

**REPORT OF THE 2ND COMMON REVIEW MISSION
FOR
THE NATIONAL RURAL HEALTH MISSION
THE STATE OF ORISSA**

The Team and the Process

The members of the 2nd Common Review Mission visited Orissa state from 26th November to 3rd December 2008 to review the status of implementation of the National Rural Health Mission. The 1st CRM had been undertaken in November 2007. The objective of the 2nd CRM was to assess the progress of the Mission after a year, against the stated goals, objectives, outcomes, time lines and strategies. Since the NRHM process is an ongoing effort at 'architectural correction' through fast track innovations, the focus was on changes since initiation of the NRHM as well as ways of implementation of strategies as they have evolved in the context of Orissa.

Members of the team were the following:

Team leader: Dr H. Sudarshan, Honorary Secretary, Karuna Trust

Rapporteur: Dr. Ritu Priya, Advisor (Public Health Planning), NHSRC

Team Members:

1. Dr K.R. Antony, Director, SHRC, Chhattisgarh
2. Dr Prabha Arora, Deputy Director, NVBDCP, GOI
3. Ms. Deepika Shrivastava, Specialist (Child Development & Nutrition), UNICEF
4. Dr Rajmohan Panda, Public Health Specialist, Public Health Foundation of India

The team members were briefed about key issues before the common review mission and the schedule of the mission at a meeting held at the Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi on 25th November 2008. They proceeded to Bhubaneswar the next day and reviewed the programme activities in the state as per the following schedule:

26th November 2008: Visit to State Headquarters for by a briefing of NRHM activities in the State with the Mission Director Mr. S. Lohani, the State Program Manager (SPM) Ms Seema Pati, and presentations by the various programme officers.

The review method included presentation by the state team, probing by mission members and discussion with key functionaries. After discussion on various options with the State Mission Director, the review mission members decided to visit the Districts of **Dhenkanal** and **Subarnapur** as suggested by the State Mission Directorate. The team members split into two teams with each team going to one district. Team A, comprising of Dr. Antony, Dr. Prabha Arora & Dr. Deepika Shrivastava visited Subarnapur district and team B comprising of Dr. H. Sudarshan, Dr. Ritu Priya & Dr. Rajmohan Panda visited Dhenkanal district. At the selected district headquarters, after a detailed briefing on each component of the NRHM activities by the CDMO and SPM, each team visited various blocks, those with good accessibility as well as those "hard to reach", and covered all levels of health care from sub centers to district hospital. Besides evaluation of health service delivery outlets, both teams also interacted with village community members, ASHAs, AWWs, PRI members at various levels, Rogi Kalyan Samiti members and opinion leaders.

The mission members reviewed the status of implementation of NRHM in the state with an orientation towards the following mandate:

- To review the changes in health system since launch of NRHM through field visits and spot examination of relevant records.
- To document evidence for validating the key paradigms of NRHM including decentralization, infrastructure and HR augmentation, communitisation and others,
- To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM
- To recommend policy and implementation level adaptations which may accelerate achievement of the goals of NRHM

The specific themes focussed on were the nineteen points spelt out in the TOR of the 2nd CRM for assessing change in key aspects of the health delivery system. In addition, the CRM Team also focussed on additional points like Governance, Equipment procurement and maintenance, AYUSH, IDSP, and Public Private Partnership (PPP).

Returning from the districts on the 31st, the entire team sat together and shared observations to identify the major issues emerging from the review visit. Intense discussions over one-and-a-half days (till late into the night of the the 1st + 2nd Dec. morning) led to drafting of observations and recommendations. A preliminary presentation was made for feedback to the State Health Secretary, Mission Director and various division heads on the afternoon of the 1st. The report has been written as a consolidated one for the state, with mention of the specific districts visited being made only in case of major differences or specific issues and initiatives relevant to only one of them, or as illustrations with corroborative data.

2nd Common Review Mission				
25th November 2008 to 3rd December 2008				
Name of State			ORISSA	
Names of Districts visited				
Sl.no	Name	District HQ	Name of DM	Name of CDMO
1	Dhenkanal	Dhenkanal		
2	Subarnapur	Sonepur	Ms. S. Aswathy IAS	Dr. Harihar Dora
3	Ganjam	Berhampur		
Health Facilities visited				
S. No.	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
District Dhenkanal				
1	Dhenkanal District Hospital		DH	
2	Guneibili PHC (N)	Block Kamakhyanagar	PHC (N)	

3	CHC Anlibereni	“	CHC	
4	Mahulpal SC	“	SC	
5	Kamakhyanagar SDH	“	SDH	
6	Sarang SC	Block Parjang	SC Village	
7	Parajang CHC	“	CHC	
8	Sriramchandrapur SC	Block Gondia	SC Village	
9	Village Gundrapasi	“	Village	
10	Khankira PHC (N)	“	PHC (N)	
11	Village Badapokharia	“	Village	
12	Sadangi SC	“	SC Village	
13	Sriramchandrapur CHC	“	CHC	
14	Deogan PHC (N)	“	PHC (N)	
District Subarnapur				
1	Tarva CHC		CHC	
2	Kamsara SC		SC	
3	Charbhatta PHC(N)		PHC(N)	
4	Charbhatta SC		SC	
5	Ullunda CHC-II		CHC	
6	Kotsamalai AWC		AWC	
7	Kotsamalai SC		SC	
8	Naikenpali PHC		PHC	
9	Khaliapali SC		SC	
10	Subarnapur DH		DH	
Institutions Visited: Orissa				
	District Dhenkanal— 3 blocks	District Subarnapur— 3 blocks	Total	
DH	1	1	2	
SDH	1		1	

CHC	3	2	4
PHC (N)	3	2	5
SC	4	4	8
Village	5		
AWC	1	1	2

Introduction of the state

Administratively, Orissa state has 3 revenue divisions, 30 districts, 58 subdivisions, 171 Tehsils, 314 community development blocks, and 47,529 inhabited villages. As per the 2001



census, Orissa has a population of 368.05 lakhs (Urban 14.99%, Rural 85.01%, SC 16.53% and ST 22.13%).

The population below poverty line (BPL) is 47%. Levels of socio-economic and

infrastructure development is highly varied across the districts and blocks, and the socio-economic

context acts as a major constraint to improvements in health, as is reflected in the health indicators as well.

The State had developed a Health Strategy under Vision Orissa 2010 through consultative processes over the period 2001-03 and initiated Health Sector Reforms accordingly. When NRHM came, there was already a framework ready in the state. Both the Vision 2010 and the NRHM roll out have been focused primarily on strengthening of management systems and secondarily on relating service delivery to the situation on the ground.

Major Health Indicator of the State

1. Birth Rate (SRS 2006)	-	21.9 (Per 1000 population)
2. Death Rate (SRS 2006)	-	9.3 (Per 1000 population)
3. IMR (SRS 2007)	-	71 (per 1000 births)
4. MMR (SRS -2003)	-	358 (for 1 lakh live births)
5. TFR (NFHS-III)	-	2.4
6. Life expectancy at birth	-	61.64 years
7. Couple protection Rate (NFHS-III)-	51%	
8. % of children > 3 yrs Underweight for age (NFHS-III) –	44	

All health status indicators of the state have shown an improvement over the NFHS rounds, however IMR is the second highest in the country and high levels of under nutrition and anaemia are major causes of concern. MMR was still high at 358/100,000 live births in 2003 as against the national figure of 301 (SRS-2003)., and malaria continues to be a major public health problem (Orissa contributes around 23 % of total reported malaria cases in India, 40% of P falciparum and 17% of total reported malaria deaths of the country, while it constitutes 3% of population of India).

Public Health Infrastructure in the State

➤ Medical Colleges	3 Govt. (+ 3 Pvt)
➤ District Head Quarter Hospitals	32
➤ Sub-divisional Hospitals	22
➤ Block level Hospitals (AH, CHC, PHC)	1630
➤ Sub-centers	6688
➤ Anganwadis	41697
➤ Total Inhabited villages	47529

Observations of the 2nd CRM Team

There have been significant improvements under NRHM as far as transforming public health services, with greater decentralization and responsiveness, strengthening basic management structures, infrastructure and human resources are concerned. The progress of the ASHA initiative is also very impressive and effective, contributing to better community involvement, linkages with the health system and convergence with ICDS. However there are gaps in physical infrastructure vis-a-vis the requirements by population norms (for instance, the sub-centers in the districts visited cover from over 5500-9000 population) norms. Even the existing physical infrastructure continues to suffer from serious deficiencies at all levels. Despite appropriate infrastructure and manpower in many places the requisite services are not being provided due to non-residence of personnel. Patients are unable to access the existing centers for a variety of reasons including poor transport and 'out of pocket expenditure' due to inadequate availability of drugs and payment of informal fees.

