KERALA

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KERALA

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Introduction to Kerala

The State is geographically classified into coastal belt, midlands, and highlands (hills and valleys) and has an area of 38,863 sq. kms. There are 14 districts in the state with 63 Taluks, 152 Development Blocks, 999 Panchayats, 1452 Revenue Villages, 5 Municipal Corporations and 53 Municipal Councils. According to 2001 Census, the literacy rate for Kerala is 90.92 per cent as against the All India average of 65.38 per cent. Kerala has an urban population of 26%. The Scheduled Caste population of Kerala is 31.24 lakh constituting 9.81 per cent of the total population, as per Census 2001. (NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008)

Kerala's achievements in terms of some of the basic indicators of human development and health are well known and have been much commended upon. The State has a population of 31.84 million as per 2001 census. There has been reduction in the decadal growth rate from 14.32 (1981-91) to 9.47 (1991-2001). Birth rate of 15, death rate of 6.4 and infant mortality rate of 12 (SRS 2006) is the lowest in the country. Institutional delivery rate is almost 100 %. Sex ratio is 1058 female per thousand men. Female literacy rate of 86.87% is the highest in the country. The total fertility rate is 1.93 (NFHS 3).

Demographic Profile 2001		
Population	Total	31 841 374
	Male	15 468 614
	Female	16 372 760
Population Density (persons per sq. km)		819
Male Population (%)		48.58%
Estimated Urban Population	Total	8 266 925
	(%)	25.96%
Scheduled Caste population	Total	3 123 941
	(%)	9.81%
Scheduled Tribes population	Total	364 189
	(%)	1.14%
Sex ratio		1058
0-6 age group	Total	3 793 146
	(%)	11.91%
	Male	1 935 027
	(%) of total 0-6 age group	51.0%
	Female	1 858 119
Disabled persons	Total	860 794
	% of population	2.7%
	Male	458 350
	Female	402 444
	Seeing	334 622
	Speech	67 066

	Hearing	79 713
	Movement	237 707
	Mental	141 686
Household size		4.7
Population above 60 years in 2001 (%)		15%

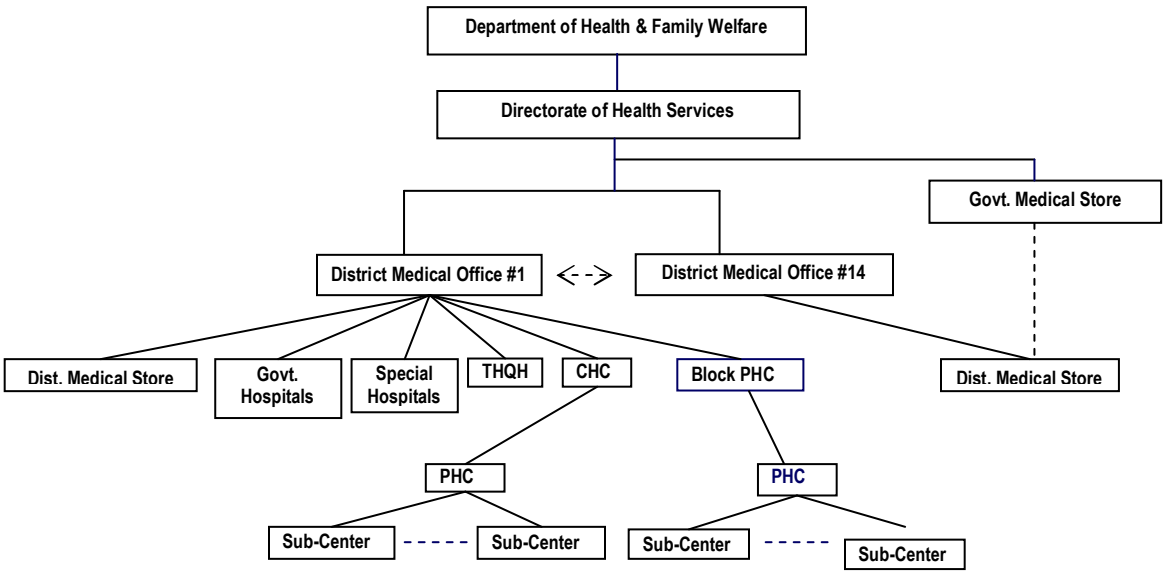
Source: NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008

However Kerala is facing new health challenges like return of Infectious diseases, increase in Accidents and Injuries, increasing Geriatric population and their problems, high level of suicide, diseases due to environmental degradation, new diseases like Dengue, JE, Chikungunia and HIV/AIDS. Further the increasing trend of traffic accidents is a matter great concern. The total number of road accidents in Kerala during 2001 was 37256, which increased to 42365 in 2006. Kerala registered 42365 accidents (116 per day) in which 3203 persons were killed and 51127 persons were injured in 2005-06. Other health related problems includes diseases due to pesticides and other industrial chemicals and decreased health status of coastal and tribal population. Sustaining the momentum of change and resource mobilization are the two tasks ahead. (NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008)

Health Infrastructure

There are five directorates under Health Services Department.

1. Health Services Department
2. Medical Education Department
3. Department of Indian Systems of Medicine
4. Department of Ayurveda Education
5. Department of homeopathy



Source: NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008

Health Infrastructure

NUMBER OF MEDICAL COLLEGE HOSPITALS (MCH) *Economic Review 2006, Government of Kerala*	TOTAL	13
	Government	5
	Co-Operative	2
	Private	6
Number of Dental Collages	TOTAL	9
	Government	3
	Private	6
Nursing Schools Integrated General Nurse-cum Midwives (3year)	TOTAL	200
	Government	15
	Medical College	3
	Private	182
Junior Public Health Nurses Schools (18 Months)	TOTAL	15
	Government	4
	Private	11
Nursing Colleges BSc Nursing (4 year course)	TOTAL	45
	Government	3
	Private	42
Nursing Colleges MSc Nursing (2 year course)	Government	3
Number of District Headquarter Hospital (This includes General Hospitals situated at District Head Quarters also)		18
Total Number of Institutions under DHS		1274
Number of Community Health Centres (CHC)		114
Number of Primary Health Centres (PHC)		929
Number of Sub Centres (SC)		5568

Source: NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008

AYUSH

The three branches of health care system of modern medicine, ayurveda and homoeopathy has acceptance in Kerala. Three systems together have 2711 institutions in the government sector. Out of the total institutions, 47% are under Allopathy and 53 % under AYUSH. There are 115 Ayurveda Hospitals with 2744 beds and 747 Ayurveda dispensaries. Hospitals include 14 district hospitals, one nature cure hospital, one Marma hospital, one Siddha hospital, one Panchakarma hospital, one Ayurveda Mental hospital and 96 government hospitals. During 2005, 207.7 lakh patients were treated in ayurveda institutions and out of them 207.2 lakh were outpatients and 0.5 lakh inpatients. There are 14 Ayurveda colleges in Kerala, of which 3 are in Government sector, 2 are in private sector and 9 are in self-financing sector. These colleges have an annual intake of 680 students for BAMS/BSMS courses and 82 students for postgraduate courses. There are 31 hospitals and 525 dispensaries under Directorate of Homoeopathy. Hospitals include 14 district and 17 other hospitals. Total bed strength of these hospitals is 970. There are 5 Homoeopathic Medical Colleges in the State, of which 2 are under government sector and 3 are in private aided sector. Total annual intake for BHMS course is 250 and for PG course is 60. (NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008)

Private Medical Institutions

Kerala has a vast health care infrastructure under Modern Medicine, Ayurveda and Homoeopathy systems of medicine. In the health sector the role of private sector is significant. Under private sector, all the three systems together have 12383 medical institutions. The total bed strength in the three main systems viz. Modern Medicine Ayurveda, Homoeo is 63386. Out of it, 88% of beds and 37.35% of medical institutions are under Modern Medicine, 33.53% medical institutions and 8.53% beds are in Ayurveda. Homoeopathy institutions constitute 24.97% and beds under it are 1.26%. There are 24401 doctors under private sector. The strength of nurses available for health care services under private sector is 20164, paramedical staff consists 12910 excluding nurses. In Kerala, one interesting aspect in the health seeking behavior of the State's population is that a sizable percentage approaches the Private sector for curative care. (NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008)

System Wise Details of Private Medical Institutions in Kerala

SL.NO	SYSTEM OF MEDICINE	YEAR		
		1986	1995	2004
		No.	No	No.
1	Modern Medicine	3565	4288	4825
2	Ayurveda	3925	4922	4332
3	Homoeopathy	2078	3118	3226
4	Others	95	290	535
Total		**9663**	**12618**	**12918**

Source: NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008

Human Resources

There are 24991 medical and para medical personnel attached to Directorate of Health Services 3862 are medical officers, 81 dentists, 8646 senior/junior nurses and 12538 para medical staff. While analyzing doctor Population ratio in Kerala, for every 8545 population there is one medical officer under Directorate of Health Services with considerable inter district variation. Doctor population ratio varies from 1:6252 in Pathanamthitta district to 1:11486 in Malappuram district.

In the government medical colleges, there are 39 categories of specialty departments and in each department there are four categories of posts viz. Tutor/ Lecturer, Assistant Professor, Associate Professor and Professor. The total number of clinical/ non-clinical doctors in the five government medical colleges and attached institutions comes to 2183 doctors. The doctor population ratio, where doctors working in government system (allopathy) only were counted stood at 1:5388. (NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008)

Registered medical and para medical practitioners in the State

Number of doctors in health services department		3862
Number of JPHN		5583
Number of JHI		3511
Number of LHI		962
Number of HI		876
Number of LHS		157
Number of HS		168
No of Doctors in Public Health Care Institutions	TOTAL	5758
	DHS	3862
	Medical Collage	1342
	ESI	554
Doctor Population Ratio. Public		6162
Doctor Population Ratio. (Private and Public)		2305

Source: NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008

Health Indicators

Vital Statistics		
Life Expectancy at birth (Male) (in years)		70.90
Life Expectancy at birth (Female) (in years)		76.00
Total Fertility Rate (per woman) NFHS 3.		1.93
Sex Ratio (females per 1000 males)		1058
Birth Rate (per 1000 population) SRS 2006	Total	15.2
	Rural	15.4
	Urban	14.6
Death Rate (per 1000 population) SRS 2006	Total	6.1
	Rural	6.0
	Urban	6.4
Natural Growth Rate SRS 2006	Total	9.1
	Rural	9.4
	Urban	8.2

Source: NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008

Health Status	
Infant Mortality Rate (per 1000 live births) SRS 2006.	12
Under -5 Mortality Rate SRS 2005	3
Neo-natal Mortality Rate (1998) SRS 2005	11
Maternal mortality ratio (per 100,000 live births)	110*
Deliveries assisted by a health professional (%) NFHS 3.	99.7%
Institutional Births (%) NFHS 3.	99.5%
Number of public and private hospitalization per lakhs	7480.00

Source: NRHM Kerala, State Health Action Plan, Part A, B, C, 2008-09, GOK, Jan 2008 (*Special Survey on MMR 2003)

Findings and Recommendations

Kerala is the first state in India which has attained health and demographic goals of the National Rural Health Mission several years before this is being launched. Therefore, the challenge before the state of Kerala through NRHM support is three folds, reduce out of pocket expenditure on health, move towards highest attainable global status of life and optimum use of resources. Further the morbidity profile of Kerala is fast changing with the decrease in childhood diseases and rising old age health problems. Secondly, while prevalence and resurgence of infectious diseases are part of the unfinished agenda, there is rising trend of life style related non-infectious diseases. Therefore, more location and community specific planning guided by the epidemiological approach would be required.

Methodology

The CRM members were briefed by the state officers on 26th November, 2008. Thereafter the two teams were formed and one team visited Thiruvanthapuram district while the other team visited Waynad District. The Team visited the districts during 27th November to 1st December 2008. The teams in addition to the visit to the facilities had detailed briefing by the District Officials at the District HQs, Meeting with Panchayat members in each of the districts visited. After the visits to the districts the team provided a feedback to state health Secretary and other officers on 1st December, 2008 at Thiruvanthapuram. Integrated summary of findings and recommendations are given below.

The Positives

- The increased public awareness about health and the good health indicators for the state is a matter of pride.
- There has been a marked improvement in infrastructure (buildings, equipment) and human resources by the utilization of NRHM funds.
- There is increased availability and quality of medication after the setting up of the Kerala Medical Services Corporation Limited.
- The successful setting up and use of the E Banking system including the debit cards for ASHAs for the state is highly commendable.
- The setting up and use of a FM Radio Health Program which can be heard in 3 districts is a good innovation.
- The state wide Pain and Palliative Care program for terminal illness in the community is a good innovative program.
- The Compulsory Rural Service for doctors is a major step forward in augmenting the human resources for providing health care in rural areas of the state.

- A new school transfer certificate and health record introduced in the state will become an important document that would track the children's health status.

- The quarterly newsletter "Ner Rekha" published regularly provides information on the health status, institutions and services all over the state.

