not in place. Community monitoring programme has not begun in Uttar Pradesh.

NGO involvement in district planning and in RKS and in other state level processes are yet to take off.

In PNDT act implementation one NGO has played an active role, but otherwise NGOs do feel that they are kept waiting without any space or work for them emerging.

RECOMMENDATIONS:

District Planning and Integration:

District Planning requires greater participation and capacity building while making the plan. Further once it is made copies of the plan need to be widely disseminated preferably in Hindi**.**
Much more work is required on integration.

Staffing:

The staffing is far short of IPHS guidelines and there is no clear effort to achieve these guidelines or some clearly defined intermediate stage of adequacy in staffing.

At least in having a MOCH in all the additional PHCs and a staff nurse in the additional PHCs and CHCs as per norms and laboratory technicians and pharmacists there is no immediate problem of availability from the open market provided some restrictive rules are re-examined. In particular the order that rules out qualified nurses and ANMs on the basis of the stream in which they completed schooling is arbitrary and not in conformity with nursing council guidelines and completely unhelpful. Lack of nurses is crippling the system and should be urgently addressed. In comparing the two districts it is obvious that the level of service delivery is much higher when the nurses in place – though both have comparable level of doctors. The stay order on contractual appointment

Lack of specialists relates to issues of specialist posting policy and the need to formalize many of the current informal and irregular sharing arrangements between facilities. The aim should be to a) that all facilities meant to provide specialist services- district hospital and CHCs- have some access to specialists , at least by rotation on specified days. b) that postings be based on ensuring that the minimum number of skill sets are available in each facility and c) multi-skilling be used to close specialist gaps where requisite skills are not available and d) where already MBBS doctors are providing specialist services these be encouraged, provided some degree of skill upgradation and certification so that they can continue and be used more effectively.e) keeping the skills intact is another important dimension as many specialists are getting de-skilled through inappropriate posting and support policies.

ASHAs:

Despite the major lacunae in the rolling out of the ASHA programme, from both our visits and from reports from NGO sections and within the lower levels of the health sector, the overwhelming impression is that the programme has still much vibrancy and great potential. It is difficult to quantify the extent of programme achievement and the extent of functionality of ASHAs but a common figure quoted is 60 to 70% functional!! The range of their work is largely limited to JSY, immunization session, polio. The gaps have been in the selection process which largely seems to have been at best done by a

consultation between the health functionary and the pradhan and at worst with undue monetary influence. Despite this most of the selected women are middle level groups of the village – neither too influential nor the poorest, are educated, are the bahus and are in the 25 to 45 age group and like most women are concerned about health and eager to help in anyway available to them. The other major gap is the lack of support of any sort – in terms of visits, or regular meetings or regular trainings or in provision of drug kits – but these can and must be easily remedied. The budget provides for this and should be used for this. Incentives payment is also a major problem though even the level of incentive currently reaching it is enough to keep the system going. Problems relate to delayed payment, non payment, contestation of payment on flimsy grounds, payments being given to husbands or relatives. A clear strategy of strengthening the payment process is required- but this needs to be discussed further.

Functionality of Sub-centers:

This has been enhanced by the provision of untied funds. Immunisation has been enhanced by the use of 'alternative delivery systems'. ASHA programme has also helped in achieving all sub-center level outputs. Institutuional delivery has occurred at sub-centers though these effectively represent only an increase in access to skilled birth assistance- and whether it is a shift or an increase differs from place to place. Quality of antenatal care, post partum care and care at delivery, care of the sick child , support to ASHAs etc however are all very weak – basically because of an almost complete invisibility of any training activity. Thus no ANM met has received skilled birth assistance training or has heard of a partogram, no one has received IMNCI training etc etc. Even in untied funds though the immediate use has been good the second Rs 10,000 is spent slower and there is a need for a greater menu of ideas from which they can draw upon to make effective use of the money. The lack of a village plan also restricts possible uses of these funds. One major problem in most sub-centers visited was the lack of electrification – though the village had been electrified. Related to this is the lack of water. This should be rectified on a priority basis.

The ANMs service conditions require enhancement especially in terms of career progression.

Another recommendation is that the existence of the sub-center should be indicated by a sign board on the main road.