Reviewing the action taken against the recommendations of the 1st CRM

It was found that the positive findings of the 1st CRM have been maintained and enhanced. There have been some improvements in PHCs and Sub-centers in the last year, but there is still a long way to go for strengthening them to provide the services expected of them. Action is ongoing to improve State procurement and distribution mechanisms for drugs and consumables. Training systems have made some improvements but long-term Human resource policy formulation and planning for the public health system is yet to take off. The HMIS has been put in place and now the quality of data needs to be strengthened. Considerable progress has been made in the formation of VHSCs (Gaon Kalyan Samitis) and their participatory decision making processes for village health and development have begun. Similarly the active RKS and good use of 'untied funds' at different levels of the health system has made a difference in the health facilities at all levels. The achievements in health service systems, service delivery, convergence and community processes need to be taken forward in the coming year.

Part 1

Change in Key Aspects of the Health Delivery System

(i) Assessment of the case load being handled by the Public System at all levels:

NRHM has transformed public health service delivery in the state. The decentralisation, responsiveness to local needs, paradigm shift in health system management and availability of untied funds has improved the facilities and their credibility among members of the public. JSY, community mobilization by ASHA, and proper referral transport have contributed to a large extent in increasing the case load. However greater patient load has been noted in the district and sub-divisional hospitals and CHCs as compared to PHCs and Sub-centres. It was observed that there was a total dependence on the government health system in the absence of significant private sector in both districts. This is true of the overall situation in the state.

Increased number of deliveries in the District and Sub-divisional Hospitals in both the districts (averaging around 300 per month) has made a significant image change among the public. Both OPD as well as bed occupancy in the district, some of the sub divisional hospitals, and CHCs has improved eg; 61-91% in Subarnapur District Hospital. OPD Rates have gone up at all levels. Staff Nurse Vacancies and doctors not residing in the premises are reasons for fewer admissions for inpatients in some facilities. At the PHCs, OPD attendance is increasing, but there is hardly any indoor admission. No deliveries are being conducted at PHC (N). Even minor surgeries are rarely conducted or patients kept under observation.

The Sub-centres are hardly seen as service delivery facilities any longer. There are hardly any general drugs for treating minor ailments, providing contraceptives and ANC as well as immunisation for children are the only services, especially since deliveries are shifting to CHCs/hospitals.

(ii) Preparedness of health facilities for patient care and utilization of services–

The no of beds, basic equipments, investigations are adequate in only a few facilities in the state. There is an urgent need to upgrade the infrastructure.

Inadequate budget for the drugs (Rs.1 Lakh for CHCs, 0.5 lakhs for Block PHC & 16000 for PHC (N) have put “out of pocket” burden on patients including for emergency surgery and treatment.

This is despite the fact that the utilization of untied funds, maintenance grants and RKS grants to improve preparedness of health facilities was very impressive in both districts.

Effective use was observed, for example for the following:

- Out sourcing hospital linen & laundry services.
- Cleaning of hospital premises by out sourcing cleaning services.
- Engaged security services by out sourcing security services.
- Alternative electricity supply by operationalizing of DG Set, generator repair, new wiring, purchase of inverter and batteries for power back up.
- Implementation of Photo Identity Card for all staff of DH.
- Procurement/Repair/Maintenance of minor medical equipments/instruments, such as Oxygen cylinder, footwear for OT staff, X Ray films and reagents-at DH maintenance of driver and vehicle of ambulance, purchase of BP apparatus at CHC..
- Repair/maintenance work at hospital & residential quarters.
- Small construction like kitchen shed to be utilized as canteen for patient’s attendant etc.

Vacancies of Specialists (Anesthesia, Ob & Gyn), MBBS doctors in PHC (N), and Staff nurses are significantly affecting service delivery. Ayush doctors are contributing effectively

to OPD services in Dhenkanal DH & to Mobile Health Units in Subarnapur. In Subarnapur, the number of beds, basic equipments, investigations and most of the drugs seem adequate for the present, but the binding constraint is continuing vacancies of medical and paramedical staff. There are 14 vacancies of doctors out of 68 posts. The major gap is among Staff nurses in the hospitals- 17 of 49 posts are vacant. This directly affects the Emergency care arrangements.

Sub-centre buildings, even those in rented spaces, were observed to be satisfactory. They were equipped with labour table and other basics, but were hardly in use, either due to non-residence of the ANM, or because of referral to CHCs/hospitals under JSY. MPW (M) were not posted in any of the sub-centres visited, affecting the provision of basic curative care and the disease control programmes. In Subarnapur 21 out of 69 MPW (M) posts are vacant. 21 MPW (Male) posts out of sanctioned 69 posts are also vacant in the district. 42 MPW (Male) contractual posts have been allocated to the district. The district has initiated the task of appointing these. However the existing vacancies of MPW (Male) also need to be filled up.

The PHCs are generally ill-equipped and grossly under-staffed.; all PHCs in Dhenkanal being termed 'New' PHCs, even if they have been in existence for 10 years, since they are single doctor PHCs,. The medical doctors in position are commonly not in residence, beds even for keeping patients under observation and laboratory facilities are often lacking. They are now largely being manned by AYUSH doctors who have been appointed only 2 months ago. Construction/maintenance works of Staff residential quarters need urgent attention. Many designated FRUs are not fully functional as per FRU norms in terms of provisions for EmOC, including Caesarean Section and blood transfusions. Despite not being termed FRUs some of the CHCs were offering commendable EmOC services like conducting C-sections. There are 1162 new PHCs which need to be upgraded to include laboratory services (microscope and a lab technician) for programme and routine tasks.

(iii) Quality of services provided

Overall some improvements have been made in the services like cleanliness, waste collection, electrification, water supply but are inadequate. While there were extra sweepers appointed from untied funds and maintenance grants, there is still scope for improvement in the cleanliness of toilets and availability of water supply in some hospitals. Many hospitals have colour coded bins supplied but the practice of segregation of hospital waste at source is not practised by all the staff. Incinerator is not erected in district hospitals and CHCs. Containment areas for bio medical waste management have been constructed. However injection safety pits for sharps though constructed have not been secured in the containment area. There is considerable scope for improvements in casualty management, new born care facilities availability, upkeep of operation theatre and waste management (segregation at source and disposal as per PCB norms.).

While there has been a marked increase in case load especially institutional delivery, there is considerable scope for improvement in quality of services. Quality of care for institutional delivery is impeded not only by Staff nurses vacancies, but by inadequate facilities in the labour room for staff and patients such as hand washing and scrubbing area, nearby toilet for women in labour, poorly maintained labour table, lack of mackintosh, linen, screens for privacy. It was uniform observations that all the toilets had no illumination at night as they were no bulbs. It is encouraging to note that neo natal care equipments are in the pipeline with NRHM funds such as Ambu bag, radiant warmer, photo therapy units, suction machine. In some facilities with neonatal care equipment (SDH) it was observed that there was an abundance of radiant warmers /incubators and other much of it was unused despite the presence of a paediatrician. Mobile Health units in Subarnapur are managed only with AYUSH doctors. There is a need for scaling up of telemedicine facilities for “hard to reach” areas in KBK plus districts.

It was observed that there is a bypassing of the PHC and SC for service delivery, village ASHA to CHC / SDH/ DH being the major channel for public system service utilization, especially with impact of the JSY. This is linked to the preparedness and quality of services being provided at the PHC and SC, since the PHCs are still to be adequately strengthened with requisite infrastructure, supplies and personnel to provide the preventive and curative services envisaged for them. Absence of the MPW (M) at the SC and high population coverage also preclude performance of several of its preventive and curative tasks. Appointment of the second ANM is too recent to assess the impact, but while their presence can be anticipated to improve the situation of MCH coverage, involvement of male members in FP, promotion of NSV, and disease control may still not get addressed.

(iv) Diagnostic facilities and their effectiveness:

There was an effective pooling of lab technicians from malaria, TB, HIV/AIDs for efficient handling of investigations and diagnostic workload in the DH/SDH/ CHC level. Blood banks at the DH are functional with a lab technician. However basic infrastructure is often found lacking, such as water supply and registers for lab technician are not in place. It is recommended that these be reviewed and strengthened.

Lab facilities are not available at PHC (N). X ray facility is not available at Sub divisional hospitals and CHC levels.