- The initiation of comprehensive health insurance scheme in collaboration with Department of Labor would enhance the access to health services especially the poor

- The selection process for ASHAs has been good and the selected individuals are motivated.

1) Assessment of the case load being handled by the Public System at all levels

- The out-patient case load is good in all hospitals, CHCs and PHCs.

- State wise data suggest that OP has shown an increase during 2007-08.

- In- patients services are variable (e.g.CHC Kanyakulangara good; Kesavapuram poor; PHC Kuttichal had none) The IP figures show marginal decrease over the years. In the Government sector there was strike of the Medical Officers during the last months of 2006-07 and early months of 2007-08 which adversely affected the system in service delivery and reporting. The in-patient case load can increase in many CHCs and PHCs if the full range of services are provided. For example, while the CHC at Kanyakulangara was overflowing with in-patients the CHCs at Kesavapuram had fewer in patients than the bed strength the PHC at Kuttichal had none.

Case Load in Public Facilities in Kerala						
Deliveries						
	Institutiona l Deliveries	**% change**	**Total deliveries**	**% change**		
2005-06	572168		572893			
2006-07	540085	-5.61	541747	-5.44		
2007-08	535968	-0.76	537757	-0.74		
IP/OP/Operations						
	IP	**% change**	**OP**	**% change**	**Operations**	**% change**
2005-06	1888615		44668182		323220	
2006-07	1658146	-12.20	43863068	-1.80	274133	-15.1869
2007-08	1531413	-7.64	51414151	17.22	246292	-10.156

Total number of beds in Public Facilities in Kerala					
	Hospitals	CHCs	PHCs	Others	Total
2005-06	23665	4730	7675	366	36436
2006-07	23665	4730	7675	366	36436
2007-08	23871	4730	7675	366	36642

Source: Information provided by Officials, MOHFW, Kerala Govt. 2008

- Not all CHCs providing 24x7delivery services. There is a wide variety and quality services provided at Women and Children's Hospital at Thycaud (e.g. deliveries, Caesarian Sections, Hysterectomies, Blood bank, laproscopy services, neonatal nursery, ARSH clinics, sperm bank, infertility etc.). Similarly, good services provided at the hospital at Sulthan Batheri, Wyanad. It is observed that there is very marginal decline in the deliveries reported in the State. The reason may be the decrease in the rate of growth of population as revealed by the SRS data. Crude Birth rate has come down to 14.9 from 15 and the TFR is 1.7 from 1.9 as per latest SRS.

- Except the CHC at Kanyakulangara, the other CHCs even those designated as 24x7, were not providing services for deliveries.

- The provision of in-patient and delivery services at peripheral institutions will reduce the workload at tertiary centers as the community is willing to accept such care provided the service is good. However there is a need for a detailed needs assessment should be done prior to expansion of specialty services Eg. Nalloornad, Wyanad.

- Peripheral institutions and districts have OP and IP statistics. This should be collated at the state level.

- There is wide variation in the performance between districts, district/ taluk/ subdivision hospitals, CHCs, PHCs, and Sub-centers. There is a need to focus and improve supervision and support for the poorly performing regions and facilities to improve their performance.

- The setting up of league tables comparing different institutions of same category/type on different parameters (E.g. Numbers of out-patients, in-patients, deliveries, Caesarian sections, % of completed immunization, %funds spent) of service and feedback to all institutions will help improve service delivery. This can be part of the regularly published newsletter.

- It was brought to notice of the members that more than 60% of the deliveries in the state take place in private facilities and large number of people seek services from private health sector for other morbidities. This pattern is required to be reversed because it's a major drain on the limited economic resources of most families of Kerala.

- Optimum use of Resources is an area in which Kerala's health system has to formulate strategy in order to bring cost effectiveness in services delivered. In many, well equipped facilities were found to be grossly underutilized and there has been unnecessary high burden on many facilities. Practice of over medicalisation of deliveries (normal deliveries also to be performed by gynecologists) should be reduced by amending people's mindset through public education/campaign. Sub centres and PHCs should be optimally utilized.

- There is a need to focus on lifestyle diseases (Diabetes, Hypertension,) as many of the standard health indicators for the state are already very good.

2) Quality of Services

- Wide variation in the quality of services provided between similar type of institutions. The variation in performance of peripheral institutions is related to the motivation, commitment and skill of the head of the facility. There is a need for leadership training for heads of the peripheral institutions.

- PHC buildings have been renovated and new buildings have been constructed. Non-utilization of space observed (e.g. Poruaannore- Wyanad; Kuttichal-Thiruvananthapuram).

- An audit of space available prior to constructing new building is necessary for optimal utilization and prioritization of available space.

- TVs with DVD facilities in many hospitals in Wyanad district.

- Display of list of medicines available at hospital at Sulthan Batheri, Wyanad.

- IMAGE is providing services for large hospitals and CHCs in Thiruvananthapuram. However, not all the smaller hospitals are covered by the scheme. The service is only available in Wyanad at the district hospitals. There is a need to enforce segregation of hospital waste.

- The people will use services when they are of good and acceptable quality as demonstrated by a few existing institutions which are providing a high quality of service (E.g. Women and Children's Hospital Thycaud and CHC, Kanyakulangara). There is a need to monitor the services from the point of input vs services.

3) Utilisation of Diagnostic facilities & their effectiveness

- The state has appointed consultants in bio-medical engineering who are responsible for supervision and ensure that the equipments are in working order.

Overall the equipment is good . However old and unused equipment dumped in some hospitals, eg. CHC at Kesavapuram. The use of equipments at various institutions should be evaluated

4) Drugs and Supplies (including Vaccines)

- The Setting up of Kerala Medical Services Corporation Ltd. is a major step. It has become operational in April 2008 and has slowly increasing its activities and reach and overcoming the problems of the system they inherited.

- The process for the procurement and distribution of medicines and supplies has been streamlined. Computerization, pass book systems and an essential drug list have been established

- The systematic and regular testing of all batches of drugs received for quality will ensure a high standard of drugs distributed through the government health system.

- There is a need to standardize the indenting procedure for peripheral institutions. There is a need for capacity building about the new system at the peripheral institutions.

- There is a need to increase the storage facilities and computerize the peripheral institutions and pharmacies for optimal utilization of services.

- There is a need for buffer stock of drugs at all district warehouses and institutions so that medication is never out of stock.

- Family planning drugs and not being managed/distributed through KMSCL and this should be incorporated.

- Some drugs are supplied in concentrate form and diluted at the peripheral level. The procurement should in the form as intended for patient use.

- There is a reduction in State Health budget for medical supplies subsequent to setting up of KMSCL as computerization has plugged many loop holes.

- Testing of all batches of drugs received for quality is being done.

- Shortage of DT and TT in PHCs in Thiruvananthapuram needs to be rectified

- Need to standardize the indenting procedure

- Need for capacity building about the new system

5) Human Resources

- In 2008 as per the information provided there were Medical Officers – 3724, Dentists – 79, Senior Nurses -1699, Junior Nurses – 7163, Lady Health Inspectors – 966, Pharmacists -1612, JPHN 5571, Junior Health Inspectors – 3509, Health Inspectors – 857, Nursing Assistants – 5481 and 776 Lab Technicians.

Human Resources in Kerala

Year	MO	Dentist	Sr. Nurse	Jr Nurse	Lady Hlth Insp.	Pharmacist	JPHN	Jr Hlth Insp.	Hlth. Insp	Nursing Asst.	Lab Tech.
2006	3726	80	1593	6053	962	1642	5570	3511	853	5530	775
2007	3862	80	1699	7163	966	1612	5571	3509	857	4240	744
2008	3724	79	1699	7163	966	1612	5571	3509	857	5481	776

Source: Information provided by Officials, MOHFW, Kerala Govt. 2008

- Various categories of human resources have been employed in many facilities under the NRHM on a contractual basis and they have added to the services at these centers.

- As medical officers are deputed as District Program Officers, they are more aware of the issues and are better able to coordinate with the health service.

- The introduction of Compulsory Rural Service for MBBS and postgraduate doctors is major step in providing health care in rural areas. Specialists doing such compulsory service should be posted in CHCs or 24x7 PHCs.

- Efforts should be made to recruit specialists as per requirement in CHCs and PHCs.

- Biomedical engineers employed by the state to maintain laboratory / equipment will improve standards and provide continuous service.

- The NRHM coordinators seem not to be integrated into the health system with some of them not even being given a table and chair to work. They should be better integrated into the health care system.

- Human resource management can be improved. At Kuttichal PHC there was only one doctor as doctors were said to be refusing to work in the area. However, according to the doctor, his wife, also a doctor was posted in another district. Coordination in postings will help the situation.

- Short term (6 month) appointments are given for pharmacists and ANMs and they have to be reappointed through the Employment exchange in Wyanad. Longer term appointments will ensure continuity of service.

- Currently, health personnel are appointed into three different main categories – regular permanent appointments; contractual appointments under NRHM; and under the Compulsory Rural Posting. Placement of entire human resource drawn from different streams need to be taken as common pool and is required to be posted on the basis of existing and potential case load.

6) Infrastructure

- Building and equipment infrastructure is being provided under MP, MLA and Panchayat funds and supplemented through NRHM funding and has improved many institutions.

- The planning and monitoring of new building infrastructure is done at the state level by a special cell- the Engineering wing of the NRHM, Kerala.

- The Engineering wing now ensures that the new building and renovations meet the Indian Public Health Standards; the contract are being given to approved Government institutions and the quality and cost of constructions is being monitored by the special cell at the headquarters.

- There is no master plan for buildings resulting in mushrooming of structures. A detailed assessment of space available prior to constructing new buildings is necessary for optimal utilization and prioritization of available space.

- Panchayats should feel the sense of ownership of sub-centers and regular dialogue between panchayats and health officials is essential.

- Some sub centres (Chulika, Wyanad) had delivery kits/table that were not being used which can be redeployed.

- Equipment bought should be audited for their utilization and the value addition to services. Buildings have been renovated and new buildings have been built through NRHM funding. Further, an audit of space available prior to building new structures is necessary for optimal utilization and prioritization of available space. The use of existing buildings after construction of new ones also needs to be properly planned.

- A state wide emergency ambulance service needs to be established.

7) Empowerment for effective Decentralization and flexibility for local action

- Ward Health and Sanitation Committees have been operationalised.

- The member secretary of the WHSC should be ASHA as per national norms.

- Untied, Annual Maintenance and RKS funds being regularly used to upgrade facilities and services.

- Panchayati Raj Institutions are part of and involved in RKS.

- Panchayats have also been providing funds for sub-center facilities and are involved in their running. However, some panchayats are not paying for electricity and such recurring expenditure leading to lack of supply and the consequent failure of the JPHN to live on the sub-center premises.

8) ASHAs

- In the year 2008 the target was of appointing 8469 ASHAs, nearly 8435 ASHA positions filled and the selection of ASHAs was done by Panchayat and norms for selection followed and many are 10^{th} std pass. For example tribal ASHAs selected from tribal areas.

- Training of 7 days in Wyanad and11 days in Thiruvanthapuram completed.

- ASHAs were confident and aware of the NRHM program.

- Two booklets have been produced to provide information and training to ASHAs in Malayalam. Modules incorporating state specific needs like life style diseases have been prepared.

- The coordination between ASHAs and JPHN is good.

- Remuneration is paid regularly for JSY, immunization, DOTS, NSV, WHND. There is wide variation in remuneration of ASHAs and this seems to be linked to the proportion of BPL/SC/ST families served.

- There is a need to increase the number of activities for which remuneration can be paid (E.g. Follow up of terminally ill patients in the community under the State Pain and Palliative Care program, identification and treatment of leprosy, and for life style diseases).

- Regular drug kits are yet to be provided and replenished for ASHAs.

9) System of Financial Management

- The Government has set up the ebanking facility across the state for the transfer of funds from the state to the district level and to the CHC, PHCs and Sub centers.

- The facility is operational and allows for transparency, audit and speed of operations. (for more details see Annexure) However, this has resulted in the tendency to centralize this service at the district level.

- ASHAs have been issued electronic cards for financial transactions.

- The NRHM supports untied and annual maintenance funds. However, the state has mandated the use of 80% of such funds and the need for SOPs to be in place for replenishing these funds. The failure to meet these criteria occasionally results in the failure to replenish funds for some centres.

10) Health Management Information System and its effectiveness

- The current manual HMIS system and is not meeting the needs.

- The state is in the process of developing new HMIS and the hardware and software are/being deployed and developed. The program is being upgraded to become Web and GIS enabled. It will be able to provide local analysis and feedback to peripheral institutions. However, there are problems in the peripheral institutions and further training is required to improve skills and to change attitudes to computerization of health data.

- There needs to be a Government Order on accountability for the maintenance of the system.

- There need to have nodal information officers at all levels.

- The CHCs and PHCs have computers but many did not have internet access. This should be provided in view of plans to make the HMIS web-enabled.

11) Community Process

- Ward Health and Sanitation Committees meet regularly and maintain minutes.

- The Panchayat provides funds for medicines, electricity, glucometer, etc.