Functionality of Additional PHCs:

One key issue is the complete lack of awareness of the service guarantees of the NRHM and the IPHS as regards this sector level PHC.

The other key issue is in staffing and related skill sets available. The current administrative provision for two medical officers , one from the ayush stream , and one from modern medicine, of one ANM, of one pharmacist and one ward boy , one sweeper and one chowkidar should be met seriously. In addition there needs to be an effort to bring in at least one or two more staff nurses at this level. The LHV and supervisor available at this level are just not being used in most cases and their regular job description and multi-skilling is a major area of reform. Multiskilling of the pharmacist is essential. Multiskilling of all staff would be useful to achieve the necessary skill sets needed to achieve the IPHS norms of service delivery. The laboratory technician at this

level is also essential. If one DMC is needed per one lakh population almost all blocks have not reached that level.
Most additional PHCs do not have electricity and for this reason are unable to play the role of vaccine stores. The CHCs and block PHCs which did have a store had recorded tempratures above the minimum level due to electricity problems. Generators are also a priority.
The RKS have been created but are not functional. All additional PHCs have received Rs 75,000 and are about to use them. But they are going to require enabling orders support for this and this need has not been recognized as yet.

Functionality of CHCs and the block PHC- the 24 hour PHC.

All block PHCs should straightaway come into making of 24 hour PHCs. CHCs should be a selection of these PHCs taken to a higher level. Today of the nine blocks in Jhansi district , three have been chosen for 24 hour PHCs and of these two for CHCs. There is no advantage in slowing this rate. Making all 9 24 hour PHCs would be about the same as making 3 all PHCs.
The staff nurses in the critical gap in making the 24 PHC and needs to be addressed. The lack of skills is a related constraint to deliver services of desired quality.
The CHCs are the same as FRUs of the RCH. The emphasis needs to be on reaching the level of service delivery required of it. Many items in the normative service delivery package could have been achieved with available staff and available infrastructure if there is greater awareness in the system of this and if this is facilitated and monitored by the district leadership better. There is a clear and present danger of reading the IPHS as only a prescription of inputs. Thus a new building is being to house outpatient activity in CHC Moth when the existing infrastructure is far from utilized. This new out patient facility is desirable – but improving utilization of existing consulting rooms and in patient facilities would have been a priority.
The strategy of ensuring quality of services, a larger package of services with the available medical staff through skill upgradation, multiskilling and appropriate training and support is one major thrust of strengthening CHCs. The other would be the policy for getting the necessary specialists in place. This requires better posting policies and much can be done with available staff in the district.

Patient amenities like drinking water, a place to cook, a waiting space for attenders etc also need to be considered and taken up.

Rogi Kalyan Samitis:

RKS have been formed as per guidelines in all institutions visited. Funds however are not yet deposited in them. The earlier system of depositing 50% of user fees collected into the treasury account is being discontinued but the orders for this have not yet been issued. This needs to be done as a priority.
The RKS untied fund has not been received by most facilities and where received has not yet been spent, pending guidelines on spending this. This needs to be started up.

The RKS needs to meet and take decisions by meeting. The notion of RKS as decentralized and participatory management has not yet arrived.
Capacity building of RKS members, information of objectives and processes to the members also need to be planned for.
The potential of RKS as a platform for public participation with more users and weaker sections being involved has not been exploited. The state needs to discuss this and move in this direction.
The other concern relates to equity of access. The main concern is that user fees should not passively lead to exclusion of the poor from necessary diagnostics and in patient admission. Therefore RKS should be able to monitor this.
The use of RKS funds collected through User fee/ registration was largely for running of generators and for general upkeep. However after immediate needs have been met the focus needs to shift to planned use of resources – the key issue being of improving hospital management processes so as to improve quality of care with available resources and staff, by enhancing skills and building and enabling atmosphere. The amount of resources available are considerable and a system to provide such assistance needs to be planned. The only possible system for a 70 district state is to built a small group of four or five persons in each district reporting to the CHMO who can provide support to the RKS for this.

Panchayati Raj Institution Involvement:

This village panchayat pradhan is involved in three village level processes – the untied fund of the sub-center, the village health and sanitation committee, and the ASHA programme. There could be inputs to improve the quality of involvement.
At the block level and district level PRI involvement is minimal and not even present as a token. They could have been involved in district planning and in the RKS.

