Third

Common Review Mission

State Report

Jammu & Kashmir

Jammu & Kashmir

Third CRM Report

The team for 3rd CRM in the state of Jammu & Kashmir comprised the following persons :

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The team divided itself into two sub teams as follows :

Dr Tarun Seem, Dr Thamma Rao and Dr Shyam Ashtekar constituted one sub-team which went to Kargil and Prof SC Gulati, Dr Sumangala Chaudhary and Ms Gayatri Mishra constituted the other group which visited the districts of Kupwara and Pulwama. Both the teams returned to Jammu on 9th Dec 09 and visited the health facilities in the districts of Jammu, Samba, Akhnoor.

Introduction

a. Introduction of the state.

J&K is geographically, one of the largest states of the country and is divided into four zones. The mountainous and semi- mountainous plain commonly known as Kandi belt, the second, hills including Siwalik ranges, the third, mountains of Kashmir valley, and Pir Panjal range and the fourth is Tibetan tract of Ladakh and Kargil.

Jammu and Kashmir initially had 14 districts namely Srinagar, Kupwara, Baramulla, Budgam, Pulwama, Anantnag, Leh and Kargil in Kashmir Division. The new districts of Ganderbal, Shopian, Kulgam and Bandipora have been added to this division. The Jammu division has Doda, Udhampur Rajouri, Poonch, Jammu and Kathua districts. The new districts of Ramban, Kishtwar, Samba and Reasi have been added to the Jammu Division.

The state has population of 10.14 million (2001). There are 22 districts, 107 blocks and 6652 villages. The State has population density of 45 per sq. km. (as against the national average of 312).

Demographic indicators of the state :

The decadal growth rate of the state is 31.42% (against 21.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate. The Total Fertility Rate of the State is 2.3 and the Infant Mortality Rate is 49. The past surveys have not estimated the MMR in the state. The Sex Ratio in the State is 892 (as compared to 933 for the country). The state has very small scheduled caste/tribe population.

b. Base line of Public Health System in the state

i. Infrastructure

There were 14 DHs, 85 CHCs, 375 PHCs, 238 Ads, 1907 SCs, 346 MACs in the state. The state had 11 trauma centres, 8 ANM training centres run by Family Welfare (with batch strength of 30 for FMPHWs and 50 for Paramedics). In 2005 there were 3 places in the state where CT scan facilities were available in public system (GMC Jammu/GMC Soura/SKIMS). At three locations in the state PET scan facilities are available in the public system (GMC Jammu/GMC Soura/SKIMS).

A comprehensive mapping of the health facilities in the state is not available even in the PIP of the state. The two Government Medical Colleges at Srinagar and Jammu are being upgraded to level of AIIMS under PMSSY.

Large part of the health infrastructure is stated to be located in rented buildings or have insufficient accommodation. The state has reported 64 PHCs without electricity, 85 without a phone and 82 without a all weather motorable approach road.

ii. Health Human Resources

As part of the desk review of 3rd CRM, the state has reported 28 PHCs functional with 4 or more doctors, 85 PHCs with 3 doctors and 182 PHCs with 2 doctors each. A per the generic guidelines, PHCs are expected to be manned by only one MO and higher strength of MOs indicates a relatively better health HR situation in the state with relatively higher possibility of performing on 24x 7 basis and eventual upgrading of services to IPHS standards. However, the state has reported that only 96 PHCs are working 24 x 7 although 271 PHCs have 4-6 beds and 159 have a labour room. A PHC which is not 24x7 cannot ensure hospital stay of delivery cases for 24 to 48 hours as is intended under RCH II. The advantage available to the state due to relatively better availability of doctors is negated by the acute shortage of staff nurses. In fact 67 PHCs are reported to be working without a staff nurse/nurse midwife while only 2 are reported to be without a doctor.

At CHC level, state has reported availability of 35 physicians,35 gynecologists,40 surgeons and 28 paediatricians. Out of total 85 CHCs, the state has 81 CHCs with functional labour rooms and 65 with a functional OT. The availability of anesthetists is not known from the RHS bulletin but the positioning of the full team of service providers at health facilities to ensure service delivery remains a major challange in the state.

The position of critical Health HR available in the state as reported by the state is as follows[1] :

	Regular	Contractual		Total
		Regular	NRHM	
Doctors	1522 excluding PG Registrars & Sr. Residents	339	228	2089
Specialists	210	0	44	254
Staff Nurses	637	82	346	1065
Female MPWs (ANMS	1127	288	521	1936
X Ray Technicians	355	20	151	526
Pharmacists	3434	02	-	3436

In its PIP 2009-10, the state indicated that it was contemplating several measures to improve conditions of service of doctors especially those serving in difficult areas. Two years rural service has been made mandatory for the PG entrance examination. 10% seats in the PG courses are reserved for those who have served in rural areas for 5 years. Now, additional financial and non-financial incentives are under consideration. These include better avenues of promotion to the specialists, additional weightage in the PG entrance examination for service in notified difficult areas, linkage of time-bound promotions to service in certain category areas etc.

iii. Indicators

The health indicators in the state are relatively better on most accounts. The MMR estimates for the state are not available in the SRS.

iv. Status of the PRI framework in the state

[1] The HR position has to be understood in appropriate perspective in J& K. There are certain fundamental defects in the HR policy in the state and a detailed exposition of the same is attached to this report is a separate chapter at Page ?.

The state is outside the purview of 73rd amendments of the constitution of India. The Jammu & Kashmir Panchayati Raj Act 1989 has also not been implemented in the state and hence people's participation in the grass root developmental issues has lacked strong institutional support.

v. Others

vi. Special Constraints

The state has faced insurgency, terrorism, external aggression as well as natural calamities in the past and has been encumbered with serious security issues having been the site of recent wars with neighbouring country. The state has very difficult geographical terrain in most parts and the travel time across most areas is disproportionately large as compared to other states in the country. Tele connectivity and availability of electricity is also a problem in the state.

The health seeking behaviour of the citizens in the state is positive and most citizens seek early medical assistance from the best possible source even if it involves longer travel or a little extra expenditure.

vii. The complete list of the facilities visited by the team shall be compiled in the following format to permit overall collation :

Facilities visited				
	Phulwama	**Kupwara**	**Baramulla**	**Jammu**
First Referral Units (FRU)	SDH Pampore (FRU), DH Phulwama (FRU)	DH Handwara (FRU) SDH Kupwara (FRU) CHC Tangdar (FRU)	Baramulla DH (FRU) Sopore SDH / Mother & Child Hospital (FRU)	SDH Sarwal CHC Akhnoor (FRU)

24x7 Primary Health Centre (PHC)	----	PHC Chowgal (24x7)	PHC Boniyar (24x7)	----
PHC	----	PHC Drugmulla	----	PHC Misriwala
Health Sub Centres (HSC)	----	----	----	HSC Gurah Talab
Medical Aid Centre (MAC)	----	MAC Teetwal	----	----
Anganwadi Centre (AWC)	----	Lonewala AWC	----	AWC Gurah Talab

Part 1

Change in key aspects of Health delivery system

1. Infrastructure Upgradation

Base Line Resource Mapping

The base line data as available in the state is shared in the opening parts of the report. The information regarding blood banks etc as of 2005 is not available.