(v) Drugs and Supplies:

Most of the health facilities had drugs and pharmaceuticals available as per allocations but the budget provision per facility is inadequate and needs to be enhanced. Inadequate drug budget(an annual budget of rupees 1 Lakh for CHCs, 0.5 lakhs for Block PHC & 16,000 for PHC (N)). In Dhenkanal it was observed that this has led to doctors prescribing drugs that the patient has to buy outside the hospital and such prescriptions have put a heavy burden on BPL families even though provisions exist in the facilities for free supply to BPL patients by RKS / Red Cross. Availability of drugs was also displayed on the wall of DH/CHCs/ PHCs as

a measure to improve confidence of the public. In Subarnapur no shortages or stock outs of drugs were reported by service providers and beneficiaries- other than DPT/Measles vaccines for July to October 2008, which was a state-wide problem. In the state there was complete stock out Measles, DT and DPT Vaccines during July-Nov 2008. Anti-rabies vaccine is only available at the district level.

Sl. NO.	Name of Medicines	Available (Yes / No)	Sl. NO.	Name of Medicines	Available (Yes / No)	Sl. NO.	Name of Medicines	Available (Yes / No)
1	TAB. ATAGID	YES	35	SUSP. COTRIMOXAZOLE	YES	61	INJ. ARTETHE	YES
2	TAB. ATENOLOL	YES	36	SUSP. DOMPERIDONE	NO	62	INJ. BENZYL BENZICATE	YES
3	TAB. ANLODIPINE	YES	37	SUSP. FURAZOLIDONE	NO	63	INJ. CEFOTAXIME POTASSIUM	YES
4	TAB. BLISTER COMBIPACK	YES	38	SUSP. NIBENDAZOLE	NO	64	INJ. CEFOTAXIME POTASSIUM	YES
5	TAB. CIPROFLOXACIN	YES	39	SUSP. NIBENDAZOLE	NO	65	INJ. CEFOTAXIME POTASSIUM	YES
6	TAB. CEFADROXIL	YES	40	SUSP. ALBENDAZOLE	YES	66	INJ. CEFOTAXIME POTASSIUM	YES
7	TAB. CETIRIZINE DI-HCL.	NO	41	SYP. CEFADROXIL	NO	67	INJ. CEFOTAXIME POTASSIUM	YES
8	TAB. CHLOROQUINE PHOSPHATE	YES	42	SYP. CETIRIZINE	YES	68	INJ. CEFOTAXIME POTASSIUM	YES
9	TAB. COTRIMOXAZOLE	YES	43	SYP. CHLOROQUINE PHOSPH.	YES	69	INJ. CEFOTAXIME POTASSIUM	YES
10	TAB. CHLORPHENIRAMINE	YES	44	SYP. PARACETAMOL	YES	70	INJ. CEFOTAXIME POTASSIUM	YES
11	TAB. DICLOFENAC SODIUM	YES	45	SYP. PROMETHAZINE	YES			
12	TAB. DOMPERIDONE	YES						
13	TAB. FAMOTIDINE	NO	46	LOTN. BENZYL BENZICATE	YES			
14	TAB. IBUPROFEN	YES	47	LOTN. GUMMA BENZENE HEXACHLORIDE	YES			
15	TAB. METRONIDAZOLE	YES	48	LOTN. Povidone Iodine	YES			
16	TAB. NIBENDAZOLE	YES	49	CINT. NITROFURAZONE	YES			
17	TAB. NORFLOXACIN	YES	50	CINT. SILVER SULPHADIAZINE	YES			
18	TAB. OFLOXACIN	YES	51	CINT. WHITE FIELD	NO			
19	TAB. PARACETAMOL	YES	52	CINT. MICONAZOLE NITRATE	YES			
20	TAB. PREDNISOLONE	YES	53	ORS POWDER	YES			
21	TAB. PREMAQUINE	NO	54	PHENYL	YES			
22	TAB. B. COMPLEX	YES	55	PLASTER OF PARIS POWDER	YES			
23	TAB. TINIDAZOLE	YES	56	RECTIFIED SPIRIT	YES			
24	TAB. SALBUTAMOL	YES	57	RYLES TUBE	YES			
25	CAP. TETRACYCLINE	YES	58	SCALPVEIN SET	YES			
26	CAP. DOXYCYCLINE	NO						
27	CAP. AMOXICILLIN	NO	59	I.V. SET	YES			
28	CAP. FLUCONAZOLE	YES	60	I.V. FLUID	YES			
29	CAP. OMEPRazole	NO	61	INJ. ANTI-SNAKE VENOM	YES			
			62	INJ. AMIKACIN	YES			
			63	INJ. AMINOCAPROIC ACID	YES			
			64	INJ. AMINOCAPROIC ACID	YES			
			65	INJ. AMINOCAPROIC ACID	YES			
			66	INJ. AMINOCAPROIC ACID	YES			
			67	INJ. AMINOCAPROIC ACID	YES			
			68	INJ. AMINOCAPROIC ACID	YES			
			69	INJ. AMINOCAPROIC ACID	YES			
			70	INJ. AMINOCAPROIC ACID	YES			

Stock list of available medicine

A state drug management unit has been set up for procurement of medicine and this has improved timely procurement and availability. However mechanism for transparency and need based distribution of drugs to district/ facilities is yet to be put in place. Proactive role of the State in procuring Pediatric IFA syrup is appreciated. IFA syrup was observed in the field in both districts, however staff needs to be oriented on correct dosage and labeling has to be improved – eg the label needs to state that this is not for babies 0-6 months old, as exclusive breastfeeding is recommended for the first six months of life. Cold chain maintenance of vaccines was good at ILR points checked in both districts. Maintenance of temperature charts, precautions to avoid freezing of T vaccines, vaccine issue registers, knowledge of contingency measures for power failure etc. were good. Emergency drug tray was found to be appropriately stocked in most facilities.

(vi) Health Human Resource Planning:

Shortages of MBBS doctors, Staff Nurse and Specialists (Anesthesia, OBGYN), MPW (M) and LT plague the public health services. The state has taken several immediate and long-term initiatives to meet this HR crisis in the state.

For Medical Officers and Specialists

Three new private medical colleges have been set up in the state. Additions have been made in the UG curriculum, eg. IMNCI.

The state has also evolved several measures to attract doctors into the public health system like:

- Entry level post for doctors upgraded to Jr. Class-I
- Specialist pay increased from meager Rs. 150/- to Rs. 3000/- per month.
- Additional allowances are being offered to doctors serving in KBK districts
 - Rs 8000 at block level and below
 - Rs 5000 at district level
 - Contractual 18,000 (instead of 12,000)

Reportedly, these measures have already attracted a fair no of doctors in these districts.

- Post mortem allowance of Rs. 500/- per case provided.
- CDMOs have been empowered to appoint retired doctors on contract in districts.
- A proposal for restructuring of cadre of Doctors for creating better promotional avenues is under active consideration.
- A rational transfer policy for doctors being formulated.
- Recruitment process for training of LSAS has been reviewed over the past two years and modified to ensure retention and performance.
 - 1st batch: Selection of trainees was done by the CDMOs, retention of trainees and performance was extremely low.
 - 2nd batch: Applications were sought from in-service doctors. Retention better but still low.
 - 3rd batch: Applications sought from in-service doctors for specific FRUs, interviewed and counseling process undertaken for selection of those interested. Retention much better. Performance review will include giving honorarium if found to be practicing LSAS.

For Nursing and Paramedical Cadre

- Proposals are under consideration for up gradation of the nursing college at Berhampur as a Centre of Excellence for Nursing Education.
- Proposals for setting up of 8 GNM schools and 13 ANMTCs

- 816 contractual MPWs have been allocated to the state by Dte. of NVBDCP

Strategies that could be adopted or effectively implemented if already on paper include

- Increase in reservation for in-service candidates for PG admissions to be effectively implemented.
- Certificate courses for MBBS doctors to be trained in Anesthesia & EmOC.
- Incentives to be given also to ANM, Staff nurses similar to doctors in KBK plus
- Gap filling up for MPW (M) on priority basis in all sub centers
- Reservation for candidates from KBK plus districts for nursing and ANM courses
- Motivation of Health personnel working in “hard to reach areas” through timely recognition like “best doctor award” in Subarnapur

Long term Strategy:

- Diploma in anesthesia
- One programme manager for each disease programme at district level.
- Additional Nursing colleges in the state
- ANM training centers in all districts
- Creation of a public health cadre in the state
- A human resource policy for the health sector
- An HR division in the ministry/SHRC.