- Some centers did not have electricity due to non payment of bills and the JPHN was not living at some of the center

- There is a need for orienting the panchayat members about NRHM and its services.

- The variation in involvement of different panchayats and their commitment to the functioning of the sub-centers demands regular dialogue between the District Health Officials and local government for better coordination and improved delivery of services.

12) Assessment of non-governmental partnerships for public health goals

- Only one NGO (Institute of Rural Development at Kuttichal) was present in the many institutions visited in Thiruvananthapuram suggesting the vast scope for such collaboration.

- FNGO was providing ultrasound services for tribal patients at Meenangadi, Wyanad.

- Community monitoring is not formally introduced in the state but the increased public awareness in the general population has made a difference.

13) Systems in place for outreach activities of Sub-centre

- WHND days are regularly observed.

- IEC material are innovative and well displayed

- Sub-center kits need to be regularly supplied.

- The wide variation in functioning of centers suggests the need for greater monitoring and supervision.
- There is a need for the regular provision of emergency contraception pills at sub-centers.
- JPHNs need periodic in-service training covering all aspects .

14) Thrust on difficult areas and vulnerable social groups including Tribals

- The total tribals population is around 3,64,189 and they form more around 1.14 % of the State's total population and they belong to 35 communities. Wayanad district with 1,36,062 Tribal population, Idukki district with 50,973 and Palakkad district with 39,665 account for majority of the tribal population of Kerala.
- The coastal belt and tribal area in Thiruvanathapuram district face a shortage of doctors, nurses and 24x7 in-patient and delivery services.

- Services are being provided to tribal areas through the Mobile / Health Staff vists. The tribal areas and mobile health services have fixed days in the week.

- The Sickle cell anemia project targeted at the tribal population in Wyanad district is commendable. This is also implemented in Pallakkad district as well. This may be replicated in other states.

- The Comprehensive Health Care Schemes for the tribal population reimburses all expenses (transport, laboratory, medicine) incurred to the institutions.

- A good weekly health service was being provided at Pancode Tribal Health Camp and other health outposts for the tribal population living in forest.

- Liaison with the Tribal Traditional Birth Attendants will help improve home delivery services within remote forest settlements as it is difficult to bring them into the institutional delivery network.

- There is a need for increased cooperation between the Health and Forest departments in order to set up sub-centers in the region.

- Specific efforts targeted at such vulnerable areas are required.

15) Preventive & Promotive Health Care

- WHSD are regularly observed.

- Untied funds are used by WHSC for source reduction and vector control (E.g. guppy fish and IEC material). The absence of malaria, filarial, dengue and chickunguniya this year may indicate the success of such activities.

16) Maternal, Child Health and Family Planning

- PHCs, CHCs, Taluk hospitals are proving services for family planning.

- However, only a few CHCs are providing 24x7 delivery services and the PHC are also not providing delivery services.

- The public awareness of the JSY and immunization programs and their implementation are satisfactory.

17) Assessment of programme management structure at district and state level

- State Programme Monitoring Support Unit (SPMSU) for National Rural Health Mission, has been set up in 2006-07 with the objective of establishing and

strengthening the management of NRHM in Kerala. The SPMSU is headed by State Mission Director supported with qualified and well experienced Managers and Consultants in different disciplines. The key result areas for SPMSU is effective programme monitoring and management, providing assistance in policy and strategy formulation, supporting implementation of the projects and components of NRHM.

- The district level offices are headed by District Program Managers (NRHM) who is assisted by Accounts Officers, Accountants etc.

- At block level, Block coordinators have been appointed in each health block. Their primary job is to coordinate the activities of NRHM in the concerned block. They ensure the dissemination of information from State / District to health institutions in the block.

18) Pain and Palliative care program for the community

- It is commendable that the state has set up an innovative program for the community to manage terminal illness.

- The nurses and doctors are regularly going into the community to assess and manage people with severe and incapacitating terminal illness.

- The use of volunteers /NGOs and home based care is also commendable. The home based care has reduced the need for institutional in-patient services. (for more details see Annexure)

- The Institute of Pain and Palliative Care at Calicut is very good.

- There is a need to provide financial support to the state to strengthen and expand the P & P C programme.

- The above programme may be replicated in other states.

19) School TC & Health Record

- TC & Health Record Concept- First of its kind in India as a joint venture of the Health, Education, Sports Council and Local Self Government Departments.

- The Record contains comprehensive information on health of the child from LKG to plus two including information recorded during medical camps and counseling. The card contains personal information of the student & family, milestones and tests to measure normal development, BMI charts, examination tables for screening and special medical camps, fitness testing charts, blank pages for added

information, TC, photograph, unique ID number by SSA and a fitness record of each student.

School Health Record

20) Radio Health

- Thiruvananthapuram district has set up a FM radio service which produce a half hour program on health broadcast on 4 days a week through the local All India Radio Station. The program can be heard in 3 districts

- They have equipment and facilities to record these programs which are of a professional quality.

- The radio programs are developed with the help of a large number of local Radio Health Clubs (E.g. formed in schools, colleges, residential associations, cultural groups, ASHAs, etc) who are actively involved in planning and producing programs.

- The mobile 'Kerala Aroygyam' ring tone for all official of the State Health Service which highlights is an innovative ideas which can be replicated in other states.

21) Kerala State Institute of Health and Family Welfare

- The staffing and faculty strength of the centre is poor and impacts on its ability to deliver quality training for the state. The institute under its dynamic director is however conducting regular training programmes.

- While building infrastructure is good, it is yet to be operational.

- There is a need to strengthen the centre and its systems.

2nd CRM Kerala

List of the health facilities visited by the team

Waynad District

Sl. No	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	Taluka HQ Vythiri	Vythri Hospital	Sub District Hospital	Dr. Sashidharan P (Civil Surgeon)
2	Taluka HQ Hospital	Sultan Bathrey	Sub District Hosptial (2 places)	Dr. E P Mohanan (Civil surgeon)
3	Meenangadi	Meenangadi	CHC	Dr. Vijayan (Civil Surgenaon)
4	Chulliode	Chulliode	PHC	Dr. Kunhikannan (MO, Asst Surgeon)
5	Puthenkunnu		Sub - Centre	Ms. Indira (ANM)
6	Baderi	Vaduvanchal	Sub Centre	Ms. Sathybama (ANM)
7	Mepadi	Mepadi	Block PHC	Dr. Anoop (Asst. surgeon)
8	Chulika	Chulika	Sub centre	Ms. Mary Kutti (ANM)
9	Mananthawady	Mananthawady	District Hospital	Dr. Manoj Narayanan)MS)
10	Mananthawady	Mananthawady	Medical Store	Mr. Mohamed (Pharmacist)
11	Porunnannore	Porunnannore	Block PHC	Dr. Ramesh (MO)
12	Nalloornadu	Nalloornadu	CHC	Dr. Balan (MO)
13	Padinjarathara	Padinjarathara	PHC	Dr. Sri Lekha (MO)
14	Mundakutty	Mundakutty	Sub centre	Ms. Geeta Kumari (ANM)
15	Pain and Pallative Care Centre	Calicut	Care Centre	
16	MCH hospital	Calicut	Waste Disposal Treatment plant	In Charge Engineer

Thiruvananthapuram District

Sl. No	Name	Level (SC / PHC / CHC/other)
1	Women and Children's Hospital, Thycaud	Hospital
2	Fort Hospital	Hospital
3	Vizhinjum	Community Health Centre
4	Kesavapuram	Community Health Centre
5	Kanyakulangara	Community Health Centre
6	Kunnathukal	Primary Health Centre
7	Kuttichal	
8	Pulluvalla	Primary Health Centre
9	Pazahayakunnumel	Subcentre
10	Aramanoor	Subcentre
11	Karali	Subcentre
12	Muttukadu	Subcentre
13	Pancode	Tribal Health Camps
14	Kerala Medical Services Corporation Limited Thiruvananthapuram	
15	District Warehouse Thiruvananthapuram	
16	Kerala State Institute of Health Training Centre Thiruvananthapuram	

PAIN AND PALLIATIVE CARE PROJECT

E Banking Initiative in Kerala

Future Projects

Statistical Information

NATIONAL RURAL HEALTH MISSION				
State: NAME Date : DATE				
Sno	Action Point		Source	Qualitative aspects
Administrative structure of the state (as per RHS Bulletin- 2006 published by RHS Division)				
1	Rural Population (in lakhs)		To be filled up as per RHS bulletin	235.74449
2	No.of Districts			14
3	No. of Blocks			152 (234 health blocks)
4	No. of wards			18003 (rural – 16009)
	No of Panchayat			999
Rural Health Infrastructure				
5	Number of District Hospitals		To be filled up as per RHS bulletin	18 (10 district & 8 General)
6	Number of Sub Div. Hospitals –THQH			41
7	Number of CHCs			114 106 (RHS)
8	Number of PHCs			931 911 (RHS)
9	Number of SCs			5094
10	Number of Aanganwadi Centres			25382
11	Number of WHSC Constituted & Operational Ward Health and Sanitation Committee		To be filled up by state	18003
12	IMR	SRS 2005	As per published statistics	14
		NFHS 2006		
		SRS 2006		15
		SRS 2007		13
13	MMR	NFHS 2006		NA
	MMR	SMMR 2003		110 (DHS data-2007 : 32)
14	TFR	SRS 2005		1.7
		NFHS 2006		1.93
15	Sex Ratio			1058

16	Unmet Need			9
Institutional Framework of NRHM				
17	No. of meetings of State Health Mission held till date (06-07)		To be reported by the state	0 *
	No. of meetings of State Health Mission held till date (07-08)			1
18	Total No. of meetings of District Health Missions held till date (06-07)			0 *
	Total No. of meetings of District Health Missions held till date (07-08)			14
19	Merger of Societies	State level Y/N		Y
		No of Districts		14 100 %
20	No of Hospital Management Committees (Rogi KalYan Samitis registered)	DH		18
		CHCs		114
		PHCs		931
21	MoU with Government of India signed			Yes
Appointment of ASHA/Link Workers (as certified by training division)				
22	Total No.of ASHA to be selected over the Mission period		To be reported by the state	32753 (Sanctioned in 2007-08 in lieu of 2nd ANM)
23	No. of ASHA selected during (including ASHA in tribal areas in Non-High Focus States)	05-06		0
		06-07		0
		07-08		8435
		08-09		11945
		Total		20380
24	Training Calender of ASHA finalised (Y/N)			Y
25	Total Number of Link workers other than ASHA selected	2005-06		-
		2006-07		
26	No. of ASHA s who have received training	1st module		14035
		2nd module		5500
		3rd module		-
		4th module		-
		5th module		-
27	No. of ASHAs who are in position with drug kits			Nil (Procurement process started)
28	Total No of Monthly Health Days held till date in the state 06-07	Expected		
		Achieved		NA

	Total No of Monthly Health Days held till date in the state 07-08	Expected		-
		Achieved		10000
	Total No of Monthly Health Days held till date in the state 08-09	Expected		192108
		Achieved		5608
Infrastructure & Manpower				
Sub Centres (SC's)				
29	No. of SCs in Govt. Building (as per RHS Bulletin-2006)		RHS bulletin	2986 (RHS)
30	No. of SCs which are functional with at least one ANM		To be reported by the state	5094
31	No. of SCs which are functional without ANM (as per RHS Bulletin-2006)			0 118 (as per RHS)
32	No. of SCs where Joint Account with has been Operationalised			5094 100 %
33	No. of SCs with additional ANMs			0 (ASHA sanctioned in lieu of 2nd ANM)
34	%of SCs which have submitted UC for untied funds released (05-06)			81 %
Primary Health Centres (PHCs)				
35	Total No. of PHCs functioning on 24x7 basis	as on 31/3/2004	To be reported by the state	
		during 05-06		
		during 06-07		87
		during 07-08		105 (135 at present)
36	No. of PHCs where three staff nurses are positioned			213
37	No. of PHCs without a Doctor (as per RHS Bulletin-06)		RHS Bulletin	0 (as per RHS 2006 - 396)
Community Health Centres (CHCs)				
38	Total No. of CHCs selected for upgradation to IPHS		To be reported by the state	114
39	Total No. of CHCs where facility survey has been completed			114
40	No. of CHCs where physical upgradation work has been taken up	Identified		114
		Started		63
		Complete		10

41	Total Specialist post at CHCs (as per RHS Bulletin-2006)		Required		456 (as per RHS 2006 -424)
			Sanctioned		56
			In Position		82 (RHS)
First Referral Units (FRUs)					
42	No. of FRUs working as on 31/3/2005		DH and General Hospital	To be reported by the state	13
			SDH (THQH and Govt Hospital)		39 (15+23+1)
			CHC		8
			W and C		5
			PHC		0
43	No. of centres upgraded as FRUs (05-06)		SDH		0
			CHC		0
			PHC		0
44	No. of centres to be upgraded as FRUs (08-09)	SDH	Expected		42
			Achieved		39
		CHC	Expected		17
			Achieved		8
		PHC	Expected		0
			Achieved		0
District Hospitals					
45	Number of District Hospitals			RHS Bulletin	18
46	No. of DH which are of FRU level			To be reported by the state	17
47	No. of DH where physical infrastructure is being upgraded				12 (at present)
Availability of Consumables					
48	%of centres with at least 2 month supply of essential drugs	CHCs		To be reported by the state	100 %
		PHCs			100 %
		SCs			Drug kits will be supplied by GOI
49	%of centres with at least 2 month supply of vaccines	CHCs			DPT, Hepatitis B inadequate supply, DT not available. Polio, BCG, measles available.