Infrastructure Upgradation

Since the launch of NRHM, the state has substantially expanded its health infrastructure. However, the upgradation is at many places, ad hoc and not part of a comprehensive and sustainable plan for meeting the goals of NRHM. New constructions seen during the field visits are mostly located close to the existing old facilities and the upgradation work has been continuing for very long (sometimes over 5 to 10 years). The floor plans of new construction are not available at the existing facility and there is no board outside any new construction site indicating the range of services or the basic features of the facility under construction. The construction agency engaged by the state is often not communicating with the MO incharge of the facility which is being upgraded and the MOIC also often do not make efforts to establish liaison with the construction agency. It appears really to be a problem of ownership. At the DH Pulwama, the accommodation for service providers, though located within the same premises, is connected with a dark road which is impossible to drive on. At no places the team saw any temporary accommodation for the attendants. The existing old buildings are is rather diapalidated condition but the new construction is in good condition although the cleanliness could be improved.

Infrastructure

Facilities visited by the team included FRUs (district hospitals, CHCs/SDHs) and 24x7 Primary Health Centers (PHC), other PHCs, Health Sub Centre and Anganwadi Centres. Some buildings were

relatively new, while some are old but relatively well maintained[2]. Some others had been damaged due to either earthquake[3] or snow storm[4]; peripheral facilities like the Health Sub-Centre at Gurah Talab was poorly maintained[5]. Buildings are generally clean and well maintained. At some places, there is scope for improving the maintenance and cleanliness both outside and inside premises[6]. Since there is no dedicated persons responsible for plumbing, eolectricity maintaincene or civil upkeep, the

Several facilities are being upgraded or new sections being added to the main wing[7]. In some facilities it was observed that construction work is incomplete and not ongoing.[8] While in certain facilities, new buildings are not operational[9]. There is shortage of residential quarters for staff in most cases or where available is inappropriately located[10] or occupied by clerical staff as in SDH Sarwal.

Location of facilities is not properly planned and rational. District hospital in Kupwara is not located at the district headquarters but in Handwara block. A number of health facilities are clustered within a limited geographical area close to Handwara DH[11].

Planning within the facilities was not found rational in some cases. Few instances include the location of the immunization room next to the mortuary in the SDH Kupwara. Wards in most facilities do not have any nursing stations. In some facilities, newborn units were located away from the labour room (LR)[12] and in some they were seldom used. The LR was located on the 1st floor[13] which is not conducive to convenient movement of patients; in some others, LR had no attached toilet/running water supply/lack of privacy[14] (seen in Drugmulla PHC).

Diagnostic facilities of X-ray, ultrasound, ECG, laboratories are available in all DHs, SDHs / CHCs and even at the level of 24x7 PHCs[15]. Adequate recording of information is not being done in registers[16]. The X-ray room in Tangdar CHC has wooden walls and provides little

[2] Baramulla DH though an old building had been painted and was reasonably clean & well maintained

[3] Tangdar CHC, had been damaged during the earthquake of 2005, has been partially renovated; however presence of cracks and fissures in the roof and walls in a section of the hospital, raises concern of safety issues.

[4] At Handwara DH, window panes in wards are broken and one of the toilets attached to the ward had been damaged in snow storm but has not been repaired

[5] Two storied building of the SC has three rooms in the ground floor with a non functional toilet, no running water or electricity; the upper floor is not used and the walls are damp with seepage.

[6] Pit for disposal of waste was located just outside the OPD room in Mishriwala PHC; In Akhnoor CHC, there were half open manholes in hospital compound owing to the on-going construction work. There is no compound wall in Kupwara SDH

[7] Laundry plant is being built next to the mortuary and the dental section is being renovated in Akhnoor CHC.

[8] Construction in emergency unit in Kupwara SDH started a year back, no work has been ongoing for 6 months due to lack of funds; in Drugmulla PHC new building for upgradation of the facility is under construction for 8 years and currently no work is going on

[9] At Handwara DH, the paediatric building/wing with expensive equipment, wards donated by the navy and another building donated by the MP is not being used.

[10] DH Phulwama

[11] SDH Langate (4kms), PHC Chowgal (5 kms), PHC Natnosa (5 kms), PHC Vadipora (4kms) from Dist Hospital Handwara

[12] Kupwara SDH, Handwara DH, Baramulla DH. While in Pampore SDH, it is located in front of toilets. In Chowgal PHC it is not used.

[13] Mother & Child Hospital, Sopore, Chowgal PHC, Boniyar PHC

[14] Chowgal PHC had no running water supply, Sarwal SDH, Tangdar CHC, Boniyar PHC, Drugmulla PHC had no attached toilet. Toilet in Akhnoor CHC opened in the room for newborns. There was complete lack of privacy in Drugmulla PHC.

[15] In Chowgal PHC & Boniyar PHC ultrasound machine is available but is not optimally utilised as skilled HR not available

[16] Some instances: Drugs given to patient are not properly documented in the register and there is no means of monitoring their use. An approximate figure is written against each medicine at the end of the month as seen at Gurah Talab SC. In ultrasound registers, only the registration number of the patient is written; exception is Akhnoor CHC where the reasons for conducting USG mentioned (50% of cases include monitoring foetal well being).Separate inpatient registers for Medical, Surgical, Gynae wards are maintained but there is a mismatch of total IPD cases and sum of all cases from different wards.

protection against radiation leakage posing a hazard[17]. Telemedicine unit was found operational at the level of SDH[18]. *Most blood banks/storage* units available were not registered as they were not as per the guidelines of GoI[19], only the blood bank in Baramulla DH was functional.

Citizens charter, signages with services available and user charges were seen outside most facilities visited by team. Grievance redressal was not seen in almost all facilities visited[20].

Equipment & Maintenance

Equipments, HR & services are not utilised optimally[21] (often the available equipment is not aligned to availability and skills of corresponding human resources). While basic equipments for monitoring ANC, labour and weight of newborn were not available / functional / used at critical areas in PHCs / CHCs / DHs[22]. In several facilities, the baby weighing machines though present were not properly calibrated and was being shared between wards & LR. Nodal officers did not display ownership of the equipment[23].

There was absence of sufficient seating arrangements, sufficient lighting, direction sign boards etc. in the facilities. At several facilities, temperature log books for Deep Freezer and ILR are not being maintained and updated and the inner walls of the DF is coated with a thick layer of ice.

Skills to use equipment and availability of equipment varied; while in some basic equipment were available in others they were not in place[24]. Services provided were not aligned with the availability of consumables[25]. While in higher facilities, doctors were found prescribing higher order

[17] Around 10 X-rays are being conducted in a day while a mobile X-ray machine is being used; the capacity of the machine is 100 MA.

[18] Unit is connected with Govt. Medical Colleges Jammu & Kashmir, SKIMS, AIIMS, Apollo hospital, Delhi, Amrita Institute, Cochin, Fortis Hospital, Noida. 12 consultations has been conducted in 2008 and in 2009, 25 consultations have been held.

[19] In Pampore SDH, BSU was not functional; in Kupwara SDH area was too small, while in Handwara DH, wooden roof was not dust proof.

[20] At Handwara DH, a complaint box was seen

[21] Some instances: At Handwara DH (Kupwara District), only 1 OT is functional out of the 4 OTs. At Baramulla DH, three new phototherapy units are placed together in the LR while only one was operational as the remaining did not have any electrical connection. At Tangdar CHC, defibrillator was in OT, though no cardiologist in hospital. The baby warmer at Sarwal SDH, Chowgal PHC, Handwara DH were placed in a paediatric room away from the LR. At Kupwara SDH there were 6 radiant warmers, 3 Phototherapy units, 2 X-ray machines (one of 100 MA & the other 300 MA capacities) and an endoscope which is not being used as there is no skilled HR to operate it. Lot of equipment in new, unutilised, condition was seen at several places.