Training:

- Strengthening SIHFW faculty
- Capacity of the District training unit should be strengthened
- ANM Training centers should ensure hands on experience in conducting deliveries
- The pace of SBA, IMNCI training in the state needs to be accelerated to meet NRHM goals
- Strengthening the quality by monitoring and evaluating training and post training performance
- Training of all contractual MPW (M) and LTs.

(vii) Infrastructure:

There is a huge backlog of construction activities under NRHM funds and State funds. The State needs to expedite and rejuvenate infrastructure development mechanisms. A separate engineering unit has been set up a year ago under the NRHM which has contracted out civil works to 8 PSU, but work is yet to start. These Government agencies involved in construction need to be guided by the district health societies and users of the facility eg. matron in charge of labour room while remodeling the labour room or a staff nurse and surgeon for OT remodeling. Placement of a civil engineer at district level has hastened minor repairs and districts are making attempts to improve facilities with RKS funds; this could be enhanced seeing their effectiveness.



CHC in Subarnapur

In spite of OHSDP interventions, quality of infrastructure still remains poor. The State should coordinate with the Electricity department for preferential direct lines from the transformer for health facilities – especially the district hospital and for the block CHCs to serve 24*7 facilities.

In the state, only 2542 out of 6688 sub centres have buildings. Some construction is in the pipeline and flexibility needs to be enhanced for expediting construction, especially since a substantial percentage of the ANMs in position reside in the area. Essential equipment procurement has not been adequate. However, existing equipment is also not being properly utilized. An effective system for maintenance of equipment is not in place and the equipment maintenance unit is yet to be established. Condemned equipment & vehicles need to be disposed off.

(viii) Empowerment for effective decentralization and flexibility for local action:

Untied funds at different levels have contributed significantly to addressing local needs

effectively and towards empowerment for local action and convergence. In Subarnapur 1 District level, 6 block level and 17 of 19 PHC (N) and other hospital level Rogi Kalyan Samitis have been constituted, guidelines disseminated widely and are meeting regularly. Action taken by these RKS are reported and followed up. A mechanism tracking the register recording proceedings of RKS meetings and “Action taken” on decisions is also soon to be introduced in the State.

The utilization of Rogi Kalyan Samiti and other untied funds at various levels of the system is effective and locally relevant. Examples include generator repair and wiring, X-ray films and reagents (District), invertors, contracting of sweepers, (CHC), an oxygen cylinder, operation theatre chappals, labour table (PHC), examination table for ANC, cold box (sub centre), transportation for referrals. While suggestions for using untied funds and maintenance grants are being taken, the participatory process can be further strengthened by introducing a suggestion box or a notice board to display suggestions from any hospital staff who wishes to do so.

The state has reported setting up of 11774 VHSC known as Gaon Kalyan Samitis (GKS) in a fast-track campaign mode. In Subarnapur 317 of 331 Village health & sanitation committees and 38 of these have opened bank accounts. In Dhenkanal 909 out of 1076 have been constituted and 636 bank accounts have been opened. NGOs are also supporting the process of operationalising GKS. The district NRHM has proactively provided Rs.2000/- as seed money to the Gaon Kalyan Samitis to resolve the issue of opening new account with zero balance. Panchayati Raj Institutions, women’s SHGs and ICDS AWWs are being involved in the functioning of RKS, GKS and in the health system. eg: In one of the PHCs visited Naikenpalli there was visible community ownership. One of the Sarpanches in Naikenpalli suggested that like the Best Doctor award instituted by the Collector- there should be a best Village award, like Nirmal Gram Puruskar of Total Sanitation Campaign.

The district and block NRHM teams are vibrant. DPMs, BPMs have brought in professionalism in health system management, which is now more receptive to decentralised planning and participatory processes. A Community Processes Resource Centre has been set up at state level recently, incorporating the ASHA resource centre.

(ix) ASHA:

The state has selected and positioned 34,252 ASHAs. Induction training has reportedly been completed for all. The selection of ASHAs was through a decentralised, community based process during the village level meetings facilitated by NGO/PRI representative who had been nominated by the District/Block level health functionaries.

26 out of 30 districts have District ASHA Coordinators. Thematic training has been given to the ASHAs selected in 06-07 and training has been completed as follows: 15,945 ASHAs (73%) trained in 2nd Module, 14,025 ASHAs (65%) in 3rd Module & 10,268 ASHAs (48%) in 4th Module. Similar figures have been noted in the district; 74% of ASHAs in Subarnapur are in place and 52% have been trained in the 4th module.

- By and large no backlog of JSY payments but there are some instances of delays
- JSY payments are displayed publically at JSY counter in PHCs and many Sub centers

The ASHAs have been provided with drug kits and by and large they have opened bank accounts and are currently receiving payments through cheques in both districts. Hardly any backlog in JSY payments was found in both districts, as there has been very good progress in e transfers, cheque payments after opening ASHA bank accounts. Overall value addition by the ASHAs towards improving the health delivery system is visible through increased demand for and utilisation of health services, increased outreach to mothers and children, strengthened linkages with ICDS, SHGs, converging actions for health nutrition and women's empowerment. This is evident through a substantial increase in the number of institutional deliveries, immunization and early initiation of breast feeding within 1 hour. SHGs who were earlier concerned only in savings and credit activities are now engaged in health activities like emergency transportation, lending small credit in emergencies, sanitation activities and this has been possible with the active involvement of ASHAs. This was observed in all the blocks visited in both districts. ANMs are progressively delegating their tasks to ASHAs. The ASHAs have also been trained in making slides for fever cases for diagnosis of malaria and as DOTS providers for TB patients under RNTCP.

Posters in Oriya highlighting entitlements of ASHA have been prominently displayed in DH/ CHCs/PHCs, and sub centres visited. A JSY payment counter was also earmarked, with a list of JSY beneficiaries and payments at PHC Naikenpalli in Subarnpur. ASHA Diwas (on a fixed Saturday of every month) is a forum for sharing, learning and problem solving through discussion on specific themes and issues between themselves and with the health staff, NGO staff and ICDS staff. This process is facilitated by the ASHA district coordinator in the state. It appears to be a good way of mentoring the ASHAs. Good teamwork was evident and reported between ASHA, AWW and the ANM in both districts. VHNDs have provided a forum for strengthening this teamwork. The involvement of AWW by making her a signatory, along with the panchayat member for operating the bank account of the Goan Kalyan Samiti has strengthened her teamwork with ASHAs.

ASHAs were found to be rooted in the community, highly motivated, and the competencies and skills were good, as assessed through group interaction- SAB training, ASHA Diwas, and individually, and through interaction with health staff and perception of mothers/ community. ASHAs are contributing significantly to increased institutional deliveries, early initiation of breastfeeding and improved immunisation coverage, as assessed from records and community validation exercises. Their good teamwork with AWWs, linkages with women's SHGs in Subarnapur have increased their potential for addressing a broader health strategy including aspects related to nutrition and women's empowerment.



ASHA Diwas for ASHA mentoring & Support

Suggestions to improve the processes, including those that came from ASHAs include:

- Familiarising ASHAs with the district hospital, its casualty, key people in the labour room (OG specialist, ward sister, etc.) by including a visit to the district hospital in training or on the occasion of ASHA Diwas. (In addition to the CHC)
- Creating a space for ASHAs within hospital premises in all districts--for waiting time, a help desk and JSY payment counter. This would also be used for pregnant women as they come in for antenatal check ups and facilitate them when coming for delivery.
- Currently training in the state for ASHAs is not designed as residential training. However in some blocks long distances and lack of public transport require that residential arrangements be made through using hospital spaces where available and linkages with schools etc.
- Increase mobility by providing cycles to ASHAs.
- Current guidelines provide for Rs 150 to be paid to ASHAs per immunisation session. However more than 1 ASHA may be supporting the session, in which case the incentive is divided among both. It was suggested by ASHAs that the norm should be fixed per ASHA supporting immunisation session and not per session. Similarly, the issue is of sharing of incentive with AWWs for organisation of VHND and with the ANM for family planning –.
- The dream of many ASHAs is to become an ANM one day in her life. Some also want to study further and aim to have a regular job.

(x) Systems of financial management:

The enhanced financial allocations for health under the NRHM and also outside it from the State treasury have been utilised at an exceptional pace. In 2007-08, only 51% of the funds received under NRHM were utilised, and in 2008-09, 99% of the funds received (which is equal to the total of last year) have already been spent/disbursed by the mission directorate. Financial reporting is timely with a fixed date for monthly reporting from block onwards. Various Societies at State and District are in the process of unification. Transfer of funds to all districts and 281 out of 314 blocks is through e-banking.