		PHCs			DPT, Hepatitis B inadequate supply, DT not available. Polio, BCG, measles available.
		SCs			DPT, Hepatitis B inadequate supply, DT not available. Polio, BCG, measles available.
50	%of centres with at least 2 month supply of contraceptives	CHCs			100
		PHCs			100
		SCs			100
Manpower					
51	No. of contractual manpower positioned	Specialist	Expected	To be reported by the state	0 (At present 200)
			Achieved		169
		Doctors	Expected		790
			Achieved		746 (CRS + Contractual)
		SN	Expected		3000
			Achieved		1456
		ANM	Expected		0
			Achieved		0
		Others	Expected		Depending on NABL accreditation
			Achieved		103
52	PMU setup at State level(Y/N)				Y
53	No. of Districts where PMU set up				14
54	No. of Districts where the PMU has persons	Accounts			12
		Managerial			14
		MIS			14 (existing Statistical wing in District is in position, further, Jr.Consultant (Docu) is being recruited
55	No. of Blocks where PMU set up				234
Institutional Delivery					
56	No of Institutional Deliveries as per NFHS-III			Published data	100 %
57	No. of Institutional Deliveries (in lakhs)		05-06	To be reported by the state	5.79
			06-07		5.43
			07-08		5.38
58	No.of beneficiaries of JSY (in lakhs)		05-06		0.20
			06-07		0.59
			07-08		1.93 (1.62 reported earlier)
59	No.of pvt institutions accredited under JSY		Exp.		621
			Ach.		277

Decentralised Planning					
60	PIP Received (Y/N)		2006-07	NRHM Division	Y
			2007-08		Y
61	Perspective Plan of the State Mission Period received (Y/N)				N
62	Date by when Perspective State Action Plan under NRHM shall be finalised for Mission Period			To be reported by the state	N
63	No. of Districts where Annual Integrated District Action Plan under NRHM prepared for 07-08				14
Immunisation					
64	Number of Polio Cases during 06-07			To be reported by the state	0
	Number of Polio Cases during 07-08				0
65	% of fully immunised children		NFHS-I	Published data	54
			NFHS-II		80
			NFHS-III		75
			CES 05		82.1
			CES 06		87.9
66	No. of Children vaccinated (in '000s)	BCG	since Apr 08	To be reported by the state	298069
			During last month Oct 08		45328
		DPT	since Apr 08		257242
			During last month Oct 08		41041
		Measles	since Apr 08		278700
			During last month Oct 08		43908
		Full immunization	since Apr 08		265975
			During last month Oct 08		38553
67	No of Districts where AD (.1ml, .5ml & 5ml) syringes are NOT available				0
Others					
68	No. of Districts where mobile medical units are working			To be reported by the state	7
69	No. of Health Mela held)		05-06		0
			06-07		0
			07-08		108

		08-09		13
70	No. of beneficiaries of Male Sterlisation 06-07	Exp		4600
		Ach		875
	No. of beneficiaries of Male Sterlisation 07-08	Exp		3739
		Ach.		1597
71	No.of beneficiaries of Female Sterlisation 06-07	Exp.		157804
		Ach		129014
	No.of beneficiaries of Female Sterlisation 07-08	Exp		128491
		Ach.		122528
72	No. of cases in prosecute of PNDT launches			0
73	No. of cases in which action has been taken under PNDT			0
74	No of districts implementing IMNCI			5
75	No of People trained on IMNCI till date			3 (TOT)
76	Funds released for selection of MNGOs 06-07 (Rs. in Lakhs)			90
77	Total No. of MNGOs in the state	as on 31-3-2004		
		Selected during 2005-06		10
		Selected during (06-07)		4
		Total		14
Ayurveda Yoga Unani Siddha Homeopathy (AYUSH)				
78	No. of PHCs where AYUSH practitioners have been co located (05-06)	Exp.	To be reported by the state	0
		Ach.		0
79	No. of PHCs where AYUSH practitioners are being co located (06-07)	Exp.		0
		Ach.		0
80	Whether AYUSH officer included in (Y/N)	Health Society		Y
		State Mission		Y
		Rogi Kalyan Samities		N
		ASHA Training		N
81	No. of AYUSH Doctors Posted on contractual appointment	CHCs		0
		PHCs		0
82	No. of AYUSH Paramedics posted on contractual appointment	CHCs		0
		PHCs		0
83	No. where AYUSH facilities is co-located	DH		0
		PHCs		0
		CHCs		0
84	AYUSH components included in NRHM PIP			Y

85	Funds sanctioned for AYUSH schemes during (In Lakhs) (as reported by DO AYUSH)		2006-07		
Financial Matters					
FINANCIAL MANAGEMENT UNDER NRHM					
86	Allocation in State budget for health & Family Welfare	2005-06	Amount in Rs in crore	To be reported by the state	1171.70
			% of total State Budget		4.18
		2006-07	Amount in Rs in crore		1295.57
			% of total State Budget		4.10
		2007-08	Amount in Rs in crore		1421.64
			% of total State Budget		3.65
		2008-09	Amount in Rs in crore		1543.13
			% of total State Budget		3.73
FINANCE REPORT IS ATTACHED SEPERATLY					
National Leprosy Eradication Programme					
105	Prevalence Rate/ 10,000			As reported by the state	0.23
106	Annual New Case Detection Rate /100,000				1.31
107	Among newly detected cases		Multi Bacillary%		63.20
			Female%		33.86
			Child%		8.35
			Visible deformity%		10.83
National Programme for Control of Blindness					
110	Total Cataract Surgeries in 06-07 (in lakhs)			As reported by the state	0.98
111	% Achievement				98%
112	#Intra Ocular Lens (IOL) implanted 06-07				93545
113	% IOL				93.5%
114	No. of School going children 07-08		Screened (in lakhs)		16.6765
			Detected with Refractive Errors (in lakhs)		0.5299
			Provided free glasses (in lakhs)		0.2001
115	Eye Donations in 2005-06				727
116	Eye Donations in 2006-07				786
	Eye Donations in 2007-08				992
National Vector Borne Diseases Control Programme					
117	Annual Blood Examination Rate for malaria (per 100 population)			As reported by the state	5.85
118	Annual Parasitic Incidence of malaria (per 1000 population)				0.058
119	Deaths due to Malaria				6

120	Cases of Kala azar		0
121	Deaths due to Kala azar		0
122	Confirmed cases of Japenese Encephalitis		2
123	Deaths due to Japenese Encephalitis		0
124	Dengue Cases		677
125	Deaths due to dengue		12
126	No of confirmed cases of Chikungunya		909C
National Iodine Deficiency Disorder Control Programme			
127	No. of Districts Surveyed	As reported by the state	14 + 6 (Resurveyed)
128	No. of Endemic Districts		14
129	Total No. of samples of iodised salt collected in 05-06		358
	Total No. of samples of iodised salt collected in 06-07		804
	Total No. of samples of iodised salt collected in 07-08		809
	Total No. of samples of iodised salt collected in 08-09		350 (upto July)
130	No. of Samples of iodised salt found confirmed to the standards		
	Confirmed (05-06)		228
	Confirmed (06-07)		487
	Confirmed (07-08)		441
	Confirmed (08-09)		262 (upto July 08)
National Tuberculosis Control Programme (3rd Quarter 1st July to 30th September 2006)			
131	% of TB suspects examined out of total new adult out-patient (target 2%-3%)	As reported by the state	2%
132	Annualized total case detection rate(per 1 Lakh Population)		76 / lakh population/year
133	Annualized new smear positive case detection rate (%)		64 %
134	Success rate of new smear positive patients (in %)		83 %
Integrated Disease Surveillance Programme (IDSP)			
135	Setting up of State surveillance Unit	As reported by the state	1
136	Setting up of District surveillance Unit		14

137	Establishment of EDUSAT Centre		15 (1 VSATSSU + 7 VSAT MCH + 7 Brad band)
138	Training of trainers		77

Acknowledgments

We take this opportunity to thank the entire team of officials from the department of health for their unstinting support and assistance in facilitating the visit of the CRM 2 team to the State of Kerala to observe the functioning of the National Rural Health Mission. To each one of us the visit was very beneficial and enriching.

We would also like to thank the office of the Mission Director, District officials in Thiruvantahpuram and Waynad districts for facilitating the field visits and interactions with various functionaries at the State and district levels. The enthusiasm of the official's right from the Secretary to the ASHAs in the villages was very infectious and encouraging. It gave a very positive view of the strengthening of the public health services.

We are not naming specific officials who contributed towards making this mission successful since there were too many of them who participated in the mission in a team spirit. We very much appreciate the kind assistance in arranging a suitable programme. We would like to express our gratitude for the courtesies

extended to the team during our stay. Many of the officials went out of their way to make our travel and stay comfortable.

May the spirit of the 'Arogya Keralam' spread beyond Kerala in the provision of health care services.

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Checklist for preparation of report				
2nd CRM 2nd Common Review Mission				
Sno	**Item**		**Done or Not**	**Remarks**
1	In title Chapter mention addresses & emails of officials		√	
2	Complete list of the facilities visited by the team should be compiled in the format given in the ToRs		√	
3	State specific mandate of the CRM articulated in the report			It is too huge
4	Are all the aspects mentioned in the chapter on findings of the 2nd CRM included in the reports. These include :			
	1	Assessment of the case load being handled by the Public System at all levels	√	
	2	Preparedness of health facilities for patient care and utilization of services		Incorporated in above section
	3	Quality of services provided	√	
	4	Diagnostic facilities at facilities and their effectiveness	√	
	5	Drugs and Supplies	√	
	6	Health Human Resource Planning	√	
	7	Infrastructure	√	
	8	Empowerment for effective decentralization and flexibility for local action	√	
	9	ASHA	√	
	10	Systems of financial management	√	
	10	HMIS and its effectiveness	√	
	11	Community Processes under NRHM	√	
	12	Assessment of non-governmental partnerships for public health goals	√	
	13	Systems in place for outreach activities of Sub-centre	√	
	14	Thrust on difficult areas and vulnerable social groups	√	

	15	Preventive & promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health	√	
	16	Effectiveness of the disease control programmes including vector control programmes		
	17	Performance of MCH & Family Planning seen in terms of availability of quality of services at various levels	√	
	18	Assessment of programme management structure at district and state leve	√	

MADHYA PRADESH

Report on CRM Madhya Pradesh

Index

Executive Summary

As part of the visit, before going to the districts, the CRM team met with the State authorities on 16th December 08 and briefed them about the overall implementation of NRHM.

The briefing included presentations by the State programme officers for the various national programmes. The team also discussed the districts to be visited. It was suggested to visit the two districts viz. Khargon and Chindwara, but in view of the fact that the team consisted of only four members, of which one had to leave early, it was felt that it would not be practical to split into two teams. Chindwara district was felt to be inappropriate for the visit under the because of the logistic impossibility.

The Mission Director was keen that Khargon block was to be evaluated because of the fact that, though it is a backward tribal district, there had been the focus of especial efforts to implement the NRHM in the district. The team therefore decided to visit Khargon to do an extensive evaluation and pick another adjacent (unprepared) block to get a more comprehensive view of the progress of NRHM implementation in Madhya Pradesh. Therefore, instead of Chindwana it was decided to visit Dhar District. The team visited Khargaon and Dhar Districts of Madhya Pradesh.

During the visit it was observed that, since the implementation of NRHM in MP, a visible change is seen in the public health delivery system, especially in improvement of the health facilities due to the financial empowerment of the health functionaries. The presence of ASHA in each village has lead to an increase in the utilization of public health facilities, especially under the JSY scheme, although quality of care provided still remains an issue. The increase in number of JSY beneficiaries is not yet corresponding with similar increase in family planning acceptance due to various reasons including shortage of trained manpower.

The awareness about NRHM in the general public and the stakeholders in the villages was found to be very low which defeats the main purpose of the scheme/mission! Sensitization of all the stakeholders needs to be addressed on an urgent basis for proper, desired and efficient utilization of services and to bring about positive change in the public health system as envisaged in the mission.

As observed in the field, the funds movement till the block levels has been streamlined through electronic transfer but the disbursement of incentives to the ASHAs remains a major issue to be sorted out. A backlog of 4-5 months in most cases was seen, they had to travel to block headquarter for their payments. The record maintenance needs attention, as it was possible to verify the claims of each ASHA in many centers.