[22] Some instances: At Drugmulla PHC, where around 19 deliveries are carried in a month, there is no autoclave/sterilizer, radiant warmer. In Tangdar CHC, Baramulla DH & Sarwal SDH, there is no baby weighing machine in LR. At Mother & Child Hospital, Sopore in the OT, both suction apparatus and the probe of Boyles apparatus were dysfunctional, the latter led to error in the readings of the monitor. Slit lamp in Akhnoor CHC and electric centrifuge in Boniyar PHC were not functional. At most facilities emergency drug tray & baby tray are not in place in the LR. During delivery, medicines are taken from patient or from store / cabinet. Several hub cutters that were available are rusted and need urgent replacement with better quality equipment, where it is available the same is not being used routinely as in Tangdar CHC they were in the store and not in LR and wards. While in Akhnoor CHC, in emergency room, hub cutters were available but not being used.

[23] e.g. Several ILRs & DFs could be seen lying in the district store, through broken window panes. Key could not be found and the CMO of the district could not say as to "why" the cold chain equipments are being kept in the store.

[24] ANM did not know how to use the BP instrument in Teetwal MAC and no deliveries were being conducted (as there was no delivery kit in place) however a register had been prepared where weight of newborns had been recorded as "10 kg, 8kg etc"; while at Gurah Talab SC no BP equipment / slides or reagents were found; a register had been prepared indicating slides made.

[25] At Medical Aid Centre Teetwal, a surplus of drugs (which can't be used at the peripheral level), had been supplied and the store had a whole range of drugs ranging from Haemaccel, Roxithromycin, Theophylline and a several others; and a new vaccum extractor; while oral pills & IFA tablets were not available. Medical Officer from Medecins Sans Frontieres along with their staff are using government

prescription medicines instead of basic generic preparation leading to high out-of-pocket expenditures for the patients[26]. In several facilities, "co-operative" pharmacy shops were seen within the hospital premises selling drugs.

At several facilities (DH/SDHs/CHC/ PHC), toilets were without light / dirty or without proper maintenance with leaking roofs[27]. In Akhnoor CHC, the female OPD was being carried out in a small room which was overcrowded and provided little privacy and Chowgal PHC, ANC examinations were being conducted in general OPD. There were no screens / curtains providing little privacy. In several facilities, no attached toilets were present in the labour room (eg Boniyar PHC, Sarwal SDH).

The full complement of essential drugs was not available at many places[28]. No supply of IFA tablets in most facilities visited. Few facilities had recently received supply of IFA tablets.

2. Human Resources Planning

Availability of Human Resources & Gap analysis

The position of critical Health HR available in the state as reported by the state is as follows[29] :

		Contractual		
	Regular	Regular	NRHM	Total
Doctors	1522 excluding PG Registrars & Sr. Residents	339	228	2089
Specialists	210	-	44	254
Staff Nurses	637	82	346	1065
Female MPWs (ANMS	1127	288	521	1936
X Ray Technicians	355	20	151	526
Pharmacists	3434	02	-	3436

premises of MAC & conducting OPD twice a week. Medicines are also provided by them free of cost to patients along with referral services. In addition there are 2 ambulances in the MAC. At Drugmulla PHC; a microscope is lying in the store but no skilled HR available to use it.

[26] As in Chowgal PHC, Tangdar CHC in Kupwara district, Srinagar & Sarwal SDH in Jammu. In Sarwal SDH, Jammu no oral medications were available except Amoxycillin & Ciprofloxacin; while Cap Fegain was being prescribed though IFA tablets were available.

[27] As seen in Pampore SDH, Phulwama DH, Tangdar CHC, Kupwara SDH, Chowgal PHC

[28] At Chowgal PHC, injection Magnesium Suphate, Nifedipine tablets were not available, at Tangdar CHC, injection Magnesium Suphate, Lignocaine Hydrochloride inj., Nifedipine tablets were not available, at Drugmulla PHC inj. Oxytocin was not available. Magnesium Sulphate injection was not available in Handwara DH, Sopore SDH (Mother & Child Hospital).

[29] The HR position has to be understood in appropriate perspective in J& K. There are certain fundamental defects in the HR policy in the state and a detailed expositioin of the same is attached to this report is a separate chapter at Page ?.

The ward staff is found to be universally inadequate and shortage of cleaning and maintenance staff is reported at almost all facilities. There is no dedicated person(s) responsible for the maintenance of the equipments, lighting, civil construction, plumbing, water supply, electrical supply at the health facilities. This is showing up in the less than satisfactory availabilityof basic services at most facilities.

Pre-service Training capacity

The state has overall shortage of health human resources. The impact foot print of these shortages is however disproportionately large due to inefficient and suboptimal positioning and general lack of compliance to the rules of employment by the employees of the health system. The training capacity of the various cadres in the state is as follows :

The state has not introduced any short courses or undertaken any substantial medical / paramedical education reforms since the launch of the NRHM. Efforts to collate the training capacity and track the changes since the launch of NHRM were not very successful. The state could not make available the analysis of training institute wise batch size and whether there had been any improvement since the launch of NRHM.

Training of Human Resources:

Adequate planning of skill development and multi-skilling of various cadres has not been scaled up to meet the overall needs of the state (EmOC training has commenced, while LSAS training is progressing).

Progress on multiskill training to plug the gap in availability of key specialities is slow, with only 9 MBBS doctors trained so far[30] in Life saving anaesthesia skills (LSAS) against a target of 70; while comprehensive Emergency Obstetric Care (EmOC) training has just begun[31] (target - 70).

2 medical colleges have been identified for training on Life Saving Anaesthesia Skills (LSAS), 5 state level trainers have been trained in LSAS. 2 medical colleges has been identified as training centres for training in comprehensive Emergency Obstetric Care (EmOC), 11 master trainers and 12 district level trainers have been trained so far; and NIL MBBS doctors have been trained so far against the target of 70.

6 districts have been identified for Skilled Birth Attendant training (SBA), 10 state level master trainers and 47 district level trainers and 56 SNs/ ANMs have been trained as SBA, against a target of 561.

[30] A new batch of 4 MOs (2 each from Jammu & Srinagar divisions) has just commenced training on LSAS since last month

[31] 8 MOs from Srinagar and 6 MOs from Jammu are currently undergoing EmOC training, which started last month

There has been no progress on training of Medical officers as District trainers for RTI/STI case management and training for RTI/STI for ANM/LHV/SN against the proposed target of 96 and 660 respectively for the year 09-10.

Training for Bio Medical Waste Management was outsourced to State Pollution Control Board in 2008-09. However no monitoring of the training program was done at the state level and no report of the same has been submitted so far.

ANM Training Centre
(District: Kupwara; Division: Kashmir)

ANM Training School was visited in Kupwara district which was located within Kupwara SDH and it was found to be functioning inadequately. At 11.00 am few students had gathered outside the institute. Students in the institute are being trained as Ophthalmic assistants / X-ray technicians / Dental assistants / Pharmacists and Staff Nurses. They have been in the institute for more than 3 years and only 1-2 exams had been held as classes were not held regularly[32]. Moreover the faculty was inadequate and consisted of only 2 Junior Nurse Tutors; while 2 PHN tutors have joined last month.

Recruitment and cadre management

The number of regular posts of various cadres since 2005 and the change in the position is as follows :

The number of regular posts of various cadres since 2005 and the change in the position is as follows:

Cadre	Regular posts as of		Regular persons Available as of		Additional Contractual persons recruited under NRHM as of March 2009
	Mar-05	Mar-09	Mar-05	Mar-09	
Specialists	604	609	197	274	08
Doctors	2320	2340	1128	1661	533 ^
Staff Nurses	888	927	662	793	231
Female MPWs	1137	1180	917	1059	297
Pharmacists	2376	2427	2327	2363	---

[32] Students expressed their discontent about the delay in completion of courses

X Ray Technicians	270	286	193	241	103
Others	6772	6998	6519	6713	489 #

^ includes 357 AYUSH Doctors

includes 250 ISM Dawasaz

Has the state expanded the HR base by creating new post and recruiting various cadres under NRHM. Is the gap between "needed" and "available" reducing. Have new posts been created.