NRHM financial guidelines are being followed very effectively, with state specific innovations. A document, 'Financial Guidelines under NRHM', has been prepared for use in the State and has been disseminated to all districts. Similarly a 'File Routing Procedure at District Level under NRHM' has also been prepared and disseminated. Delegation of financial powers to district and sub district levels has been done. In Subarnpur these were found to have been widely disseminated, including use of a booklet giving details of financial delegation to RKS and GKS. Cheque payments to ANMs, ASHAs & JSY beneficiaries are, by and large, timely. Concurrent audits are taking place at district and block level which has accelerated timely settlement of accounts and submission of Utilization Certificates. Induction of accounting staff at the district & block level is paying dividends.

(xi) HMIS and its effectiveness:

Comprehensive HMIS reporting formats have been introduced in the State since April, 2007 by integrating CNA, RIMS, NRHM and the vertical National Program reporting. Computers are in place at district & block levels. Although HMIS formats are in place and data collection, compilation and entry are taking place at various levels there are serious issues with data quality. Filling up of the 4 NRHM forms by ANMs was found to be inconsistent and incomplete. Therefore strengthening of ANM skills is necessary.

Analysis of the HMIS data is done first only at district level. Data validation needs to be strengthened- there are issues of both over reporting and under-reporting. However in Subarnapur when the team visited the Khaliapali Sub-centre under PHC Naikenpalli and interacted with Ms. Mamata Sahu, ANM, the registers were in order. Three immunizations, one Malaria smear test and one post natal visit recorded in the register were undertaken at random for validation and the individual beneficiary traced to their house and confirmed of having received the services.

Feedback to PHCs & Sub centers for action needs to be strengthened too. About 30 registers (mostly locally purchased and handwritten, not printed) are maintained by ANMs which is a huge burden on them. The number should be reduced, and whatever registers are found necessary must be printed and supplied. An integrated Mother & Child – Health, Growth & Development Card should be used, as in other states, which would be common for both NRHM and ICDS, with new growth standards as adopted by GOI. An excellent GIS has been generated for all districts, and is ready for use. Now the State and district teams need to be capacitated to use it for in situational analysis and planning.

(xii) Community Processes under NRHM:

The processes of ASHA selection and her functioning in the village, the GKS and RKS, have initiated community processes that require constant nurturing and enhancement. Involvement of SHGs and PRI in GKS has just begun with the formation of the GKS a few months ago in both the districts visited and is still to take off in several others. However, it was evident that it was beginning the process of community ownership. The quality of public participation observed in the few villages visited with involvement of ward members and women SHG members is very encouraging.

The VHND are perceived by various personnel as good forums for increasing community ownership and convergence with ICDS. Prompt payment of JSY entitlements is also generating a good interaction of the health system with the community.

The progress of the ASHA initiative is also very impressive and effective, as discussed above. Community monitoring processes have been initiated on a pilot basis in 4 districts in the state. Neither of the districts visited was a community monitoring district – but what emerged was the possibility of building on the community ownership being created by ASHAs, GKS, and linkages with SHGs and PRIs.

The perception of the State Mission Director was that the pilot exercise has been a very elaborate one of interaction and dialogue between the community and the health care providers, which was very useful, but that this is difficult too time consuming and resource intensive to follow in all the districts. A simple community based monitoring system was suggested, with a few lead indicators, to promote assessment, analysis and action, closest to the level at which data is generated. Community monitoring data needs to be linked with HMIS & Survey data for triangulation, and for promoting sustainable improvements in health behaviours and the health system. This system could also form the basis for a community owned process for grading villages / sub centres for an NGP kind of award, as suggested under (viii) above. But this may need to be envisaged in the context of a better understanding of these processes at community levels before such incentives are initiated.

(xiii) Assessment of non-governmental partnerships for public health goals:

Good NGO participation in NRHM activities was observed in both districts at various levels. They have been largely involved in ASHA training, the community process for setting up of GKS in a campaign mode, referral transport and management of a few PHC (N) as a PPP arrangement, PRI sensitisation, organising health melas etc.

17 MNGOs and 88 FNGOs cover 2891 villages in 22 districts under the MNGO programme. An NGO coordination committee exists in both districts visited. 36 NGOs and 1 corporate agency have been selected for management of PHC (N), of which 2 have been doing so for over 2 years. Karuna Trust a Karnataka based NGO has taken over the management of 6 PHCs in Ganjam district under the PPP model.

In Subarnapur MNGO VJSS and 4 FNGOs are involved i.e.: CPSD in Ulunda, RARE in Binka, JAWARD in B.M.Pur, NRDC in Tarava blocks are working in 104 villages, focusing on RCH activities, such as ASHA training (completed 119) in 3 blocks and constitution of GKS in 305 villages. A revolving fund of Rs 1000 is placed with 53 SHGs to meet emergency needs. In Tarava, ambulance arrangements have been made by pooling in MPLADs and RKS funds for the vehicle maintenance and driver. Similarly in Ulunda also there is NGO participation.

In Dhenkanal too, NGOs have been involved with similar activities—NYSADRI is managing one PHC (N) since 2006 with EU project funds and partial support by the district health society. It caters to a 30,000 population, but does not deal with the Sub-centres at all. It gets Rs. 5 lakh/year from the EU, spends Rs. 48,000/- on medicines from this and gets 16,000/- for drugs from the district health society+medicines for the national disease control programmes. All staff, including a retired doctor, are in place, the building has been improved and this was the first PHC to form a RKS in the district. OPD, IPD and institutional deliveries have gone up, and the DHS is getting a new wing built with beds for the indoor services. Thus, the facility functionality was clearly strengthened but outreach services were not part of the MOU. NGOs are managing the Janani Express in Dhenkanal that is providing effective referral transport for pregnant women. The transport money of Rs 250 meant to be spent by ASHAs is being used for this scheme, along with a grant of Rs 15000 paid by the DHS annually. The vehicle is owned by the NGO (which is not an ambulance but a general vehicle dedicated as a JE), and fuel and driver are also paid for by the NGO. The transport services are provided by the NGO @ of Rs.5/- per kilometre to be paid by the patient. These partnerships are helping in improving service delivery in hard to reach areas as well as in working out various management models. Such models need to be examined for the minimum inputs required for providing the requisite services, as well as for their cost-effectiveness in relation to the local context and the whole range of activities expected.

Private sector presence is limited in Orissa and scope for partnerships with the private sector is therefore restricted, mainly occurring in the setting up of medical and nursing colleges.

(xiv) Systems in place for outreach activities of Sub-centres

Fixed VHNDs at the Anganwadis are increasing ANC registrations, immunization, growth monitoring & nutrition counseling activities. 6 Mobile health units are in place in Subarnapur managed by AYUSH doctors. 548 sub centers have additional ANMs in the state. Recently appointed second ANMs were present in some sub centers visited in Dhenkanal. They were not residing in or near the ANM sub-center, and their roles and responsibilities were still to be worked out.



ANM sub centers operating from a rented center

Absence of the MPW (M) in most of the SCs visited and vacancies of Health Assistants limits the disease control activities and provision of basic curative care at the SC and village level. Though some of the ANMs were found to be involved in providing radical treatment to malaria cases during home visits, in areas with high BPL population and a burden of disease still heavily weighed by the poverty complex of high exposure to communicable diseases and under nutrition, the absence of an MPW (M) and HAs is an issue of serious concern.



Village Health and Nutrition Day for Immunization

(xv) Thrust on difficult areas and vulnerable social groups-



The state annual report refers to a tribal health strategy and cluster village approach for vulnerable hard to reach groups- including SC/ST, fishing communities- but this did not come through in the interactions and field visits. Vulnerable social groups have

been included in the GKS but it was observed that their participation in the meetings and activities is limited. This needs to be pro- actively sought and encouraged. The KBK districts are clearly identified as underserved ricts and special provisions have been made to strengthen services, such as special incentives for health staff serving in KBK plus districts. A few 'hard to reach' areas in other districts too are managed by NGOs under PPP. However, all districts need to map the most vulnerable pockets and ensure convergent services for them. No user fees are charged from BPL families. Despite this and the JSY, institutional deliveries amongst SC/ST are less than others and were found to be largely performed by TBAs. Since travelling distances to access services is more difficult for these sections of society strengthening sub centers and PHCs will contribute to equity in access and availability of health services.