The Training Centers:

One of the most important priorities should be to get the ANMTCs and RHFWTCs fully functional.
This mainly requires a) putting the staff in place and b) getting the programmes going immediately with a training calendar for each training center put in place. The current infrastructure is adequate for this purpose c) Identifying the trainees on a systematic basis so that all the facilities have trained staff within two years d) getting the staff trained and putting in place a faculty development programme for these institutions and e) improving the infrastructure and equipment. We note that whereas the last element of this has got due attention, the rest of these need to be followed up.

NGO participation:
The Mother NGO funds constraints needs to be addressed. At present the programme is at a complete halt and a decision needs to be taken on whether the state is proceeding with this or not.
Community monitoring programme has not been initiated. The NGO participation in RKS or district health societies or in facilitating village committees or in facilitating

ASHA programme is minimal or almost absent. We do not know the full potential for the role of NGOs as such in UP, but from discussions with the NGOs it does appear that the known and existing potential has also not been used optimally and there is much frustration amongst some senior and respected NGOs on this score. This could be discussed further by the state authorities with the NGOs and an optimal partnership be built up.

State Level: These would be discussed further before being finalized.

At the National Level:

a. Looking the current NRHM sanction and revision to ensure funds needed for RKS and JSY. by the state for finding the funds needed to give to RKS. Other dimension of revision are not automatically recommended but could be discussed further.
b. Finding out what the bottleneck is with respect to JSY funds release and taking appropriate steps needed to get the funds on flow.
c. Strengthening facilitation support for a number of these initiatives and recommendations made by the team.

IMMEDIATELY ACTIONABLE PRIORITIES

Some key issues for immediate action (this is not the full list of recommendations– but a selection from the list of recommendations as emerges with the discussion with the principal secretary health):

a. Changing the restrictive clauses on nurse and ANM recruitment which excludes a substantial or major part of qualified nurses and ANMs from recruitment.
b. Issuing the orders needed to retain the 50% of user fees collection of RKS that is currently going to the treasury.
c. Issuing the enabling orders and guidelines needed for RKS of the additional and main PHC and CHC level to be able to open their bank account and start expenditures.
d. Reviving the ANM TC and RHFWTC and MPWTCs and restarting all district level training activities.
e. Immediately closing nursing staffing gaps and making full use of the contractual appointment provisions for nurses under NRHM and overcoming the mis communications and misunderstandings that are the immediate bottlenecks currently.
f. Immediately generalizing the MOCH posts to all additional PHCs and making use of contractual provisions to hasten this.
g. Finding ways of encouraging and quickly certifying many medical doctors who are providing services which have today got classified as specialist services especially as regards emergency obstetric care. Also ensuring that those with

specialist skills are not de-skilled through weekly once or even monthly once opportunities of retaining these skills and facilities which are to have specialists are provided some degree of specialist functioning through weekly once postings and weekly special clinics. In parallel to this expand on multi-skilling as a general strategy for closing specialist skill gaps.

h. Closing electricity supply gaps in all sub-centers and additional PHCs.
i. Strengthening the ASHA programme through provision of drug kits, streamlining incentive payments, increasing frequency and periodicity of training and better on the job support and community mobilization. All this requires the ASHA mentoring group and ASHA resource center to be in place.
j. Circulating the list of services that each facility is expected to deliver – with reference to IPHS standards-, building up enabling tools like standard treatment guidelines to deliver this and orienting district training , monitoring and facilitation work to achieve as much of this is possible with available human resource, in parallel to the work that goes on to increasing staffing. In particular this needs a district node/pmu/resource and training center that assesses the level of skills each facility has as against what they need to have and closes the gap by imparting these skills to the available human resource there – to the extent possible. It also means that those providing these services are brought upto the requisite skill levels. (eg all those conducting deliveries should have the skills that SBA training gives them – like using a partogram etc..)
k. Improving drugs and supplies logistics and bringing in sub-center and ASHA supplies into the logistics systems.
l. Making a combined plan for strengthening the directorate, for operationalising the state programme management unit, for strengthening the SIHFW both in terms of faculty and quality and area of responsibility and for operationalising the SHSRC so that such a large state has the right numeric and quality adequacy of leadership that it requires.