The state has taken up multiskilling of doctors and paramedics under NRHM. 1589 person have been trained so far. These are MBBS Doctors 456, ISM Doctors 186 and paramedics 947.

Note any initiatives taken for multi skilling of para-medical staff. What are the measures to improve work-force management and work force performance: incentives, participation, support, cadre management etc? What type of PPP engagements have been planned to manage the HR issues.

Plan for Augmentation of Health Human Resources

The steps, if any initaitied by the state to ensure numeric adequacy and skill mix of health human resources in rural areas especially for Primary Health Care RCH services and priority disease control programmes have not yet started showing appreciable results. The state needs to prepare a detailed short-term and long-term HR plan especially with regard to nursing and para-medical staff.

Skill quality of Health Human Resources

A random test check of the quality consciousness of the health functionaries at some of the health facilities visited during the state visit indicated a serious absence of technical and managerial supervision. At most places basic equipments like ambu bag, suction machine, BP

instrument, IV canula, emergency drug tray was not found in ready condition in the casualty. In the wards, the Oxygen tanks, nebulisers were not functioning at many places. The following of basic asepsis in procedures like cannulisatioin was being violated at one of the places (in the presence of the BMO). At most places the understanding of biomedical waste management guidelines were missing. The behavious and deminure of the doctors was at many places not inspiring confidence. At many other places some specialists were found to be doing exemplary work in very difficult conditions, with very limited resources (both men and machines). As such the states appears to be a land of contradictions, just a wisker away from comprehensive improvement of health services with minor tweaking at critical tipping points.

It was apparent that at many places, positioning of equipment was not as per need and there was corresponding lack of ownership. Most of the health HR is unclear of its work profile and the doctor in charge appear to be contributing nothing to improve this situation. The guidance by the head of the institution to the employees in the institution was almost entirely missing and every one seemed to be working in their own world, oblivious that the lack of synergy is compromising the service range and quality for the citizens. There is no evidence of any technical supervision and monitoring mechanism in the state. No records of such events wre seen at any place. Also no evidence of regular refresher trainings was witnessed in the state.

Availability of Human Resources

Skilled human resources are available; however owing to the HR policy of the state wherein those with post graduate qualifications in Obstetrics & Gynaecology and Anaesthesia (but are not designated B-grade specialists) function as GDMO / assistant surgeons; however they cannot provide specialised services independently. This results in sub-optimal utilisation of the available skilled HR.

Unregulated large scale long term “attachment” / deputation of staff at all levels does not reflect true “availability status” of skilled HR & paramedical staff and creates an impression of availability of HR in adequate number in peripheral facilities (since all HR analysis is in terms of number of sanctioned posts versus positions filled)[33]. There is misalignment with supplies/services/patient

[33] Handwara DH has attached 3 drivers from the block which may impact referral transport at the peripheral levels

needs and general lack of skill verification / building of the personnel[34]. In few facilities in Jammu district, OT technicians and pharmacists were found in the nursing station / emergency room but didn't have any designated duties[35]. In addition 4 pharmacists (under training) were in the emergency[36].

There is a complete lack of the need for and understanding of monitoring and supportive supervision. There is no systemic monitoring of programme implementation and quality in services. Absence of formal / structured system for monitoring and supportive supervision at all levels - state, district, facility and community is diluting the accountability of staff, reducing ownership of the services amongst providers. At many places low motivation levels among staff, inadequate apathetic supervision was seen as the key reason for lack of focus on "quality care"[37]. A well defined and implementable system for monitoring and supervision through field visits is needed urgently both from state and district level for guidance and supportive supervision to the staff.

The salaries of contractual staff are relatively low and resulting in discontentment and high level of attrition in DPMUs. In most facilities close to district headquarters, there are number of doctors / specialists posted & attached while remote areas have relatively limited number of skilled staff. There is shortage of nursing staff at all levels.

3. Assessment of the case load being handled by the Public System

The teams visited several health facilities during its state visit. The profile of case load being handled at each of these facilties has been compiled with the assistance of the state govt and is as follows :

Sno	Name of Health Facility	Level (PHC.AD. CHC/SDH/ DH/Others)	Total Doctors (including regular and contractual)	Average monthly OPD		Average monthly IPD		Average monthly deliveries	
				2005-06	2009-10	2005-06	2009-10	2005-06	2009-10
	Pampore	SDH	6	3889	4154	168	325	09	15

[34] e.g. most ANMs could not take BP, did not know proper use of ANC protocol including the need for Hb examination. Knowledge of health workers regarding site of administration of DPT vaccine (most were injecting in gluteal region) or the chances of loss of potency/ damage when adsorbed vaccines like Hepatitis B, DPT, DT, TT are subjected to freezing temperatures is lacking.

[35] At Akhnoor CHC, a pharmacist, OT technician were in the nursing station and an OT technician was in the emergency but had no designated duties. Similarly in Sarwal SDH, a number of pharmacists were seen in the ER

[36] At Akhnoor CHC, pharmacy student was found giving i.v. injection in the ER

[37] At Handwara DH, MoIC expressed concern over the limited clerical staff in the facility; however there appeared to be an absolute lack of focus on "quality care" for patients and monitoring service delivery trends (IPD / OPD case loads/deliveries).

	Pulwama	DH	33	7417	12513	526	404	104	103
	Kangan	SDH	5	9234	10045	215	277	44	55
	Drass	SDH	03	378	1282	38	85	09	17

Sno	Name of Health Facility	Level (PHC.AD. CHC/SDH /DH/Others)	Average monthly Tubal ligations		Average monthly NSVs		Average monthly Surgeries		Remarks
			2005-06	2009-10	2005-06	2009-10	2005-06	2009-10	
1	Pampore	SDH	10	07	01	01	36	14	
2	Pulwama	DH	10	07	05	02	103	95	
3	Kangan	SDH	10	07	01	01	08	14	
4	Drass	SDH	0	0	0	0	71	76	Only minor surgeries

Assessment of case load

The presence of number of people in OPDs and at least a few patients in IPDs[38] suggest that utilization of services has picked up. **OPD** services functional including EYE and ENT were available in district hospitals, CHCs / SDHs while Dental chairs were available and services were being provided at the level of PHCs.

4. Preparedness of facilities for patient care services

The team visited several health facilities in the state, some during and some after office hours. Some were visited on Sunday when regular services were off, it being a holiday. Most facilities (baring a few which are listed separately in this report in Chapter) had at least a few in patients and the OPD was crowded. Clearly, the Public Health delivery system in the state is receiving a steady and regular flow of patients both for consultations as well as admissions. At remote, inaccessible locations also, the health facility was seen as functional entities where citizens were arriving in steady numbers to seek services. This can only happen if services are indeed available at the facility. The presence of a service provider (allopathic or AYUSH), some paramedics etc appears to have sustained the interest of the citizens.

[38] Exceptions were Boniyar PHC & Drugmulla PHC

The same should not however mean that the desired status of functionality of services has been achieved. Over time, substantial installed capacity has been created in the state to provide health services, OPD, IPD, procedures, both minor and major, dental care, lab facilities and so on. However in most cases these services are working at suboptimal level with questionable quality and standards and largely in an unsupervised manner. There are major service delivery gaps relating to rational medical treatments, availability of medicines and consumables, ensuring patient comfort, heating, toilets, drinking water, food etc. There is no specific provision for safety or comfort of service provider (male or female). This approach continues to service delivery to patients also.