JSY counter for disbursement of JSY money to Beneficiaries

xvi) The preventive and promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health

NRHM implementation has clearly contributed to better linkages of Health Staff with ICDS, TSC and SHGs. It is perceived as a comprehensive approach to health care, with ASHAs seen as a critical link with mothers and convergent programmes. The most visible face of this is the teamwork of ASHAs AWWs, ANMs in organizing fixed monthly Village Mother Child Health and Nutrition Days, as seen in Kotsamalai Anganwadi Center in Subarnapur. What also emerged was the need for ASHA, AWW and ANM to have a common mother child card for use in VHNDs that links health, growth and care for development aspects during pregnancy and for the first three years. This is important because, while the immunization card tracks immunization coverage and some antenatal care aspects, it does not include nutritional status of the child and advice on other health related issues such as new born care, danger signs, diarrhea management, referrals etc. The growth chart is currently maintained by the AWW in a register and not shared with the mother or family, when providing nutrition counseling. The growth chart needs to be updated with new growth standards adopted by GOI from 15 August 2008. An improvement has been seen in referrals of severely undernourished children after NRHM and there are now fewer children with grade 3 and 4 malnutrition.

As ICDS moves towards universalisation, the linking of village clusters of ASHAs and AWWs with ANMs, will be required for extending outreach. Thematic joint training on maternal and child health, growth and development should also be considered, especially in

districts with high levels of maternal and child under-nutrition. Joint Health & ICDS staff reviews are being held on fixed days eg in Subarnapur at district (10th of every month), block (26-28th) and sector levels (25-28th). AWW is participating in sector level ASHA DIWAS to strengthen this convergence (ASHA Diwas on 3/ 4 th Saturday of the month). AWW, along with panchayat ward member is also a joint signatory to the GKS account, strengthening teamwork of ASHAs/ AWWs /ANMs.

In Subarnapur a district level meeting was organised in September with TSC to involve ASHAs as animators for sanitary latrines and communicators for hygiene. ASHAs are promoting Sanitary Latrines and gets additional incentives for that.

(xvii) Effectiveness of the disease control programmes including vector control programmes:

Orissa comprises of 4% of country population & contributes around one fourth of malaria cases in the country. Despite the seriousness of the problem in the State, there are no programme officers for malaria at the district level. Dedicated programme officers for each disease at district are required. The vector borne disease control programme is mainly based on vector control, protection from vectors, the surveillance of fever cases and prompt treatment of these cases with appropriate anti-malarial drugs. All these activities are being undertaken with a specific focus on malaria. Vacant posts are a major problem in implementation of the programme. 27 Districts do not have DMO and they need to be filled up. 13 Malaria Consultants appointment (contractual) is under way. Malaria Technical supervisors under the project have been engaged and are undergoing training at RMRC Dibrugarh.

Time taken for reporting of positive cases of malaria by the laboratory is three weeks to one month, with gross shortage of Laboratory Technicians. LTs were also allocated to the State by GoI from the Malaria budget. There are problems in finding candidates who are trained in malaria (MLT), so the state has decided to engage the candidates and train them in Malaria Microscopy and rename the post. The state may consider opening institutions for the training of LTs to meet the emerging demand of LTs at the sector level PHCs.

The posts of MPW (M) are vacant and contractual appointment is underway, which is expected to result in improvement in surveillance and delivery of treatment to the patients. ASHAs, who have received additional training as per the state's needs, are facilitating detection of Malaria/TB/Leprosy cases. They make blood slides for malaria and give them to the ANM. For TB and Leprosy, they are familiar with the symptoms and signs and counsel the suspected cases to go for medical help. The registers for case records were not found and the entries were being done in the locally purchased school copy books.

The reported API of district Subarnapur was 4 and the IRS was done only in areas reporting API more than 5. Contractual Lab technicians under TB programme were performing the sputum microscopy at DH and at the block CHCs. The latest drug policy was not known and needs to be communicated at all levels for effective implementation.

The supply of Insecticide Treated Bed Nets is inadequate even in high endemic zones. One impact of using ITN claimed by the staff of Tarva CHC in Subarnapur is the decreasing number of cases. eg: in Badvainro Sub Centre the API has come down from 5.82 to 4 and SPR from 3.43% to 2.31% before and after supply and propagating use of ITN among families. Integrated vector control, with engineering works and use of biological control (Gambusia fishlings) needs to be strengthened; GKS could be involved in this along with other departments.

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

Under nutrition and anemia, factors that limit the outcomes of all efforts being made to improve maternal and child health continue to be high in both adult women, and children and are still inadequately addressed.

As observed earlier, there is a bypassing of the PHC and SC for service delivery. The way the JSY is being operationalised, has led to a dominant pattern where the expectant mothers access services and information from the village ASHA/ANM during the ante-natal period, then travel to the CHC / SDH/ DH for delivery. PHCs are still to be adequately strengthened with requisite infrastructure, supplies and personnel to provide the preventive and curative services envisaged for them.

Maternal Health

The number of Institutional deliveries has gone up markedly. In 2007-08, calculations based on total rural population and the crude birth rate estimate by the SRS 2008, show that JSY beneficiaries are 73% of the estimated births in the state. 84% of JSY beneficiaries had institutional deliveries, thus 61% of all estimated births in the state were JSY-supported institutional deliveries. Calculations from the data of district Dhenkanal give a similar picture. The state is thus well on its way to achieving the objective of 85% institutional births by 2012.

While the impact on MMR will be known when reliable data on maternal deaths is available, the quality of maternal care needs immediate attention, as also the likely impact on health systems strengthening of this 'demand-driven' strategy. It was observed that the ANMs at Sub-centres are now working mainly as 'ASHA managers' and data providers for the HMIS, at best providing some ANC and contraceptive services. Even the quality of ANC services is severely limited by the fact that in most cases, neither weight gain, BP nor Haemoglobin are being monitored. Only prophylactic dose of IFA is being given with no one receiving the therapeutic dosage. Institutional deliveries are happening at the CHCs and above since the PHCs do not have MBBS doctors or Staff nurses. The most vulnerable ST families still depend upon home deliveries which the ANMs are NOT conducting. This is evident in the

data provided at district level in Dhenkanal, and at the sub-centres visited. Dai training has been discontinued but the home deliveries are being conducted by the dais (TBAs). In this way, a 'de-skilling' of ANMs and no support for dais is likely to weaken the service delivery system at the peripheral level, especially for the more vulnerable sections who are unable to travel to institutions at a distance, despite JSY support. Mechanisms for linking of TBAs with ANMs needs to be evolved for reaching skills of ANMs in yet the underserved areas/ population groups.

After institutional deliveries, mother and child are being discharged within a few hours, leading to a serious gap in PNC, without cover for the critical 48 hours. Therefore quality of ANC, PNC and deliveries by ANMs needs priority attention. A related issue is the definition of the role of the second ANM – and whether this can be focused on maternal newborn and child health, with time clearly allocated for this. eg fixed time MCH clinic at the sub centre.

341 institutions in the state which have been selected to be upgraded as 24x7 service delivery institutions needs to be operationalised on a priority basis, taking care of the requirement of three nurses for 8 hourly shifts. 48 hrs post natal stay has to be promoted for improved maternal and neonatal health and survival. Presently neither is this preferred by mothers- nor are institutions adequately prepared for the same. Maternity wards were found to be overcrowded in almost all CHCs, SDH and DHs, The appointment of 'Yashodas' at the hospitals to support and counsel women through the delivery and post-natal period is an innovation undertaken by the State. The scheme is still to show results; and relationship of the Yashoda with the ASHAs is still to be determined. Will the Yashoda become another layer to share the JSY benefit given to the mother, or will she prove better than a relative in providing support to the woman during and just after delivery remains to be seen.

FRU operationalisation needs to be given high priority. Most of the designated full FRU in the state (20 out of the 22) are at the district level and this should be extended to the sub district level i.e. CHCs. Existing facilities listed as FRUs still need to complete the full set of services expected. The lack of Anesthetist and non-residence of the Ob & Gyn specialists is limiting the performance of Caesarian sections. However, there are facilities where Ob&Gyn specialists are conducting Cesarean under local infiltration and/or spinal anesthesia even without an anesthetist or blood storage facility and these need to be strengthened based on the patient load, with appropriate beds, equipment procurement and maintenance, improving OTs etc. The only Blood Bank in Dist Hospital Subarnapur is functioning without a qualified blood bank officer. Blood storage units are not functioning/not available at sub divisional Hospitals & CHCs.

Child Health

IMNCI training was planned for 96 MOs and 2880 ANMs/LHVs/AWWs and facility based Newborn care (FBNC) for 394 MOs/Pediatricians/Staff Nurses in 2008-09. TOT on care of

sick children and severe malnutrition was also planned for 32 Pediatricians, SNs, Sister Tutors and LHV.s.