The acute shortage of electricity and water supply was seen in almost all the facilities especially in PHC and SHC level. Although inverters were provided in all the places but they could not charged due to very low electricity supply.

The replenishment of the drug kits given to ASHAs needs to be streamlined.

The programme management staff in place was not clear about their roles and responsibilities; hence it was not possible to measure their output.

The involvement of NGOs in the districts visited was negligible. Their involvement in community monitoring, capacity building of village health committees could be utilized to increase effective utilization of health systems.

The NRCs in the District Hospitals visited were a very encouraging endeavor to tackle the issue of malnutrition in the area.

Integration of various programmes has still not taken place.

Many innovative schemes were seen on the ground of which the most visible was "Janani Express"for transporting patients to the hospital; all the ASHAs and other health functionaries were using this facility. A scheme of insurance for BPL families for treatment at private facilities within a limit of 20,000 per family is in place.

There are mobile medical units under PPP known as Deen Dayal Chalit Aspatal, which are providing OPD services in remote villages on fixed days.

Many private hospitals and nursing homes have been accredited for institutional deliveries and caesarean sections under PPP.

The report provides detailed information of various health facilities visited in both Khargaon and Dhar districts of Madhya Pradesh as well as the observation on key Community Processes with a set of actionable recommendations, which are as follows:-

Capacity Building of Support System

- **Capacity Building of CMHO, SPMU and DPMU along with State functionaries on Implementation Framework and Financial Management of NRHM**
- **Advocacy on NRHM Strategic Milestones with the effective engagement of multiple stakeholders from Government, NGOs and Private Sector involving intersectoral coordination within various programme managers of health department**
- **Capacity building on HMIS involving SPMU, DPMU and Concerned functionaries for effective monitoring, reporting and documentation**
- **Capacity building of state functionaries along with SPMUs on 'Advocacy on intersectoral coordination under NRHM' is suggested for maximizing intended benefits of convergence of services at the implementation level.**
- **Capacity building for institutional strengthening of support systems for more than 20,000 ASHAs (as in the case of Madhya Pradesh) should be made in place for effective facilitation of 1 ASHA coordinator for 10 to 12 ASHAs as per guidelines outlined under NRHM strategic implementation framework, GOI.**

Programme Management

- **Operationalisation of District Health Society and district management team including deployment of District Community Mobilization Coordinators need to be addressed in bridging the gaps between Community processes – ASHA Strengthening, VHSC functioning, use of untied fund, "Rogi Kalyan Samiti/Hospital Management Committees" and District PMUs for effective coordination of programme management operations. This will surely facilitate the field visit and field level input to the programme management in the state.**
- **Approval of pending commitments along with availability of guidelines on VHSC, use of untied fund, information on integrated compensation package for ASHAs, functioning of VHNDs will ensure effective linkage among ASHA operations, NGOs and government health functionaries. This will contribute to sustain the ongoing effort on Community Processes in the state.**
- **Establish mechanism for facilitation of ASHA Support Systems as per the GOI guidelines for the states having more than 20,000 ASHAs starting from Block level of Facilitation for 10-12 ASHAs and ASHA Resource Center at the State level.**

PIP Revision & Health Planning

- **Strategic planning and inclusion of suggested recommendations in the revised PIP is critical for Sustaining of ongoing effort under NRHM involving multiple stakeholders from Disease Control Programme and District Health Society**
- **Prioritization of system strengthening efforts needs to be executed along with strengthening capacities of support system for effective utilization of health services and health systems in the state. Key components under this should be placed as programmatic priority with appropriate budgetary request in the revised PIP.**
- **Emphasis should be given to the preparation of District Health Action Plan involving multiple stakeholders from various disease control programmes and District Health Society**
- **Selection, deployment and training of ASHA Team coordinators for 12-15 ASHAs with adequate support systems involving BPMU & DPMU is critical for ensuring effective support systems measures at the state level through 'ASHA Resource Center' with clearly delineated 'Terms of Reference' and revised work plan as per the requirements of District specific facilitation of support systems strengthening. This should be reflected in the revised PIP to ensure the revised requirements for strengthening of support systems for key community processes under NRHM.**

Governance Issues

- **Issues of "Governance of NRHM" and ownership of health department are critical and need immediate attention of the state authority to address.**

- **Continuity of Mission Director in the state for providing strategic direction to SPMU and effective implementation of NRHM.**
- **Functional coordination between department of Health & NRHM with appropriate support systems for coordination of technical assistance within the state**
- **Clearly delineated reporting responsibilities, review system, financial accountability and performance management system needs to be streamlined**
- **Functional merger of Disease control programmes with District Health Society with clarity on physical and financial reporting responsibilities**
- **Concept of 'joint programming and review system for effective coordination ensuring supportive supervision and 'on the job' facilitation support at all level of utilization of health services systems and facilities**

System Strengthening

- Ensure availability and maintenance of Village Blindness register to HSC
- Ensure maintenance of MCH register with supportive supervision periodically
- Ensure that Nodal officer for M&E is designated at the BMOC and CMOC facilities
- Ensure that various Guidelines for VHC, HMS, untied fund, Annual maintenance Grant, Waste disposal guidelines, infection control & waste management guidelines, Specification of pits are disseminated and oriented to concerned health officials for effective implementation and on the job supportive supervision
- Ensure that regular monitoring visits conducted by the PHC in-charge of the nearest PHC where the MMU is functional as per the root chart
- Ensure that various data collected at the MMU are analyzed with the involvement of MOIC of the nearest PHC and these data are fed into district specific coverage with appropriate feedback on various diseases addressed

ASHA Effectiveness

- Ensure Functional coordination among ASHA, ANM, AWW and MOIC
- Ensure availability of Information about Integrated compensation package for ASHA with ASHA, ANM, MOIC or DPM/DAM/BAMs.
- Ensure availability of ASHA dairy along with compensation details to all ASHAs
- Ensure effective linkages with health system, ASHAs & DPMU in facilitation of ASHA support systems at all levels
- Ensure effective facilitation of support system at the dist & sub-district level prior to the implementation of key community processes with active involvement of 'ASHA Resource Center' in the State with an well defined TOR for capacity building and coordination of technical assistants from time to time
- Ensure availability and provision of ASHA incentives at the SHCs instead of at the Block level PHCs

- Ensure timely deployment of support systems at the dist & sub-district level along with the strengthening of 'ASHA Resource Center' in the State

Community Process

- Ensure use of untied fund for SHCs and VHSCs appropriately
- Initiate appropriate review mechanism for RKS through periodic meeting with brief minutes and sharing of decisions taken to all the members with active involvement and clarity in decisions taking processes
- Ensure availability of various guidelines pertaining to community processes to MOIC, ANM, AWW and DPMUs/BAM as per their involvement
- Ensure streamlining of incentive payment systems for ASHAs and refilling of drugs in the drug kits
- Ensure that the formal training and orientation with adequate facilities for handholding is conducted urgently for all district level officers and DPMUs/BAM and key district stakeholders including administrative officers
- Ensure availability of resource trainers from NGOs at the Training Centers and District Health Society for functional effectiveness and facilitation of Training support at the district and block level
- Ensure involvement of Health functionaries and trainers from the Training institutes, and also ensure that ANM training centers are involved in training of ASHAs, VHSC and related Community Processes under NRHM
- Design and development of comprehensive IEC/BCC strategy involving DPMU, NRHM and disease control program managers

- Ensure capacity building of Block Account Managers for streamlining financial management support system for key community processes under NRHM

- **Ensure development of District specific mechanism of reviews for key community processes (ASHA, VHSCs, VHND and functioning of RKS) with involvement of health professionals and DPMUs and BPMUs**

REPORT OF COMMON REVIEW MISSION'S VISIT TO STATE
Madhya Pradesh State Report (Period of visit: w.e.f. 15.12.2008 to 21.12.2008)

Common Review Mission was set up by the Government of India with the objective of taking stock of the progress made for the implementation of the PIPs during the following years 2008-2009, highlights of key strengths in the health system in the state, along with the identification of key implementation bottlenecks and delineation of corrective measures needed as observed during the visit of the state of Madhya Pradesh as described in the detailed report.

The members of CRM team were assigned to visit the state of Madhya Pradesh and submit the report to Ministry of Health, Government of India. The Madhya Pradesh CRM team comprises of following members-

Composition of team

Shri Javed Chowdhury, Former Secy. FW, MOHFW, GOI

Dr. Kiran Ambwani DC(FP) MOHFW, GOI
Dr. L.M.Nath, Former Director, AIIMS
Dr. Manoj Kar, Advisor, NHSRC

Process: The process followed was as per the TOR of the CRM prepared by GOI and discussed on CRM, briefing on 15 Dec. 2008 at MoH & FW, New Delhi.

State provided the information about the overall implementation of NRHM, as communicated earlier, to the visiting team on 16th.December 2008. NRHM State Team also involved in selection of specific facilities under each districts for the team for conducting field visits to service delivery facilities and to capture perspectives from key stakeholders including local community & beneficiaries. The facilities for Khargon district were chosen keeping in view the notification of one backward block, situated in remote area and another block connected by highway as consulted with state authority, CMHO and Program management team in the district**.**

Team:

This team consisted of above members was accompanied by Joint Director, Health Department, CMHO, DPM unit, ASHA Program Manager, Consultant, Quality Assurance, District IEC officer and State Facilitator, Community Participation, NHSRC.

Facilities visited:

i. 1 Dist. Hospital and CMHO Office cum DPMU, Khargon
ii. 1 ANM Training Centre, Dhar
iii. 1 Dist. ICTC Services Centre, and Blood Testing Center, Khargon
iv. Regional Director, HFWTC, Indore
v. 8 Primary Health centres (7 BEmOC PHCs & 1 Addl. PHC)
vi. 2 CHC and CEmOC
vii. 5 Health Sub Centres
viii. 2 Mobile Medical Unit
ix. 1 AWC
x. 4 PRIs members involved in NRHM
xi. Around 50 ASHAs

As per briefing by the Commissioner FW & Mission Director (NRHM) and input to the feedback from the field was shared along with major recommendations and consensus achieved on these specific observations from the districts. On behalf of the State some assurances were given to the actions to be undertaken for the effective implementation of the activities in the end of CRM feedback presentation, which was attended by the state officials presided over by the Commissioner FW & Mission Director (NRHM).

REPORT OF COMMON REVIEW MISSION'S VISIT
Focus on NRHM, Madhya Pradesh

Objective: **To assess the performance of NRHM with emphasis on achievements and challenges of its impact on the successful implementation of various health activities in the state.**

Details of visits :

District Kahargone Day 2- 3	**CMHO Office** District Programme Management Unit District ICTC Services Centre	**6 PHCs** BEmOC PHC Padalia BEmOC PHC Karhi PHC Pipalyabujurg BEmOC and Sector PHC Bamnala Block PHC & BEmOC Unn BEmOC PHC-Segaon	5 Health Sub Centres, 1 VHSC 1 AWC in NRHM 1. SHC Dodwa , Block : Bhikangaon **2.** SHC Bablai , Block : Maheshwar 3. SHC Kavadiya , Block : Maheshwar 4. SHC Lalkheda, Block : Bhikangaon 5. SHC Thibgaon , Block : Gogawan 6. Village gogariakhedi	**Distt. Hospital** **MMU – Mobile Medical Unit,**
District Dhar (Day 4)	ANM Training Centre	(2 PHC, 1 CHC) BEmOC PHC Nalchha BEmOC PHC Amjhera CEmOC CHC Sardarpur	-	**MMU at Sardarpur**

NRHM Common Review Mission is an opportunity to understand the success of implementation of NRHM in the state while identifying key strengths of the programme and highlighting ongoing challenges for the health system to effectively respond to these challenges in the state.