At most places there is a front office where the patients register and pay the small amount of user charges. The staff here is not particularly forthcoming as a facilitator and mostly does not record ANY information at all about the patient (not even the name) on the register listing the issue of OPD slips. The serially numbered slips are issued in tranches of 1000 each by the store to the front office where they are issued to the patients. The doctor writes the prescription on the OPD slip and a separate slip for the pharmacy where the serial number of the slip is mentioned. The doctor maintains a register with line listing of each patient. Here also the line contains only the serial number of OPD slip (although in some cases names, diagnosis were also being written). In most cases the age of patient, history, full address etc are not recorded at any level. What is note worthy is that there is no office copy record of the medicines which are prescribed in the OPD and which are expected to be purchased from outside the pharmacy by the patient. The team noted with concern the rampant habit of prescribing higher order prescription medicines by the doctors instead of basic generic preparations available in the pharmacy. The general lack of availability of the full complement of medicines desired by the practitioners in the pharmacy appears to be a contributing reason (excuse).

At most facilities, OPD load is not commensurate to the number of doctors or specialists positioned. The OPD does not have appropriate tools of trade (BP instruments are often shared across the labour room, wards, and the OPD). The general ambiance of the OPD is dark, cold and stark, not really reflecting

the rich cultural tradition of the region. Most OPD equipment and furniture was found to be dusty and ill maintained. Apparently there is no one person at the health facility who is responsible for the upkeep and cleanliness of the essential equipment. The patient examination areas need cleaning and small items like torches, thermometers, weighing, height scales provided.

The IPD load also appears clearly elective on part of the service provider. The patient who is admitted to the facility is not really owned up by any particular doctor and the treatment line in many cases was seen to be meandering from being directionless to being irrational to being downright ridiculous. There is no regular nursing care (BP, temperature, general condition etc) mentioned on the inpatient records. Most patients need to bring many medicines from the market and there is no arrangement for food from the facility. No temporary accommodation for the attendants was seen at any place. Patients were seen to be staying in the dimly lit, cold, dirty wards on unclean linen, close to dirty toilets, with almost no ward support staff, nursing staff to assist or support them. The suction machines, oxygen cylinders, Nursing tray with BP apparatus, thermometer etc were either not there or were dysfunctional. The attention to asepsis was missing and while multicoloured bins (sans the disposable bags) were seen at some places, the understanding of concepts of Biomedical waste & Infection management and protocols for waste disposal were not understood by the stakeholders. At the casualty ward at one of the facility, there was no nurse and an attendant were seen crowding around to assist the doctor establish an IV line. What was worse, however, was that the doctor was doing an unsterile job at that. Since there is no IV tray, there is no spirit swab and tourniquet available to the doctor. What was worse, however, was that the doctor was noticing nothing amiss.

Access to emergency services is one of the important aspects of public health delivery system given the often violent and disturbed conditions in the state. The team however did not see any specialised preparation for emergency services at any of the facilities. The emergency wards at most facilities were merely areas designated to be so. There was no designated ER staff/nurses and the general staff was managing the emergency also. The emergency room equipment also left much to be desired. The examination table,

illumination, BP instrument, suction, ER tray with essential emergency medicines, IV sets etc were not inspiring confidence. At one facility, it was reported that the ambu bag was under lock in almirah and concerned person was on leave. The access to blood was tortuous at most places. The supervisory structures were not seen to be making documented visits to the emergency room areas in health facilities. The state may like to revisit its emergency preparedness and establish more robust O&M for emergency and critical care at the public health facilities.

Normal deliveries are conducted at a very large number of peripheral facilities in the state. The labour rooms at most facilities are reasonably clean and privacy is ensured. The basic equipments for delivery are also available. Attention to infection prevention is however missing. Partograph was not being maintained at any of the facilities. It is difficult to ensure even 24 hour stay at the facility especially in cold weather since the wards are simply inhabitable in the cold weather [39].

RTI/STI are reported to be very common amongst the population but there is no specific initiative visible at the health facilities in this regard. There are no separate clinics for this aspect of RCH II or ARSH etc. The state can ameliorate a lot of suffering by undertaking a sensitive and concerted effort in this regard.

There is no documented referral chain amongst public health facilities. The FRUs are mostly not complying to the definition under RCH II (blood banks have been constructed in large numbers but are mostly not functional and there is severe shortage of gynaecologists and anaesthetists). Given the generally positive health seeking behaviour of the community in the state, maternal mortality reported at locations providing maternity & obstetric care is

[39] At one facility the labour room (doing over 60 deliveries per month) was seen to be surrounded by a wide drain which needed to be jumped to enter the labour room. At the same place the baby room was located next to the toilet and was away from the LR. The doctors here have been posted here since a long time and have not reported a single maternal mortality in past several years. These providers did not indicate any specific improvement in services post NRHM. They were using a defective weighing scale (showed many kg over) which had replaced the older defective scale (which showed many kg less). The weight change across ANC visits in the past six months would therefore give no comparable weight change data because of the defective weighning scales. Minor mechanical defect, albeit fatal missing link in ANC.

very very low. When specifically asked, it appeares that cases which are seen as complicated are referred to another facility. This referral in undocumented and does not leave an audit trail. At higher level facilities, say a SDH, all walk in cases are treated equally and referrals are not recorded separately. In case there is a second referral, that is also undocumented and leaves no trail. The last word in maternity care in the state are the tertiary care facilities at Srinagar and Jammu which have been documented to have a higher than normal cesarian rate (mortality rates at that level need to be analysed in this perspective). The MMR in the state has not been estimated in the state in the past surveys. This leaves a serious vacuum for planning for RCH services. However, establishing a designated (and documented) referral chain may compensate for the absence of data regarding MMR and improve RCH services to large extent. Another effort in this regard can be Maternal death audit which does not take place in the state.

Untied funds, AMG and RKS funds have reached most facilities over the various years of NRHM. However, there do remain many missing links and capacity to utilise the same has not yet taken roots amongst service providers. The CMO, BMO, MO facility do not really provide the ownership of their respective levels and hence the flexibility provided in these strategies of NRHM has not really rejuvenated the system as it has done in many other states. The major policy shift in the state of allowing the respective facility to retain its user charges at its own level for local use is indeed a path breaking improvement. Maintenance of separate bank accounts for this Hospital Development Fund and the RKS funds however exhibits a misalignment that needs tweaking. The large balances in these accounts further indicate a need to sensitise the committees at various levels towards the need to use the funds optimally.

The new health facilities which are under construction in the state are being provided with central heating. Since the team visited the coldest parts of the state, we can vouch for the wisdom of such a move. Provisioning of canteen services at the facilities, telecom services, better signages (local language), temporary accommodation for attendants are some of the missing links which need to be addressed. The washing services for hospital linen need to be

improved as the tam did not notice any designated protocols for the same. Mechanised laundries may be an option worth examining.

Most public facilities which were visited were seen to have ambulances and drivers too. The team also saw a large number of dysfunctional, old vehicles scattered around public health facilities. These tombs of transport vehicles appear to be typical signage proclaiming a public health facility. The state would do well to dress up the facilities well and get rid of the dead weight of these dysfunctional vehicles. They do not work and are really eye sores and would surely be having a demoralising effect on the visitors. In many cases there is mismatch between the location which has functional vehicle and facility which has the driver. Given the terrain and the inordinately large travelling time, it may be appropriate for the state to examine a central GPS controlled ambulance service which tracks the movement of the vehicles ensures operationalisation at all times and documents referral transport.