Childhood illness care at primary level needs strengthening, and the IMNCI training roll out appears too slow for that. Key child survival interventions need to be promoted system wide, irrespective of whether the district has been declared an IMNCI district or not. IMNCI training needs to be accelerated, backed by service provision at PHC/CHC for referred cases.



SBA Training in Progress

There is an urgency to supply new born care equipments to sub district hospitals appropriate to patient load, and to ensure its use wherever it has been supplied. At one SDH where a large number of deliveries were occurring, there appeared to be a surfeit of neonatal care equipment which remained unused. Training for staff in the use of equipment and a rational distribution of the equipment between facilities is necessary. At least one SNCU per district needs to be operationalised, as part of a more comprehensive approach to maternal and new born care and child health.

The State has initiated the setting up of Nutrition Rehabilitation Centers in 2 districts, but a more comprehensive approach is needed, integrating preventive, promotive and curative nutrition interventions. Simultaneously, strengthening the data on child weight collected by the ICDS and developing a system to use this information on child nutrition to identify early signs of growth faltering and provide cover at community level is also necessary, so as to prevent under nutrition as early as possible and limit IMR. Coordination with the ICDS to share and analyze the data on weight on a monthly basis is necessary, especially in a State

such as Orissa where despite improvements between NFHS-II and NFHS-III, child under nutrition levels remain high.

Family Planning

While overall contraceptive performance has improved marginally, it needs to be noted that achievements in tubectomies is less than 40% of the target, while use of oral contraceptives has increased substantially. IUD insertions are being done by all ANMs, while there is an increasing use of oral pills without any monitoring of side-effects.

Achievements in NSV are impressive against targets and need to be sustained with more mobilization efforts. Male participation in family planning needs to be promoted further.

It has been observed by Ob& Gyn specialists in the facilities of the districts visited that there has been increase in incomplete abortion coming to institutions. They attributed it to Misoprostol misuse by unqualified practitioners. The issue of increase in incomplete abortions needs to be examined urgently, since it can be one of the major causes of maternal deaths.

(xix) Assessment of programme management structure at district and state level

The State PMU has strong leadership and very good working ethos. District PMUs are active, professional and vibrant. Good team work and integration with district and block medical teams exists in the state. PMU are burdened with routine repetitive work and this has resulted in less time for critical analysis and reflection for program quality improvement. Some programme retreats are required for them together with the medical/technical officers' team in the district.

The professionalization of health systems management in NRHM in Orissa has been a major factor in enabling the process of paradigm shift and effective decentralization in the state. A suggestion which emerged was the need for State and District Health Resource Centers, to provide technical and professional support for health system reforms, facilitating decentralized planning, coordinating training and capacity development across different national programmes/themes and improving the training quality, behavior change communication and monitoring with quality assessment. (The nutrition component of health would also be included in the above). This will also help in linking the new cadre of social sector management professionals – DPMs, BPOs to a resource network and institutions of excellence.

The District Health Action Plans have been prepared by the district teams in the previous year in a commendable way. They need to be further strengthened so that they go beyond just a budget document and prepare a whole DHAP, with a text explaining the rationale of proposed strategies and activities as well as reflect some micro-planning, so that the plan leads to easy and effective implementation. The process also needs to be taken to block and village levels, at least for getting an idea of the needs as articulated by the community and its representatives.

(xx) Governance

The expenditure on health from the State treasury has increased beyond the expected 10% and its contribution to NRHM exceeds the 15% requirement. However, the public expenditure on health has fluctuated in the State from 3.99% (2005-06) to 3.57% (2007-08) of the budgetary allocation, and health expenditure as percentage of the GSDP is still at 0.90%.

The State and District Health Societies are functional, with good cooperation between the General Administrators and health officials, PRI, ICDS NGO and SHG members at all levels. They have a strong representation of elected representatives. However the guidelines disseminated for preparation of the DHAPs do not reflect their role anywhere, except for final approval by the society. Given that the village health plans and block plans are still not initiated, there is no other provision for community participation in preparation of the plans. In order to improve quality of services, there is the necessity to deal with difficult problems such as private practice of doctors and non-residence of health personnel at the facility.

Systems for procurement and distribution of drugs and equipment need to be strengthened with transparency and quality assurance. E-Governance could be used more effectively for transparency and accountability, e.g. computerization of recruitment, transfers, promotions, and e-procurement.

There is a need to strengthen the role of community members in Hospital Management & Health Committees for developing local accountability and ownership. Without this the management strengthening may not yield the desired results in terms of community participation and contextually suited planning. As the BPL comprise 47% of state population, ensuring their access requires that user fees be limited to a bare minimum or even withdrawn.

The process of Community Monitoring including dialogue between users and service providers appears to have been well implemented in the pilot areas. Findings of the community monitoring process should be given serious consideration and issues addressed.

(xxi) AYUSH

The State has recruited 1153 AYUSH doctors under NRHM for 'co-location' of services at PHCs and CHCs. They are providing OPD services and participating in various NHP effectively. However, in the absence of an MBBS doctor at the PHC (N), it becomes 'substitution' rather than co-location. Also, co-location of AYUSH services is still to begin at SDH and DH levels. AYUSH drugs were being supplied to some facilities and not yet to others where the AYUSH practitioners have been recently appointed. This may be a factor of time, but overall, the supply was reported to be inadequate. The Dept of AYUSH has a large no of vacancies in the regular posts yet to be filled. The NRHM provides for an AYUSH paramedic at the co-located facilities but there has been no recruitment of this cadre as yet. Technical monitoring and supportive supervision needs to be strengthened by AYUSH

officers in the district health system, both for the regular AYUSH services and for the personnel co-located in facilities under the CDMOs.

Herbal gardens are still to be planned for and developed at SCs and PHCs as per the IPHS stipulation. In a state such as Orissa, with its large tribal population and abundant forests, this should be receiving priority attention. It should be linked with the local herbalists as well as co-located with Ayurvedic doctors. Revitalization of local health traditions through NGO partnership is another related activity of NRHM that is still to be taken up. Several proposals for such projects are with the Director ISM, but there is need for policy guidelines on how to process them and integrate them under NRHM. For all of these activities, stronger coordination is required between Departments of AYUSH and Health & FW at the state and district levels.

(xxii) IDSP

The State and district level IDSP is being strengthened, with appointment of data entry operators, data managers and district surveillance officers in place. However, the Rapid Response Team needs to be further strengthened for outbreak investigation & further action.

The P, S and L forms are being routinely submitted. However, issues with data validation and feedback for prompt action still remain to be addressed at various levels. The State and District labs still need further strengthening.

(xxiii) Role of Development Partners

Bilateral donors such as NIPi and DFID are providing technical assistance in the State. The Orissa Health Sector Plan (OHSP) is a sector-wide support for the health sector from the DFID for a period of 5 years (2007-12). Its stated purpose is to provide a broad framework for implementation of the NRHM in the State through an integrated sector wide plan, and aims at moving towards principles of sector wide management. Rs. 300 cores are promised under this plan.

The UNICEF and UNFPA are also actively engaged with the State health system and are providing technical support.. While the UNICEF is involved in maternal and child health and nutrition initiatives, the UNFPA supports the State in strengthening Reproductive Health service delivery and Adolescent Reproductive & Sexual Health.

These agencies have also been active in filling in gaps in emergency relief as required by the State during disasters such as the unprecedented floods this year. They provided daily monitoring reports, proposed dignity kits for women and adolescent girls.

(xxiv) Co-ordination between State and Centre

The State appreciates the flexibility and support provided by the Centre for State specific planning and implementation under the NRHM.

Problems of timely supplies and reimbursements from the centre were pointed out as cause of some barriers in service delivery, eg. Supply of vaccines and insecticides to states by the center, and backlog of reimbursement for cataract surgeries to NGOs.

Finally, it was pointed out that too frequent visits of JRM and CRM has put a burden on the state health service system and a single review mission of NRHM was suggested.