Key Strengths and Positive Observations:

- Health infrastructure and related materials are in place with increased in service utilisation in majority of the facilities visited

- Availability of drugs in the health facilities
- Untied fund in the HSC has reached and expenditure has also been done
- Except for one PHC increased outpatient and delivery services were significant
- Certain health facilities are keeping good records
- ANMs are doing deliveries in some of the health facilities and some of them are SBA trained at SHCs visited
- Use of RKS has reached the BMOC and CMOC facilities
- Deen Dayal Mobile Medical Unit is operational for hard to reach tribal and non-tribal areas and community
- Community Monitoring is understood to Senior Management at the State level
- ASHAs interacted with, have a good knowledge, active and well motivated and most of them are involved in JSY and Immunization and Family planning activities
- Weighing machine (adult) are available at the SHCs visited
- ASHAs having an Identity card in Khargon District, all have drug kits
- ICTC facilities are available in the Distrcit Hospital
- PDC trained doctors are available in some of the CMOC and BMOC Facilities
- NSV trained MO available at one of the CMOC facility in Dhar
- Multi skilling of lady doctor has resulted in MTP and C-Section-CMOC
- Fixed day sterilization services are being provided at the BMOC and CMOC Facilities
- Blood bank services are available at the Dist Hospital
- Bed occupancy of Dist Hospital was found to be fully utilized
- IDSP unit at the District level is functional
- Toilet facilities with cleanliness is observed within the health facilities

General issues, which need to be addressed:

- No signage of NRHM seen outside institutions and NRHM inadequately highlighted in signs even at health facilities at all level
- Adequate facilities for Electricity and water supply is an immediate priority
- Quality assurance committee at various health facilities not formed
- Uninterrupted supply of electricity and water supply needs to be provided in HSCs and PHCs (Generators and inverter provided at some)
- Proper Data collection and importance of data collection needs to be informed to the health provider
- Preparation of District Health action Plan is nether understood nor shared with the team nor known to health officials including DPMU
- Data analysis needs to be done on a regular basis in keeping MOs in the loop
- Various Guidelines for VHC, HMS, untied fund, Annual maintenance Grant, Waste disposal guidelines, infection control & waste management guidelines, Specification of pits needs to be disseminated and oriented to concerned health officials for effective implementation and on the job supportive supervision
- Mosquito breeding in Water bodies needs to be looked into
- Bed occupancy is poor in BMOC and CMOC facilities
- Rationalization of manpower to overcome shortage of human resources for health
- ECR are not available
- IEC/BCC needs urgent attention including signage at the health facilities
- Village Health Sanitation Committees has not been implemented as per the guidelines

- Condemnation of various articles needs to be done at the earliest (Dhar)
- Constitution and functioning of Committees for RKS is not as per the guidelines
- GIS mapping of health facilities is not available
- Location of any new facilities should be chosen keeping in mind the needs of hinterland populations
- No RTI/STI services are provided at 24X7 BMOC and CMOC facilities
- IUD services are not made available at HSCs
- Incinerator was not seen in any of the facilities visited for use of Biomedical waste management and infection control measures
- Counselors orientation & training is critical to the quality of counseling for pre & post test counseling for HIV
- Referrals for counseling from ANC, STI/RTIs and voluntary counseling for youth friendly information services is not performed in the ICTC nor even reflected in the register
- No evidence of availability of Adolescent/Child friendly health information and services

Issues related with ASHAs:

- Functional ASHA coordination between ANM, AWW and MOIC needs to be strengthened
- Information about Integrated compensation package for ASHA is not available with ASHA, ANM, MOIC or DPM/DAM/BAMs. In addition to information at several meetings suitable documentation should be provided to ASHAs
- JSY guideline still not clear to the health providers leading to delay in release of incentives to ASHAs
- System of replenishment of drug kit is not in place
- ASHA dairy along with compensation details should be made available to all ASHAs
- Linkages with health system, ASHA involved & related activities and DPMU involvement in facilitation of ASHA support needs to be streamlined
- Support system need to be put in place at the dist & sub-district level prior to the implementation of key community processes with active involvement of 'ASHA Resource Center' in the State with an well defined TOR for facilitation of support systems at the state level
- Availability of ASHA incentives should be facilitated at the SHC instead of Block level
- Support system need to be put in place at the dist & sub-district level along with the strengthening of 'ASHA Resource Center' in the State

Issues related with community processes:

Hospital Management Society (HMS)/RKS

- Membership/meetings/functioning of RKS should be as per guideline
- Availability and orientation of RKS guideline for various health providers
- Sensitization of the Member on the scope of the functioning of RKS

- Fund utilization as per guideline, and periodic meeting with appropriate minutes and sharing of decisions taken to all the members with active involvement and clarity in decisions taking processes

Village Health & Sanitation Committees

- VHSCs should be constituted as per the guidelines
- ANM should involve in constitution and orientation of VHSC members
- Linkages of VHSCs with HSC and AWC with the involvement of ASHAs
- Orientation of key stakeholders for strengthening of VHSCs

Village Health & Nutrition Day (VHND)

- Guideline should be made available to MOIC, ANM, AWW and DPMUs/BAM
- Orientation of VHND key stack holder including ASHAs
- Facilitation of inter-sectoral convergence through VHND

Pilot on Community Monitoring

- Objective and scope of community monitoring should be made available to the health functionaries at all level
- Interface between community monitoring team, health functionaries & NGOs
- Feasibility of impact of Community monitoring
- Involvement of ASHAs in the processes of community monitoring

NGO involvement

- Involvement of NGO is negligible even not visible
- Govt. NGO cooperation in strengthening provision of ASHA support system with adequate mentoring of grassroots facilitation
- Rolling out of module 5th involving NGOs
- Streamlining of incentive payment system and refilling of drugs and documentation of community based innovations

Mobile Medical Unit

- Various test are being conducted and diagnosis is made but the list of these patients should be shared with ANMs and PHC (BMOC) in charge of the respective area
- Monitoring visits need to be conducted by the PHC in-charge of the nearest PHC where the MMU is functional as per the root chart
- Various data collected at the MMU needs to be analyzed with the involvement of MOIC of the nearest PHC and these data should be fed into district specific coverage with appropriate feedback on various diseases addressed

Training Issues

- Formal training and orientation with adequate facilities for handholding should be conducted urgently for all district level officers and DPMUs/BAM and key district stakeholders including administrative officers
- Formal training and orientation with adequate facilities for handholding should be conducted urgently for all PRIs
- Training needs assessments should be done prior to organization of any types of Training. The training programmes & strategies should be linked to functional effectiveness
- Identifying the training load and Training target should be assessed in terms of feasibility
- A comprehensive training plan needs to be prepared and periodically followed up with the training calendar
- Regular facilitation and handholding of on-going trainings
- Resource trainers from NGOs should be made available at the Training Centers and District Health Society for functional effectiveness and facilitation of Training support at the district and block level
- Involvement of Health functionaries and trainers from the Training institutes, ANM training centers should be involved in training of ASHAs, VHSC and related Community Processes under NRHM
- Use of IT in imparting training

ANM Training Center-Dhar District

- **Very shabby, no boundary wall and greatly in need of repair of water supply facilities**
- **ANM training center, Dhar is located nearer to premises of the District Hospital. There are three faculty with three faculty vacant positions including permanent principal and public health teacher**
- **There are 9 number of student vacancies in the ANM training center however only 41 have been admitted. The team inspected the training center, hostel facilities and bath room, kitchen, water sanitation, classroom and availability of teaching aid with no computer facilities.**
- **Pre service IMNCI training should be included in the curriculum.**
- **There is no full-fledged MCH lab. The library is on the first floor and it appeared that the books have been recently kept.**
- **The teaching aid is only chalk and board. TV was told to us as functional but it was not in regular use.**
- **Kitchen was also inspected and found to be in good condition.**
- **There is no boundary for the ANM training center with no watchman which is a security concern.**
- **Center needs strengthening in terms of faculty, facilities, tools and techniques**
- **Pre service IMNCI curriculum needs to be integrated in the training**
- **Use of training center for conducting district level trainings under NRHM including NACP**
- **HFWTC should act as 'Repository of Resources' with active coordination with NRHM – Team for supporting all types of training in the state**

A) Detailed observations from the Khargon district:

a) District Hospital Khargon & CMHO Office:

- Very good team spirit in DPSU and all Health officials
- CMHO and civil surgeon are observed to be committed during the interaction
- IDSP unit is functional
- Neat and clean hospitals and the NRC is functionally effective
- MOs met are enthusiastic about NRHM
- ICTC counselors (Male Female) are in place and well qualified.
- Well demarcation for different facilities.
- Trained and skilled manpower to support health service facilities
- RKS is functional
- Most of the Guidelines relating to NRHM implementation are available
- ASHA training up to module IV is completed including provision of modules
- Accounts keeping and request for utilization and compilation of district specific coverage is well coordinated.

1.1 BEmOC PHC Padalia:

- Basic Facility
- Water and electric facility available, RKS not available

- No lady Doctor
- No compensation information – in most cases a group of 10-12 ASHA

revealed that their knowledge about roles and responsibility was good.

- ASHA activity details were seen in registers but no formal handholding from

health facility was observed

- Community involvement was good but not been formalized
- MOIC was not clear about incentives attached IDSP services other than JSY
- Information about services available in the hospital is not displayed
- No functioning of RKS as per the guidelines

1.2 BEmOC PHC Karhi

- Lady Doctor with training
- No Additional ANM
- ASHA were utilized in health camp but no incentive
- Electricity water scare
- Eye camp going on by RKS efforts with no involvement of NGOs
- No streamline of RKS activities
- No regular meetings of RKs
- Record keeping of accounts related to RKS functioning is not maintained appropriately
- One Lab technician for all the program including TB and Malaria

2.3 PHC Pipalyabujurg

- This is a SHC upgraded to PHC but due to lack of lady doctor deliveries are not being conducted.
- Community demand for a lady doctor at PHC

- No information on services put up.
- RKS was not meeting regularly, neither is it reflected in the plan for expenditure though cleanliness is maintained under RKS
- No understanding about NRHM
- Community ownership is missing in real involvement of key community process

2.4 Bamnala BEmOC and Sector PHC

- Good infrastructure, new building is under construction
- RKS registered- 5 members, last meeting held- 17/03/05
- On 24th April 2007, a purchase committee is formed by BMO, ward boy and lab technician. The RKS was not involved in the same.
- Two accounts (JSY& RKS) are maintained by a dresser.
- Overwriting in JSY register in column of motivator, In the column of JSY motivators, some of the columns were vacant. When we asked we were informed that her name would be filled when the motivator will come.
- One ASHA (sagar) is compensated in 8 cases in Dec.(for village Singnur, Balfa & Lakhanpur). Not even a, single information on ASHA incentive for JSY was available at the institution from which the number of ASHAs as JSY beneficiaries could have been calculated.
- RKS is not effectively functioning as per guidelines
- Even JSY incentives is not clearly understood as per latest office order for involving ASHA as beneficiary instead of AWWs
- Waste management measures are not in place

2.5 Unn Block PHC & BEmOC

- Good infrastructure and well managed institute
- RKS exists and members are well informed about their roles.
- Meetings of RKS are irregular

2.6 Segaon: BEmOC PHC-

- Located in remote area where population can't approach PHC easily. Also no security to MOs for staying in that area.
- Janani Express is not available
- No Bank at nearby surrounding, so it's very challenging for ASHA to get encash her cheque.
- 2 Doctors including 1 Ayush Doctor
- Ayush Doctor is managing labour room

b) System Strengthening

- Orientation of DPMU, CMHO and National Disease Control program managers on NRHM
- Streamlining of financial management & accountability procedures with respect to functioning of DHS
- Deployment & orientation of District Community mobilizors to support facilitation of effective functioning of DPMU
- Development of District specific mechanism of reviews for key community processes (ASHA, VHSCs, VHND and functioning of RKS) ensuring involvement of health professionals and DPMUs and BPMUs.
- Design and development of comprehensive IEC/BCC strategy involving DPMU,NRHM and disease control program managers
- Ensuring availability of all types of ASHA incentives at SHC level except for JSY wherever the delivery is conducted nearest to her village.
- Ensuring display of information about integrated compensation packages for effective involvement of ASHA support under NRHM including incentives provided under IDSP
- Ensuring that the facilities are upgraded as per IPHS standards including implementation of Bio medical Waste management and infection control measure at all level of facility starting from DH to CEmOC & BEmOC facility
- Streamlining procurement and refilling of drug kits in linking with appropriate initiation of review mechanism for avoiding delay in refilling and reducing wastage
- Simplification of JSY guidelines for effective facilitation of incentive support to ASHA

- Involvement of MOs from nearest hard to reach locations for effective use of data collected during outreach care services provided by “Deendayal MHU”

- Initiation of ‘on the job’ facilitation support to ASHAs accompanying cases for various IDSP related services including JSY- such as ASHA help desk or deployment of ASHA Team Coordinator

- HMIS needs to be strengthened

c) Capacity Building

- Capacity Building of key stakeholders for Effective functioning of RKS

- Capacity building of Block Account Managers for streamlining financial management support system for key community processes under NRHM

- Sensitizing PRIs at all level of implementation of key community processes under NRHM starting from district up to SHC level

d) Convergence Issue

- Convergence of NRHM and disease control program

- Active program coordination with the involvement of Mission Directorate and Health Directorate

e) ICTC & HIV/TB services

- **Collection of data is with respect to the category of the sub-group (youth , ANC, STI/STDs) being counseled**
- **Data does not show mapping of population under diagnosis and treatment**
- **No indication of number of defaulter patients**
- **Involvement of NGO / Involvement of PPP – neither for record nor the interaction**
- **HIV/AIDS awareness related IEC /BCC activities are negligible per se**
- **ICTC centers which indicate counseling services are only provided to referral cases not to voluntary**
- **No referral of TB/HIV co- infection**

f) SHCs Visited

- SHC Dodwa , Block : Bhikangaon
- SHC Bablai , Block : Maheshwar
- SHC Kavadiya , Block : Maheshwar
- SHC Lalkheda, Block : Bhikangaon
- SHC Thibgaon , Block : Gogawan

Specific Observations from SHCs

- Mostly located on the road side
- Display on signage was not seen in these facilities
- Display about services available including Immunization Day was seen in Hindi
- Compensation is not provided to ASHAs at the SHCs
- Guidelines on Untied fund utilization and VHSCs functioning are not available nor understood to ANMs
- Good infrastructure and clean facilities
- All material available for ANC check ups
- Involvement of PRIs in the joint Passbook for use of untied fund is critical
- AWW undergoing training was interacted they understood the importance of ASHA and were appreciated. They were known about the objectives of NRHM
- 'Deendayal Mobile Health Unit' was observed on the location, but the data collected was not utilized effectively by the nearest block health facility for further management
- Untied fund has been spent and record keeping of fund is also good. Cash Register is used to keep the bills
- There was emergency light also available and in some cases aqua guard for drinking water
- No water supply or uninterrupted electricity supplies facilities.