5. Outreach activities of Sub-centre

The quality of outreach in the state needs substantial improvement. The terrain and inherent difficulty in mobilizing the community for health related activities appears to be the reason. The positioning of second contractual ANM appears to have created local disputes since at many places the local residency criteria seems to have been violated by the respective district societies.

6. Utilisation of untied fund

Untied funds are being received by the health facilities. Maintenance of separate bank accounts for this Hospital Development Fund and the RKS funds however exhibits a misalignment that needs tweaking. The large balances in these accounts further indicate a need to sensitize the committees at various levels towards the need to use the funds optimally.

7. Thrust on difficult areas and vulnerable social groups

The state has classified the difficult areas as two categories of A & B. However, several difficult areas in Kargil are not included in the list. The HR availability is good in difficult areas of Kargil district as ANMs and pharmacists are made available in the remote rural and snow bound areas isolated for over 5 months in a year. The state has proposed availability of contractual MOs at SHCs on weekly basis. The drugs are stocked adequately prior to snowing periods. Mobile Medical Units with surgical facilities have been made available but mostly unutilised.

8. Quality of services provided

This aspect has been addressed under on preparedness of the health facilities for patient care.

9. Diagnostics

Most of the facilities visited by the teams had a rather large number of lab technicians. At most places essential lab equipments were also there. However the utilisation of the labs by the clinicians and the range of services available in the labs was severely restricted by the sheer lack of ownership and supervision by the MO incharge and BMOs. Most labs do only Hb and routine tests. The number of these tests per lab technician is also not very large. The recording of test reports is also not in a valid format[40]. There was no evidence of PPP options being examined for lab services in the state.

10. Logistics & Supply chain management

The procurement of medicines and supplies is by the state health directorate and all health facilities send annual indents. A few facilities send mid year indents also. In the health facilities, large number of medicines are available. The essential drug list was not seen displayed for benefit of the patients. In any case almost no clinician at the facilities visited by the team appeared to be conscious of the need to prescribe friom within the essential drug lists. At most place the teams found expensive prescription medicines being purchased by the patients on recommendation of the doctors. No one in the field (BMOs or CMOs) gave a satisfactory reply to why this was not being curbed.

Since the indents are annual there are often stock outs which last for the balanmcme part of the financial year. Iron Folic acid incidentally is not within the jurisdiction of the Health directorate and the family welfare directorate gets no help from the health directorate in supply chain management. As a

[40] At the SDH Drass, the MO incharge does ultrasound himself but keeps almost no record of why he did it or what the findings were. The register only contains the serial number of the patient. This is not only defeating the purpose of an advanced investigation but also opening up issues under the pNDT.

result the godowns at state level are full of key RCH medicines but the field facilities are devoid of medicines and consumables. There is no method of certifying the quality of medicines at the facility level and the state level protocols in this regard are also not clear. The pharmacies at most health facilities stock medicines in appropriate, well labelled, catalogued manner. This is largely because there is a very large complement of pharmacists in the public system. And more and more have been (are being) recruited on contract under NRHM. State may like to re-examine whether it needs so many pharmacists. Alternately the pharmacists can be multiskilled to undertake other activities in the health facilities.

Another peculiar feature of the health facilities is the presence of chemist shops being run by Cooperative societies in most health facilities. These coop societies have over time been reported to have degenerated into single persons entities. Perhaps the state can consider making it mandatory for these cooperative societies to stock ONLY generic medicines from reputed manufacturers and sell them to patients. This will off load the logistics and management problem off the state and also make available quality medicines to patients. The state can meanwhile continue to process its proposal of setting up a procurement directorate.

11. Decentralized Planning

The District Health Action Plans were prepared once during 2006-08 period by EPOS. It is reported that detailed consultations with CMOs took place at that time. The process however has not been repeated and updated IDHAP for periods after 06-07 are not available. Recently each district has been asked to prepare a detailed status and HR map. This is a welcome step and stimulates local plan formation. However the protocols for decentralized planning and associated operational connectivity are yet to be established in the state.

However, the road ahead needs to be planned before an affirmative report on decentralized local health action can emerge. The posting of health human resources in the state is tightly centralised. The procurement and supply of a most equipments and furniture is also tightly centralised. The drugs and consumables are also procured centrally. Being centralised, these activities

often do not take into the local need assessments. This leads to suboptimal utilisation of men, machine and money. The District Health Societies are not being mentored to operate in a decentralised paradigm. Many DHSs have reported recruitment of health HR in violation of the guidelines of local residency criteria. Instead of recruiting HR to compensate key gaps, the DHS are also reported to be sometimes recruiting non essential staff. Many contractually recruited persons are also deputed away from the facility where they are recruited. While the non interference of State Health Society in these violations is an act of positive restraint, the need for supportive mentoring in these matters is clearly felt. The District CMOs and DHS need to be trained to keep the outcome goals of service delivery under NRHM in sharp focus. Tight supervision of progress of work is also needed and is seen as missing in the state. There is no PRI structure in the state and not too many NGOs are available to provide an "out of the system" perspective to the state. This can be compensated with greater technical and managerial supervision of the field formations by the state health society.

12. Decentralised Local health action

As pointed out earlier, decentralized planning is not yet fully internalised by the state. It is noted that the state has operationalised a large number of VHSCs. The RKSs are also operational at most facilities. The utilisation of the flexibility provided to these institutions under NRHM is slowly beginning to take roots in the state and funds allocated to them are being utilised for gap filling. The officers in the field who are utilising the decentralized action funds should be encouraged and facilitated to improve the performance of the facilities.

However, it must be reiterated that a larger cloud darkening the sky of local health action is the utter lack of ownership of respective level of the Public Health system by the District CMO, BMO and facility MO. Unless a specific officer becomes responsible for a specific facility, the confidence for decentralized local health action will not take firm root. The absence of this ownership was seen during the state visit as the most critical bottleneck to local health action.

13. Community Processes under NRHM

Since the PRI are not in place in the state, community processes generally take a slower pace than other states. In the field, the team did not notice any community voice in the functioning of the health system. The RKSs do have community representatives but that is not adding much value to the gap filling capabilities of the RKS. As such there is not one to encourage or mentor the community to take part in management of the health facility.[41] There is little involvement of NGOs in the sector.

14. ASHA

ASHAs had been recruited and were available. They have been trained in two parts / sessions[42], and had received drug kits in 2008-09 which has not been replenished this year. Few ASHAs were found to be unmarried and very young (around 18-19 years of age)[43]. JSY payments for ASHA are delayed for a month or more in some cases[44]. Many motivated ASHAs were found working in the system. Some of them even paid for referral services from their own pockets to bring the pregnant women to the hospital for deliveries / ANC check-ups. Few among them are tracking children due for immunisation and maintaining registers. However, knowledge of ASHAs on preventive & promotive MCH & FP services needs to be strengthened. In most cases, ASHAs are doing their work with expectations that they will eventually be regularised.

15. National Disease Control Programmes

RNTCP: Low case detection rate is perpetual problem. However, the sputum conversion rate of 92% and cure rate of 89% in NSP patients are satisfactory. The sputum conversion rate is low in Rajouri and cure rate in Leh and Rajouri districts. The DOTS Plus is to be started.

Leprosy: The state is low endemic for leprosy with prevalence rate of less than 1 /10000 population. However, new leprosy cases are detected every year (200 cases

[41] Apparently at very remote locations, the citizens are filled with gratitude for whatever services are available and do not voice any dissent at all. In any case the living conditions itself are so difficult that administrative dissent takes a back seat.