Key Issues and Major Recommendations

Need for strategic and visionary HR policy formulation with a focus on:

- Identifying and filling human resource gaps in a timely manner
- Ensuring adequate skill sets at entry level and during service period
- Need based training of all cadres at various levels
- Creating and nurturing a public health cadre for professional management of public health sector
- Sustaining motivation levels of existing staff
- Assuring career progression
- Pay parity with peers elsewhere in the country
- Incentives for serving in 'hard to reach' areas for all levels of health cadre

Ensure quality of all service components, especially at the primary level:

- Quality of ANC, PNC and deliveries by ANMs needs priority attention, in addition to that of institutional deliveries at PHCs/CHCs/DHs
- Quality of basic curative care and referral services, especially for children
- Integrate nutrition interventions in maternal, neonatal and child health interventions
- Involve all health personnel and sectors in disease control activities, especially for malaria, water-borne diseases
- Strengthen facilities identified as FRUs and 24x7 facilities
- Strengthen focus of second ANM on maternal and child health
- Use opportunity provided by JSY for improving newborn care and neonatal survival

Create the Health Systems Management support network:

- Set up a technical support institution similar to NHSRC, SHRC of other states
- Develop links with institutions of excellence at State, district and facility levels to ensure quality of planning and implementation
- District health planning capacity building of teams in each district should be accelerated, relating it to the above two measures., with teams including related sectors such as ICDS, TSC etc.
- Strengthening management and supervision by health administrators and senior staff requires training in Health & Hospital Management and in Leadership in Decision Making & Problem solving

Strengthening Governance

Focus on the Most Vulnerable

- State specific strategies for vulnerable groups should be enhanced in the State PIP ,
- The State drug budget is grossly inadequate, requiring immediate enhancement
- Strengthening of NGO partnership needs to be addressed
- Enhance monitoring and support of underperforming districts to improve their performance & budget utilization

Adopting Good Governance Practices

- E-Governance: Computerized and on-line/website information of all recruitments, transfers, and promotions, as well as e-procurement of drugs and equipment, will lead to transparency and accountability
- Effective monitoring is required of performance of the service providers, such as residence of health personnel at the HQ, Private practice, absenteeism,...
- Integrity Pact with manufacturers of drugs and equipment will improve quality of supplies.
- Strengthening Drug Control department - Immediate withdrawal of drugs which are not of standard quality with black listing and debarring of companies/suppliers
- Strengthening Hospital & Health Committees, putting up of a Citizen's Charter, a Report card system by VHSCs, and other such measures will increase citizen ownership of the public health system as well as its performance.

- Public grievance redressal at various levels is needed for the system to respond to problems of the public and to mediate in the stand-offs between patient's relatives and the service providers.

Encouraging Inclusive Decision-making

- District Mission Societies and RKS must be actively involved in the Infrastructure improvement, drugs and equipments procurement
- Decentralization and commoditization needs to be further strengthened,
- Asking for, encouraging and facilitating innovations by the GKS can lead to developing local, context specific, creative solutions for improving health of the communities.

HMIS and Reviews

- Validation, analysis and utilization of HMIS data for effective planning and implementation is now the next step required in strengthening health system management. The GIS must be put to effective use for situational analysis and planning.
- A common Mother & Child Card should be used by both NRHM and ICDS, converging Health, Growth & Development interventions..
- The Community monitoring process has to be scaled up
- A single comprehensive NRHM review annually instead of separate review missions (JRM/CRM) would be appropriate.

Part 2

Progress against the approved PIP 2008-09

The PIP 2008-09 of Orissa was focused majorly on two dimensions, on strengthening the Human Resource situation of the public health system through improving availability of doctors, nurses and paramedics and on Reorganisation of the Health Management institutions.

Strengthening Human Resources and Facilities

Discussions revealed that pro-active efforts are on to implement activities with this objective, largely as had been planned. Short-term contractual recruitment at all levels and trainings for specialized skills such as for LSAS, EmONC, are underway. The long term measures such as initiating new courses/ increasing intake for required human resources, improving service conditions and giving additional incentives for difficult areas are also being undertaken. However, the recruitment of SNs is proving difficult due to shortages. The training for dais that has been rationally justified in the PIP and budgeted for was not in evidence.

Upgradation of infrastructure of facilities such as buildings of sub-centres, PHC/CHC/SDH maintenance works are also being undertaken in PPP mode and by the State itself. This had earlier been undertaken in 1998-2004 at SDH/DH levels under the OHSDP, funded by the World Bank.

Under JSY, the target in the 2008-09 PIP was for 75% deliveries being conducted in institutions. Within JSY, this figure has been crossed, 79% of JSY beneficiaries having delivered in institutions. The JSY beneficiaries are 65% of total estimated deliveries in the State and 89% of total institutional deliveries (as per state presentation on maternal health).

While institutional delivery targets appear within reach, major constraints remain in terms of reaching criteria for FRUs and 24x7 services, IPHS standards being distant goals. 93 FRUs have been planned in the PIPs for 2007-08 and 2008-09. Of these, at present 22 are claimed to be functioning as per definition, and others have been designated at various levels of functionality – with absence of 1, 2 or all the 3 criteria as laid down in the GOI guidelines for FRU operationalisation. On-site visits revealed that even the FRUs that were claimed to be fully functional were not operating with the three basic criteria. However, there were some institutions which are delivering Caesarean services but have not been selected for upgradation to an FRU. Such anomalies need to be The PIP states a plan to establish SNCU II in 7 DHs and SNCU III in all FRUs. While baby-warmers and incubators were observed to be in use in some institutions, functioning of the planned numbers and at the requisite level of services still requires major strategic and realistic planning.

109 of the 341 PHCs selected for upgradation to 24x7 services are claimed to be providing round the clock delivery and emergency services. However, posting of requisite staff was found to be insufficient to operationalise them in the absence of residential doctors/SNs/ANMs at the facility.

314 AYUSH doctors have been recruited and posted at CHCs as per plan, and 839 AYUSH doctors have recently been recruited at all PHC (N), against the 1162 stated in the plan. However, there has been no recruitment of the 314 AYUSH paramedics/assistants that have been planned and budgeted for.

To strengthen the SCs, a Sub-centre sample survey and procurement of equipment for SC have been budgeted for in the PIP and the activities are being undertaken. Second ANMs are in place in over 500 SCs, and provision of mobile phones to ANMs is in the pipeline.

SAB training achievements were only 20% of that planned in 2007-08, and according to the PIP 08-09, it was planned to complete the 80% shortfall this year. The training schedule shows that that is not being fully met even this year. Laproscopic tubectomies, minilap, NSV trainings and contraceptive update trainings are on schedule.

Adolescent friendly centres are being set up in the medical college and DHs. And ARSH trainings appear to be on schedule.

Outreach, Communitisation and Focus on Vulnerable Groups

ASHAs were selected in the previous years largely through due process, but the 3175 planned to be recruited this year are yet to be selected, Several activities are being undertaken for strengthening the performance of the ASHAs, but thematic trainings and of the 2nd-5th module are still to be completed. TOT training is underway. Monthly meetings of ASHAs have begun with recruitment of ASHA facilitators (Sahajoginis), and preparations are on for providing them uniforms as well as for an ASHA convention on 1st Jan. 2009.

About half (approx. 17 thousand/38 thousand) of the Gaon Kalyan Samitis (VHSCs) planned for have been recently formed in a campaign mode and are already active, as observed in some blocks. PRI awareness activities have

been undertaken and results were evident by the participation of PRI members in the DHS and GKS.

A number of activities have been planned for vulnerable groups, but are still to be operationalised, for instance, appointment of a nodal officer, research studies for need assessment, and orientation of field functionaries. This is an important strategy under NRHM, especially with the focus on communitisation and decentralization, and therefore needs simultaneous attention together with the formation of GKS. Worthy of note in this context is the incentives being offered to doctors and nurses for serving in the underserved areas.

Mobile medical units have been piloted in some districts and more are to be purchased to complete the 30 planned.

The Pushtikar Diwas and Nutrition Rehabilitation Centres appear to have a low operationalisation.

RCH camps at SCs and Swasthya melas have been conducted in the tribal blocks, in the though less than planned.

Reorganisation of Institutions and strengthening management

DPMs have been recruited for all districts and the process for recruitment of BPMs is being undertaken. HMIS and GIS are being actively developed. A Community Processes Resource Centre has been set up, effectively enlarging the scope of the plan of an ASHA Resource Centre in the PIP. Community monitoring has been piloted in 4 districts, but the report is still awaited. The SHRC which was planned in this year's PIP is yet to be set up; meanwhile the DFID-supported OHSP is performing some of its tasks.

Fund utilization has improved at state and district levels, with 99% of funds received under NRHM being accounted for as expenditure, but this needs to be viewed in terms of both disbursal to facilities and their subsequent utilization at facility level. Funds of the RKS and at SC level were found to be under-utilised, no expenditure having been incurred at all in some SCs. The State has allowed the LHV as third signatory for the account at SC level in order to facilitate spending.

PPP arrangements for transport of pregnant women (the Janani Express) has been piloted in 2 districts. 2 PHC (N) are being run in PPP mode with NGO support funded by DPs and atleast another 6 have been handed over, more than planned for. However the PPP cell is still to be formed at state level. 17 institutions have been accredited for JSY services.