- No information available regarding the incentive package of ASHAs, in most cases the incentives is managed at the Block level facilities.
- Interacted with ASHAs their Knowledge and understanding of the health issues is good. Handholding of ASHAs is very much missing.
- IEC/BCC is not in place nor even displayed
- List of Drugs with stock position is not in place.
- Most SHCs visited are located on the highway.
- MCH register was incomplete Stock register was checked and found to be in-correct also signed by Medical officer in-charge.
- ASHAs' functional relationship with ANM and health functionaries, which is yet to be established in most of these SHCs visited. This aspect is critical in facilitation of ASHA support at her nearest health facilities

Meeting with VHSC members and ASHA at village – Gogariakhedi

- Earlier the VHSC had tribal representation but they have been replaced by ASHA as they couldn't be assembled easily due to usual livelihood related activities. Village has only 2 ASHA on 8000 populations.

B) Detailed Observations from the Dhar District

Institutions visited

1. BEmOC PHC Nalchha

The MOs and accountants at contractual basis are not getting salary on time
ASHAs incentive was delayed from more than 5-6 months
Although the institution was newly constructed, the cleanliness was not maintained

2. BEmOC PHC Amjhera

   JSY incentive (ASHA, AWW, TBAs)
3. CEmOC CHC Sardarpur Cleanliness

4. ANMTC (Training Centre)

Specific Observations from the facilities visited

Although the guidelines available for JSY but it has not been followed in most of the health facilities visited

1. **BEmOC & CEmOC:**

   - BEmOC & CEmOC facilities are written in English on the Signage
   - No where NRHM logo is displayed
   - Even JSY incentives is not clearly understood as per latest office order for involving ASHA as beneficiary instead of AWWs or Dais except for Rs.50 for cleaning
   - Waste management measures are not in place
   - No formal orientation or communication is made available at these facilities on NRHM implementation strategies to facilitate incentives to ASHAs other than JSY or Immunization
   - RKS funds is utilized but quality decisions on RKS fund utilization by involving Civil Society and PRI members is yet to begin
   - Bed occupancy is poor
   - Cleanliness is critical issue with having no toilet facility and no water supply
   - No sign board for details about services available.
   - No sitting arrangement for Outdoor Patients
   - No facility for Bio medical waste disposal.
   - No segregation of biomedical waste

2. Functioning of RKS

- **RKS not constituted as per guideline, at the movement it is health heavy weight**
- **There is no sensitization on RKS about functioning of members of RKS**
- **There is no regular meeting**
- **No orientation about RKS**
- **Poor utilization of fund**
- **No involvement of Civil Society or PRIs**
- **Most cases the RKS meeting got delayed due to non availability of District or Sub District Administrative officials to Chair the session and to decide on the proposed agenda of spending. This resulted into delay in decision taking or decisions taken without the formal notice of the Chair.**

3. Capacity Building Issues:

- No formal orientation of CMHOs or training of DPMUs on implementation of NRHM
- No supportive supervision in place for assisting Block Accounts Manager and Sub health Center level record keeping procedures relating to key Community Processes
- No orientation on functioning of 'Quality Assurance Committee'
- No designated point person for M&E, reporting and review of periodic progress on monthly basis is yet to be established
- No support system for initiating mid course corrective measures and strengthening implementation through supportive supervision. This was lacking throughout the facilities visited in the district
- Most cases no orientation on IEC/BCC plan is in place. Nor even any activities undertaken to support comprehensive IEC/BCC activities under NRHM

4. JSY

- **Inappropriate interpretation of guidelines as beneficiaries include AWW, Dais including ASHAs**
- **Since the incentive is linked with BCG vaccination that payment will be paid after a month or more**
- **Record does not reflect the payment of ASHAs including beneficiaries for a particular Delivery**
- **No standardized approach but payment is made at the Block level of health facilities for payment to ASHAs and others**

5. T.B

- **Laboratory- Hemoglobin and urine routine not done**
- **No referral of TB/HIV co infections**

6. Village Blindness registers are not available

- **No Nodal officer for M & E**
- **No ASHA involvement in malaria and TB program**
- **Analysis of data is critical as collected by lab technicians for Malaria, TB**

Observations on strategic issues under NRHM Implementation:

A) Sub Health Centers Untied Fund & VHSC Untied Fund:

In case of Sub-Center untied fund, the level of fund utilization has been high. However, it was observed that the SHC Untied Fund for Rs.10, 000/- has been utilized without the consent of "Sarpanch". Although the Joint Account is opened by ANM and Village "Sarpanch", but there is hardly any orientation for both of them to utilize and benefit the functioning of SHCs. In most cases the ANM takes unilateral decisions for utilization of this Fund. No guideline or Office order is available at the SHCs on this. The incidental expenses for the entire year are taken care under the Sub Health Center fund. In most cases the SHCs are functioning without any fund available as they have expensed the entire fund for a considerable 5-6 months. In some SHCs, the "Sarpanch" is even not aware of the availability or requirement of untied fund.

No separate fund allocated under VHSC Fund so far although the decision has taken under this head. No formal orientation is organized so far on VHSC's functioning in these SHCs or villages visited. For this reason no expenses under sanitation is recorded as noticed by the Team. This practice has adversely affected the intended purpose for which the SHC Fund was created. The requirement for sanitation in villages has yet to be available by making Rs.10, 000/ for each of the VHSCs created.

B) Reporting of Expenditure

Expenditure reporting was in general found to be satisfactory. With the directives from the MD, NRHM, to send the Financial Monitoring Reports on a monthly basis, the system has started gearing up for regular expenditure reporting. The encouraging aspect is that the Financial Management Reporting is being received from most of the districts by e-mail.

From the state level it is being ensured now that all the reports to GOI, both physical and Financial, are being sent in time. This is an improvement as most cases reporting from the State delayed on many occasions. Use of computerization and data management at all the PHCs is in place with the deployment of Block Accounts managers. Their orientation is critical to the effective financial management support system in the District as well as the efficiencies of the State Capacity in this context.

C) ASHA Scheme and Community Processes

i. Training

ASHAs are trained and supported by a fulltime District training team of District Resource Persons (1 batch per about 30-35 ASHAs and coordinated by 1 team & 3 District Resource Persons from the health system at the district level. A range of training manuals and support material has been prepared for the training of ASHAs. CRM team observed the translated version of Hindi training module during interaction with ASHAs as prepared by GOI.

ii.Drug Kit and Drug Distribution systems:

Distributing the drugs for re-filling the Drug-kit – is a specific problem. As there is hardly any arrangement in place for drug distribution and replenishment of drug kit as responsive to changes in utilization patterns of ASHAs specific to any Block level health facilities. Though the supply of drug kit to ASAHs is at all levels of health facilities, but it is recorded only at Block level. Therefore, the tracking of utilization pattern specific to any Sub-Health Centre is not yet been established nor at the Block level of Health facilities. The current system is to dispatch a fixed quantity of drugs to the peripheral facility (SHCs) irrespective of the pattern of usage based on the demand received from the periphery or sub health center. Even it is received on request from the Sub Health center on ad-hoc basis it has never been tracked on a regular basis.

iii. Involvement in Malaria Control -Blood Smear Examination

ASHAs are not involved to make and send blood smear slides in fever cases. Even, there is no strategy in place to address this problem as part of the village health committee nor Health Sub Center nor even MOIC at PHC level. This issue was noticed and discussed during our interaction with the Lab Technician, MOIC – PHC and as shared with SPM unit as feedback from field. The incentives attached to ASHA involvement in Blood Smear Examination is neither known to ASHAs nor even known to ANM or MOs in the nearest health facilities.

iv. ASHA Referrals to nearest health facilities & Incentives

ASHA refer cases to hospitals and often accompany them. However, often their referrals are hardly known to any in Sub Health Centers or at PHCs unlike any other patients or cases. JSY payments are given during availability of fund at the Block level health facilities by the MOIC for which they have to commute additionally on an ad-hoc basis. Payments of incentives are given by cheques, and in most cases JSY payments are given to beneficiaries and ASHAs, AWWs and Dais. Even the functionaries from health systems are hardly aware of any incentives details attached to services supported by ASHAs. Efforts of ASHA training are usually made at the District level instead of at the Block level where the compensation is managed. The issue of timely availability of compensation is critical and need immediate attention with the involvement of Block Accounts Managers and District Programme Management Units.

v. ASHAs and Immunization

ASHAs of hamlets where even half the children had not been immunized were expected to report this separately and the system is expected to take it up and hold a health and immunization camp in this village. As it was observed, in most cases ASHAs are maintaining record of their activities, but no where it was either verified or even used by the SHCs for tracking and follow up on the Immunization services. Even, medical officers were unaware of their role in response to ASHA support. This mechanism could have largely contributed to address the problems of immunisation and its coverage as was expected to have risen after the involvement of district authority. The ASHAs are even not aware of this aspect of their roles in respective hamlets or villages in assisting their role in utilization of health facilities.

vi. Cooperation among ASHA and ANM & AWW

ASHA scheme has not begun training of ANMs and AWWs on the key roles and responsibilities of cooperation of ASHA support and even ANM & AWW are not involved as trainers. No doubt these efforts could have helped the capacity of, but there is still considerable room to improve their functional cooperation. The coming-up of "Janini Suraksha Yojana" and the immunization day incentive has made no change to this general pattern of lack of cooperation from the health department functionaries. There are similar problems in different aspects of coordination between state health department and the support needed for ASHAs. There is hardly any recognition or consideration of ASHA support by state health department, and it was at large felt by the team during their interaction with officials from the SHCs, PHC, CHC and Districts health systems.

vii. Use of Untied Fund for SHCs and VHSCs

State need to orient the health functionaries and the PRIs representatives for effective community involvement and the utilization of these funds as devolved to them. Role clarity and functional complementarity can be built into systems strengthening processes for effective utilization of these funds as per the local need from time to time. Regular review of utilization of these funds with supportive supervision for record keeping, book keeping and accounts maintenance is suggested through active facilitation of Block Accounts Manager and BMOs.

viii. Role of NGOs in ASHAs

NGO involvement is negligibly observed during the visit. Only health functionaries are involved to support the ASHA activities. Therefore, the benefit of community processes has been restricted to some extent with the training of ASHAs only. It has not utilized much contribution in facilitating support system at all level. This invite attention for larger cooperation of Government - NGOs for functional clarity which are essential to strengthening of ASHA facilitation support and ASHA functioning roles in benefiting health care to the villagers from where they are selected.

Relevant Observations from the field

Operation Related Issues

- **Utilization of Untied fund is critical in the absence of input for record keeping and accounting system – a general observation in almost all the facilities visited except two Sub-health centers.**
- **Most of the sub-health centers visited is having electricity and water supply facilities. Mostly, sub health centers are located in the roadside or on the highways, which is far from the proximity of villagers. But availability of safe drinking water and uninterrupted power supply is critical.**
- **Drugs and storage facilities are largely mismanaged. This account for the poor understanding and implementation of IPHS standard for 24X7 PHCs, FRUs and diagnostic facilities for quality care for delivery of health services in demand. Under RKS, the equipment and furnishing of peripheral health facilities is yet to be taken care.**
- **Community Processes contributed to the increase in institutional delivery, but absence of minimum standard of facilities as per IPHS standards, vacancy of staff nurse and physicians critically contributing to poor quality of care. Innovations of Public-Private partnership are yet to be streamlined under RKS.**
- **Utilization of RKS through Hospital Management Committee is implemented at all level under NRHM. It was felt seriously by the team that there is lack of appropriate monitoring and record keeping systems in place, which account for ineffectiveness in utilization of benefits of RKS in the state. Similarly, health department staff members need to be sensitized in this regard; the role of DPMU and CMHO is essentially critical in this aspect. This contributes to large amount of fund transferred being unutilized or wrongly utilized or delayed in decisions taken for their appropriate utilizations.**

- **In most of the districts including Khargon are yet to prepare the District Health Action Plans based on inputs from the Block health action plans and Village level action plan. This process is yet to begin at present through NRHM support by involving health departments. Involvement of other linking department is essential to initiate inter-sectoral convergence involving multiple stakeholders from concerned programmes /departments from various vertical programmes in the state. Even, no one in the district is either aware of District Health Action Plan (DHAP) or even had an opportunity to see last year's DHAP as discussed with us. Only, approved District Specific Activity Plan is shared with us, which was given to them by the Mission Directorate at Bhopal.**
- **The role of NGOs in the state as facilitator for capacity building of ASHAs is hardly observed during the visit. This could lead to assessing multiple stakeholders' support at the grassroots for linking support from health systems. State level ASHA Mentoring Group is formulated to take up the assessment of effectiveness in the 'Community Monitoring' under NRHM. Periodic stakeholder consultation is**

essentially envisaged under the present role of ASHA Mentoring mechanism for effective engagement of NGOs in the state & district especially in the areas of IEC/BCC strategies and community participation at large under NRHM. Also, Training of "Module V" largely involves the role of NGOs in organizing, handholding and mentoring training for ASHAs.