[42] It is not clear whether they received training on two or more modules

[43] At Tangdar block

[44] At Sopore, Baramulla district, one of the ASHAs said that she had received payments for only 6 cases while she has brought 23 cases for institutional deliveries. On probing it was found that the facility did not have funds for JSY

on record) indicating active transmission of the disease and need for in-depth situational analysis in districts/blocks reporting large number of new cases and take suitable actions.

IDSP: The reporting of disease out breaks are to be initiated as several diseases (diarrhoea, typhoid etc) are showing upward trends in Jammu region during 2008 in comparison with previous year (2007).

Blindness Control: The State has relatively high prevalence of blindness with 15.1 (all India 11.2) and the cataract surgeries to be increased.

16. RCH II

The Public Health Delivery System in the state has undergone substantial improvement over the past years. Jammu & Kashmir has undertaken wide ranging reforms in the Health sector and made major efforts to improve Maternal & Child Health, Family Planning and improve immunization coverage. With a TFR of 2.3 (SRS 2007), the state achieved the 10th Plan goal and is close to the target of 2.1 for the year 2012. SRS data on MMR is not available for the state. The SRS data (2008) show that Infant Mortality Rate (IMR) in Jammu & Kashmir (at 49 per 1000 live births) is lower than the national average of 53, but is much higher than the target of 30 for the year 2012. However the Neonatal Mortality Rate (NMR) and the Early NMR in the state are 39 and 31 respectively and these are higher than the national average of 36 and 29 respectively (SRS 2007). The comparative status of the key indicators in the state is as follows:

INDICATOR	JAMMU & KASHMIR		INDIA	
	Trend (*year & source*)		Current status	RCH II/ NRHM (2012) goal
Infant Mortality Rate (IMR)	44 (SRS 2003)	49 (SRS 2008)	53 (SRS 2008)	<30
Total Fertility Rate (TFR)	2.4 (SRS 2004)	2.3 (SRS 2007)	2.7 (SRS 2007)	2.1

However, the review of comparative data from 2003 / 2004 indicates that the state shall need to undertake more vigorous efforts to reach the Goals of RCH II / NRHM. IMR in the state had **increased** from 44 (SRS 2003) to 51 (SRS 2007) and has now **decreased** to 49 (SRS 2008). With Neonatal Mortality contributing to 77% of the IMR, while Early NMR contributes to 80% of the NMR, efforts need to focus on provision of quality neonatal care services both at institutional and household level. Since SRS data on MMR is not available for the state, it is difficult to assess the improvement in maternal mortality and the efforts needed to achieve the RCH II goal for 2012. Concerted efforts will be required at this stage[45], so that the Total Fertility rate reaches the desired goal although it is close to the RCH II /NRHM goal. The issue of quality of service needs to be addressed on priority.
The state reported the following progress on RCH II interventions:

[45] NFHS-3 data shows an increase in the total unmet need from 10.6 (NFHS-2, 98-99) to 15.0 (NFHS-3, 2005-06) and DLHS-3 data which shows that use of modern contraceptives has decreased from 52.1% (DLHS 2, 2002-04) to 41.2% (DLHS 3, 2007-08) and is lower than the national average of 47.3% (DLHS 3, 2007-08).

- 39 FRUs are reportedly functional (till August 2009) against a target of 70 by 2010; and 96 PHCs are reported as providing 24-hour services (target of 187 by 2010). Referral services are being strengthened with procurement of 125 new ambulances recently.
- The number of JSY beneficiaries in the state increased from 0.02 lakh in 2005-06 to 0.13 lakh in 2006-07 and *then declined to 0.11 lakh in 2007-08 and further to 0.07 lakh in 2008-09*. However it has now **increased to 0.15 lakhs in Q1 2009-10**. State has accredited 6 private institutions to provide JSY services.

Key Findings & Issues

The Public facilities are witnessing increased patient attendance and institutional deliveries are also rising. There is a need to ensure a commensurate increase in capacities of facilities to deliver high quality maternal and neonatal health services, as well as use this opportunity for post partum family planning.

The numbers of indoor admissions have also gone up but in many instances IPD cases are admitted for day care and observations and discharged after few hours stay. The fact that patients do not stay in the facility beyond a few hours post delivery in most cases of normal delivery and neither are they encouraged to do so[46]; is an area of concern and needs to be addressed. The fundamental components of the health system including alignment of basic skills, basic equipment and standard operating procedures is not yet in place at most levels. In the absence of these and adherence to Standard, evidence based clinical protocols; MCH services provided would not be of acceptable quality. As of now, the state needs to consolidate the gains which have been made so that there is assured availability of services including presence of key staff (with appropriate skills) and all the other inputs needed for service delivery at the designated FRUs/ 24x7 PHCs.[47]

In case of skilled attendance at birth the guidelines/ standard BEmOC **protocols are not being followed** in practice for conducting labour; use of partograph, AMTSL though an integral part for the CEmOC and BEmOC training of doctors and nurses not being practised; and foetal monitoring at all facilities needs to be improved; monitoring & recording of essential parameters not being done during the course of delivery.

Maternal deaths reported from facilities are negligible[48] as complicated cases are being referred, often verbally and no documentation of the same exists in registers. Maternal Death Audit has been proposed in PIP; no progress on the same has been reported. Maternal Death Audit at the community level needs to conducted.

[46] Observed in Tangdar CHC, Baramulla DH, Sarwal SDH.

[47] The deficiencies in delivery of services are spread across all components of the RCH spectrum of services. The full complement of ANC is not yet being ensured (e.g. early registration of pregnancy, weight monitoring of pregnant mothers, physical examination of woman, taking BP, nutrition counselling, anemia prophylaxis, preparation for labour & childbirth etc). In most cases, standard/treatment protocols / guidelines are not available in LR. At several facilities women are discharged within 4-6 hours post partum (due to lack of food, clean functional toilets, encouragement by the providers, IEC etc). The links to domiciliary post natal follow up are also missing at most places. In several cases of institutional deliveries, newborn do not receive BCG and / or zero dose OPV at the facility.

[48] Tangdar CHC, Kupwara district & Mother & Child Hospital, Sopore, Baramulla district reported only 1 maternal death; however there was lack of definitional clarity on maternal death. Most facilities reported none.

The JSY disbursal is sometimes delayed by a month and sometimes for a longer period[49]. ASHAs have started generating demand and are making referrals to facilities chiefly for MH[50]. However a number of cases of institutional deliveries are self admitted[51].

Essential new born care found lacking; poor post natal care; lack of counselling leading to early discharge and poor newborn care practices: hardly any facility hosted a newborn corner in LR.

The concept of neonatal care as a planned intervention is not clear to many of the service providers at 24x7 PHCs, SDH/CHCs and district hospitals. No area had been earmarked and equipped for newborn care in the OT and labour room in FRUs / 24x7 PHCs and most equipment for "essential newborn corner" are not in place within the labour room or OT[52]. Early initiation of breastfeeding was not being practiced; neonates were found being bottle fed in few facilities and this practise was not being discouraged by service providers[53].

Awareness of medical and nursing staff to the concept and need of essential newborn care services in the labour room and OT was generally lacking even at district hospitals and FRUs (CHCs / SDHs). Weights of newborns are not being recorded in registers and the doctor on duty lacks awareness on the significance of recording weight at birth[54]. Knowledge and orientation of doctors and SNs/ ANMs needs to be imparted on new born care and resuscitation.