At the national level:

- Examining the current NRHM sanction for appropriate revision after discussions especially on two aspects – funds needed to give to RKS and funds for JSY.
- Strengthening facilitation support for a number of these initiatives and recommendations made by the team.

Annexure: Schedule of Visits

Schedule of Visits

From Lucknow:

Day and Date	Facility visited	Personnel met/ interviewed	Observations
Day 1, November 16, 2007 ***Accompanied by AD Dr. Rajendra Kumar and Dy CMO Dr. O.P. Varma***	CHC, Bachraoan	2nd MO- Dr. Sachan Child Specialist- Dr. V.K. Singh Gynecologist- Dr. Meena Singh Dr. Varma , Dr. Yadav Staff Nurse	Gynecologist on visiting bases
	CHC, Khiron	MO I.C – Dr. Manoj Kr. Shukla New PHC, MO- Dr. Srikrishna Two Staff nurses on contract	Gynecologist Dr. Neetu Agrawal (once a week) 2nd MO- on leave
	PHC, Sareni	Mo I.C- Dr. Jai Singh 2nd MO – Dr. Ashok Kumar Staff nurse- Sarvesh Kumari On contract	Sterilisation day at the facility- women were seen waiting for the lapro team to arrive
	CHC, Lal Ganj	Medical Suptd.- Dr. A.B. Singh Medical Officer – Dr. Varma Child specialist – Dr. Chowdahry Gynecologist- Dr. Leena Singh Radiologist- Dr. Dikshit Dental Surgeon – Staff nurses- contract staff	The dental surgeon posted here is the only MD in the district.
	District Hospital, Rae Bareilly	Emergency and Trauma unit CMS- Dr. Tripathi, and team	
Day 2 November 17, 2007 ***Accompanied***	District Hospital, Rae Bareilly	Male Hospital Chief Medical Superintendent- Dr. R. C. Tripathi Radiologist – Dr. Altaf Hussain	Clean and adequate premises; nearly 150 %

by Dy CMO, Dr. O.P. Varma		Female Hospital Chief Medical Superintendent- Dr. Rekha Rani Sinha	bed occupancy in female hospital
	Ayurvedic and Unani District Administrative Office	Divisional Ayurvedic and Unani Officer- Dr. D.S. Mishra	Office in a dilapidated building
	PHC, Salaun	MO I.C – Dr. R.S. Tripathi 2nd M.O- Dr. P.K. Baiswal Attached Ortho Surgeaon – Dr. V.K. Baiswal Dental Surgeon – Dr. K.S. Trivedi Gynecolgist (visiting) Dr. Meera Singh	Well designed facility, adequate space and well maintained
	New PHC, Karahiya Bazar	MO I.C- Dr. Baig ANM, Sister Mariamma K.N	In a donated building
	Sub Centre, Gopalpur	ANM- Vinodini Mishra	In a rented house; no electricity connection; no signage at the entrance to identify its as a SC
	Sub Centre, Rampur Kasiya	ANM – Annamma Samuel	In government building with minimum space being made available for the health services by the ANM
Day 3 November 18, 2007 ***Accomapnied by Dy CMO, Dr. O.P. Varma***	ABR Girija Devi Charitable Hospital, Raalpur	Shri Mishra	Well designed hospital with adequate facilities for delivery, lab testing etc; no medical staff of its own

	Village, Singhor Tara	Health volunteer- Ramkumari Yadav ASHA- Rajkumari Villagers (new mother, mother with 5 month infant- delivered at facility)	
	Sub Centre, Beni Madhoganj	Village Health Vounteer- Ramkumari Yadav ANM – Sukhrani ANM (of Raalpur)- Santhosh Kumari	In a govt. owned building; adequate space; no electricity connection; no signage for the SC and JSY
	CMO Office	Accountants- Rajendra Kr. Shukla Stores & Purchase- Ramesh kr Chowdhary	
	Village Bheera, Ganagaganj-Sohra	Villagers- Jaihannudin Dai and family, new mother, pregnant woman	ANM (Usha) was not available at the Sub Centre