Program Management Issues

- **Programme Management structure is in place at the state as well as at the district level. The state has established SPMU at the capital and DPMU throughout each districts of the the state. Continuity and retention of PMU personnel is critical to the success of contribution of DPMU to the implementation of NRHM. The coordination between SPMU and DPMU is facilitating the programme management in the state. But the strategic cooperation between NRHM team and DPMU is critical in building bridges that are essential in narrowing down the existing challenges of governance of NRHM in the state.**

This in brief can contribute to;

- ***Larger understanding of field situations by the DPMU team as well as SPMU***
- ***Optimizing the benefits of various national health programmes through convergence from the field and District Health Society***
- ***Orientation of District Health Functionaries, CMHO, MOs at Additional PHC, PHC and Sub-Health Centers on components of NRHM is critical to the functioning of DPMU and support system at the district level***
- ***Exchange of information and strategies that are essential to reduce overlapping of capacity building measures at the field level for HMIS, Systems strengthening, Monitoring and initiating supportive mechanism & strategic supervision for mid-course corrective measures.***
- ***Monitoring and coordination of Capacity Building activities starting from village, block and district level of operations with adequate involvement of DPMU in coordination with health functionaries***
- ***Involvement and support from the government health functionaries in the capacity building on key components of 'Community Processes' under NRHM - ASHA, VHSC, RKS & NGOs***
- ***Effective contribution to the operational issues involving role of NGOs in facilitation of support system, ASHA Mentoring Group, Training on 'Module V' and provision of strategic measures for improvement in utilization of 'ASHA Incentives' through availability of 'Integrated Compensation Package' for ASHAs at the village, block and district level of operations***

Capacity Building Issues

- **Capacity building of DPMU and SPMU is critically essential for the effective coordination of implementation of NRHM in the state. Formation of Health Monitoring and Planning Committees at all levels of operations is worth mentioning starting from PHC, CHC to District and State. Review of district, block and PHC level MIS reports, integrated MIS formats and use of IT in tracking of reporting and documentation revealed that there is inadequacy in the hands on training input to these functionaries in this aspect of managing HMIS involving field level functionaries. Sensitization of stakeholders for the use of HMIS format is critical. Establishing and operationalization of feedback mechanism for mid course corrective measures are recommended by the team. Data disaggregation by gender and critically vulnerable group is suggested to be included in the integrated HMIS formats.**
- **Identification of district specific capacity assessment issues and involvement in effective contribution to ASHA scheme, Village Health Nutrition Day, preparation of draft guidelines for VHSC, Hospital Management Committees, and operational guidelines on components of NRHM is critical. This can be facilitated by inclusion of 'District Coordinator' for ASHA and relevant Community Processes under NRHM as a priority for the district. In a later stage the specifically identified district level support can be supported at the state level through already conceived 'ASHA Resource Center' under NRHM.**
- **Additionally, involvement in the capacity building initiatives for district support including facilitation of health planning can be provided under ARC support with well defined 'Terms of Reference' in a later stage. Even, research support in the areas of Intra-district and inter-district variations in health status can be included in the activities of ARC contributing to effectiveness of the 'Community Processes' in the state.**
- **Most importantly, IEC/BCC intervention needs at community level can be identified and supported through ARC in the state. Additionally, district specific design and development of IEC/BCC strategies should be included in the agenda of already discussed district level coordination meeting for programmatic integration of National Health and Disease Control Programs with NRHM. And this effort has to be facilitated by CMHO under the strategic functioning of District health Society.**

Mainstreaming of AYUSH

- **Mainstreaming of AYUSH initiative is largely suggested in the following areas with the contributions and active involvement of DPMUs;**

  - ***ASHA training design on home based herbal remedies***
  - ***Allocation of AYUSH specific incentives for active involvement of ASHAs***
  - ***Support in development/modification of AYUSH Strategies in the district involving NGOs-Government (DPMU) cooperation in health services***
  - ***District level planning on integration of AYUSH under NRHM involving DPMUs***

- ***Constitution of a separate AYUSH cell in the state for the provision of research and development under NRHM***

Convergence Issues

- **Convergence Initiatives in the State & District is suggested to be supported by DPMU team in coordination with SPM in the following areas of operations;**

  - ***Coordination with ICDS in capacity building of AWWs workers involving ASHAs for effectively functioning of VHNDs***
  - ***Coordination with UNICEF on IMNCI involving ASHAs, School Health and Jointly organized IEC/BCC activities of AWWs and ASHAs***
  - ***Effective coordination with WCD, PHED, Total Sanitation Campaign and Women Self Help Group networks and VHCs***
  - ***Functional coordination of national health and disease control programs with NRHM needs to be emphasized with active involvement of DPMU, CMHO and Disease Control Program Managers at the district level on a regular basis. This should contribute to address strategic issues of convergence through designing and (DHAP) development of district health action plan***

Governance Issues

- **'Governance of NRHM'**

  - **Program coordination with active involvement of Dept. of Health and Mission Directorate NRHM**
  - **Merger of Disease Control Programmes with that of District Health Society**
  - **Deployment and orientation of District Community Mobilizes for ASHAs, VHSCs and involvement of PRIs**
  - **Development and sensitization of Village Health Sanitation Committee Guidelines**
  - **Facilitation of delegation of Financial Power with special reference to sanctioning, approving and signing authority for the effective functioning 'District Health Society'**
  - **Development of District Health Action Plan involving multiple stakeholders from Disease Control Programme and DPMUs**
  - **Use of computerization especially E-transfer through notification server**
  - **Payment of incentives for ASHAs through Bank account or through Post office account and it should be made available at the Sub Health centers instead of at the Block level health facilities**

ACTIONABLE RECCOMENDATIONS:

Capacity Building of Support System

- **Capacity Building of CMHO, SPMU and DPMU along with State functionaries on Implementation Framework and Financial Management of NRHM**
- **Advocacy on NRHM Strategic Milestones with the effective engagement of multiple stakeholders from Government, NGOs and Private Sector involving intersectoral coordination within various programme managers of health department**
- **Capacity building on HMIS involving SPMU, DPMU and Concerned functionaries for effective monitoring, reporting and documentation**
- **Capacity building of state functionaries along with SPMUs on 'Advocacy on intersectoral coordination under NRHM' is suggested for maximizing intended benefits of convergence of services at the implementation level.**
- **Capacity building for institutional strengthening of support systems for more than 20,000 ASHAs (as in the case of Madhya Pradesh) should be made in place for effective facilitation of 1 ASHA coordinator for 10 to 12 ASHAs as per guidelines outlined under NRHM strategic implementation framework, GOI.**

Programme Management

- **Operationalisation of District Health Society and district management team including deployment of District Community Mobilization Coordinators need to be addressed in bridging the gaps between Community processes – ASHA Strengthening, VHSC functioning, use of untied fund, "Rogi Kalyan Samiti/Hospital Management Committees" and District PMUs for effective coordination of programme management operations. This will surely facilitate the field visit and field level input to the programme management in the state.**
- **Approval of pending commitments along with availability of guidelines on VHSC, use of untied fund, information on integrated compensation package for ASHAs, functioning of VHNDs will ensure effective linkage among ASHA operations, NGOs and government health functionaries. This will contribute to sustain the ongoing effort on Community Processes in the state.**
- **Establish mechanism for facilitation of ASHA Support Systems as per the GOI guidelines for the states having more than 20,000 ASHAs starting from Block level of Facilitation for 10-12 ASHAs and ASHA Resource Center at the State level.**

PIP Revision & Health Planning

- **Strategic planning and inclusion of suggested recommendations in the revised PIP is critical for Sustaining of ongoing effort under NRHM involving multiple stakeholders from Disease Control Programme and District Health Society**
- **Prioritization of system strengthening efforts needs to be executed along with strengthening capacities of support system for effective utilization of health services and health systems in the state. Key**

components under this should be placed as programmatic priority with appropriate budgetary request in the revised PIP.

- **Emphasis should be given to the preparation of District Health Action Plan involving multiple stakeholders from various disease control programmes and District Health Society**
- **Selection, deployment and training of ASHA Team coordinators for 12-15 ASHAs with adequate support systems involving BPMU & DPMU is critical for ensuring effective support systems measures at the state level through 'ASHA Resource Center' with clearly delineated 'Terms of Reference' and revised work plan as per the requirements of District specific facilitation of support systems strengthening. This should be reflected in the revised PIP to ensure the revised requirements for strengthening of support systems for key community processes under NRHM.**

Governance Issues

- **Issues of "Governance of NRHM" and ownership of health department are critical and need immediate attention of the state authority to address.**
- **Continuity of Mission Director in the state for providing strategic direction to SPMU and effective implementation of NRHM.**
- **Functional coordination between department of Health & NRHM with appropriate support systems for coordination of technical assistance within the state**
- **Clearly delineated reporting responsibilities, review system, financial accountability and performance management system needs to be streamlined**
- **Functional merger of Disease control programmes with District Health Society with clarity on physical and financial reporting responsibilities**
- **Concept of 'joint programming and review system for effective coordination ensuring supportive supervision and 'on the job' facilitation support at all level of utilization of health services systems and facilities**

System Strengthening

- Ensure availability and maintenance of Village Blindness register to HSC
- Ensure maintenance of MCH register with supportive supervision periodically
- Ensure that Nodal officer for M&E is designated at the BMOC and CMOC facilities
- Ensure that various Guidelines for VHC, HMS, untied fund, Annual maintenance Grant, Waste disposal guidelines, infection control & waste management guidelines, Specification of pits are disseminated and oriented to concerned health officials for effective implementation and on the job supportive supervision
- Ensure that regular monitoring visits conducted by the PHC in-charge of the nearest PHC where the MMU is functional as per the root chart

- Ensure that various data collected at the MMU are analyzed with the involvement of MOIC of the nearest PHC and these data are fed into district specific coverage with appropriate feedback on various diseases addressed

ASHA Effectiveness

- Ensure Functional coordination among ASHA, ANM, AWW and MOIC
- Ensure availability of Information about Integrated compensation package for ASHA with ASHA, ANM, MOIC or DPM/DAM/BAMs.
- Ensure availability of ASHA dairy along with compensation details to all ASHAs
- Ensure effective linkages with health system, ASHAs & DPMU in facilitation of ASHA support systems at all levels
- Ensure effective facilitation of support system at the dist & sub-district level prior to the implementation of key community processes with active involvement of 'ASHA Resource Center' in the State with an well defined TOR for capacity building and coordination of technical assistants from time to time
- Ensure availability and provision of ASHA incentives at the SHCs instead of at the Block level PHCs
- Ensure timely deployment of support systems at the dist & sub-district level along with the strengthening of 'ASHA Resource Center' in the State

Community Process

- Ensure use of untied fund for SHCs and VHSCs appropriately
- Initiate appropriate review mechanism for RKS through periodic meeting with brief minutes and sharing of decisions taken to all the members with active involvement and clarity in decisions taking processes
- Ensure availability of various guidelines pertaining to community processes to MOIC, ANM, AWW and DPMUs/BAM as per their involvement
- Ensure streamlining of incentive payment systems for ASHAs and refilling of drugs in the drug kits
- Ensure that the formal training and orientation with adequate facilities for handholding is conducted urgently for all district level officers and DPMUs/BAM and key district stakeholders including administrative officers
- Ensure availability of resource trainers from NGOs at the Training Centers and District Health Society for functional effectiveness and facilitation of Training support at the district and block level
- Ensure involvement of Health functionaries and trainers from the Training institutes, and also ensure that ANM training centers are involved in training of ASHAs, VHSC and related Community Processes under NRHM
- Design and development of comprehensive IEC/BCC strategy involving DPMU,NRHM and disease control program managers

- Ensure capacity building of Block Account Managers for streamlining financial management support system for key community processes under NRHM

- Ensure development of District specific mechanism of reviews for key community processes (ASHA, VHSCs, VHND and functioning of RKS) with involvement of health professionals and DPMUs and BPMUs.

Any other issues/suggestions:

Assessments & Initiations of Pilot

- **Undertake Pilot on establishing functional coordination and linkages between AWW, ANM and ASHAs**
- **Undertake assessment of 'ASHA Training' and 'ASHA mentoring mechanism' in the light of assessing facilitation of support systems community processes under NRHM**
- **Undertake assessment for extension of "Pilot on Community Monitoring" for an adequate period with involvement of GO-NGO cooperation**