The immunisation performance in the state has improved substantially as per DLHS-3 data. However, the state could further improve performance in this area through more rigorous follow up and tracking of defaulters. Defaulter tracking through use of tickler bags etc is not done at most places and in many cases the counterfoils of the immunisation cards are given away/ or not being filled which should be avoided. Reorientation of health workers needed in storage and use of vaccines[55].

Sterilisations, mostly tubectomies are being conducted at DHs, FRUs and in some PHCs. The vasectomies however are very few and in some facilities male sterilisations are not being done[56]. Any systematic efforts to improve performance of terminal methods (especially post partum sterilization) and spacing methods were nonexistent. Counselling for family planning by ANMs & clinical providers, an important component of FP services, appears to be lacking. IEC material on FP was not seen in adequate quantities at peripheral facilities. The role of ASHAs as motivators was not seen. There is no involvement of male peer groups[57].

The teams did not find evidence of Adolescent Reproductive & Sexual Health (ARSH) services in the facilities visited i.e. District hospitals/ FRUs, 24x7 PHCs or PHCs.

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[49] No payment for JSY has been made since 11th Oct '09 as adequate funds are not available with the facility and CMO of district says though funds for JSY are available currently; they will soon face a shortage. JSY funds have been given to all districts as a fixed quantum of Rs. 40 lakhs not taking into account the population of the reproductive age group resident in districts.

[50] ANC & Institutional deliveries

[51] Based on interviews of admitted mothers in Baramulla DH

[52] Designated newborn corner not there in LR / OT

[53] At Tangdar CHC & Baramulla DH, mothers admitted following C-section had not initiated breast feeding even after 2 -3 days and was encouraged by the team to do the same. At Sarwar SDH, OBG specialist instead of encouraging breast feeding had prescribed artificial feeding for the child.

[54] At Baramulla DH, Sarwar SDH, Tangdar CHC no baby weighing machine was found and weight of newborn was not being recorded. Of concern is the fact that 60 neonatal deaths have been reported from the period April-08 to August-09 in Mother & Child Hospital, Sopore.

[55] Knowledge of health workers regarding site of administration of DPT vaccine (most were injecting in gluteal region) or the chances of loss of potency/ damage when adsorbed vaccines like Hepatitis B, DPT, DT, TT are subjected to freezing temperatures is lacking.

[56] Mother & Child Hospital, Sopore, Boniyar PHC, Baramulla DH,

[57] This is evident from NFHS 3 survey data which shows that there is little change in male sterilisation NFHS 2 (2.7 %) and NFHS 3 (2.6%)

IEC activity appears to be on a very low key. Within the facility, there were posters on immunization schedule, safe delivery, treatment algorithms for Pulmonary Tuberculosis leprosy in local language.

Status of Facility Operationalisation at facilities visited

None of the 8 FRUs visited by team fulfilled the definition of "FRU" based on presence of the three critical determinants of functionality as per guidelines of GoI. None of the two 24x7 PHCs fulfilled the three critical determinants of Primary Health Centres providing 24-hour delivery and Newborn care as per guidelines of GoI.

Quality of service including, maintenance, waste/ infection management and adherence to standard treatment protocols

Health care waste management and infection prevention practices and knowledge are poor at all facilities with no segregation of waste, poor storage and disposal of sharps and placenta and body parts. There is very limited understanding of the concepts of infection control and management, and waste segregations and disposal at all levels in the state. Staffs in facilities are not aware of the significance of different colours of bins which were available at few places, and most providers and staff have not received any training in waste segregation and management[58]. The guidelines issued by the MOHFW on the subject are mostly not available. No segregation of hazardous waste in coloured bins is being done as per bio-medical waste disposal rules[59]. Likewise, the PHCs visited by the team also did not have proper waste disposal systems[60].

Standard operating procedures and standard treatment guidelines were neither seen nor appeared to be followed in any facility visited. A general lack of awareness/apathy towards quality issues was observed among staff across the board from district to PHC level. Primary reason for this was non-availability of Technical Protocols/operational guidelines for most interventions. There is lack of awareness among MOs in charge of PHCs, CHCs / SDHs and superintendent of District Hospitals on availability or need of standards/protocols. This is a key issue with the district health staff also. Operational guidelines for operationalisation of FRUs and 24x7 PHCs are not available at facility level. The document available with facilities is the budget details which mention the head of expenditure but no detail on how to do things. In the absence of detailed guidelines, there is a lack of awareness of even critical determinants of functionality for FRUs and 24x7 PHCs among MOs/ District

[58] At Akhnoor CHC, Jammu, Sopore SDH, Kupwara district, Kashmir division all hospital waste (including needles / sharps & placenta) are dumped in a vat and thereafter disposed by the municipality. No burial pit for disposal of placenta was seen at Chowgal PHC. Pit for disposal of sharps not yet constructed in almost all facilities visited. At Mishriwala PHC, all waste is being disposed in a pit just adjacent to the building of OPD room where ANC, immunizations and CuT insertions are carried out. At Kupwara SDH, manual segregation of waste was being done in the incinerator plant; sharps and needles are seen lying around the hospital campus. At Pampore SDH, Waste disposal has been outsourced but no effective supervision exists on where the agency is finally disposing the waste.

[59] Little / no segregation of waste is being done at all levels. At Akhnoor CHC, Tangdar CHC syringes, sharps and needles were being disposed in the dustbin. Polythene bags in bins were not observed in Kupwara & Baramulla districts. Multicoloured bins with polythene bags were seen only in Sarwal SDH, Jammu with instructions written above them; however in the emergency, syringes and needles were found lying in the bin for general waste. In the ward, there was a mismatch in the placement of the bins aligned to instructions printed above.

[60] Hub-cutters were available were not being used and the needles and syringes were being put in dustbin. Sometimes when hub-cutters would become full they would be dumped in a shallow pit in the hospital premises. Sharps and needles were visible in hospital premises.

Programme/Managers. Apathy/lack of motivation of district officers contributes to this situation[61].

Referral Transport

All PHCs[62] visited by the team have ambulance/s, but their use and placement did not appear rational or supervised. In some cases the vehicle is being used for work other than transporting patients[63]. Overall, there appears to be a mismatch of drivers and vehicles[64]. Attachment of staff including drivers from peripheral facilities may render referral services at the peripheral level non-functional[65]. The emergency referral phone numbers are often not readily available. In few facilities, user charges for referral services were being charged from all including the BPL, which may need to be clarified[66]. At the facilities a record of use of referral services are kept; however usage of ambulance remains with the driver in the vehicle log book. A record / register indicating use of ambulances needs to be maintained at facility level as well which can track utilisation of the same. Record keeping across facilities is not standard and uniform.

IEC/ BCC

The state needs to re-examine its IEC/BCC strategy and capacity[67]. Minimal IEC / BCC activities are visible at the district level owing to minimal funds being available at the district level. Sign boards of available services were observed outside most hospitals. The strategies for IEC/BCC also need to be re-examined, most of the focus appears to be on mass media communication through relatively expensive, local cable TV channels and masjid miking are being used chiefly. Innovative, locally acceptable and relevant IEC themes are not being designed at the district level. Issues like age of marriage, malnutrition are not being addressed through convergent efforts of the ANMs and AWWs.

Gender & Equity

At Baramulla district hospital, absence of male counsellor in the ICTC centre is preventing effective partner management practices. The state has several hard to reach and inaccessible areas. However the districts need to prepare a clear road map or separate micro-plan for ensuring access to services in such areas[68]. Outreach services need strengthening and proper microplanning. There is an urgent need to integrate and streamline

[61] CMO of district Kupwara was in place since last 2 months, while prior to that also the CMO was in place for a limited period; this is leading to lack of ownership or accountability.

[62] Even the Medical Aid Centre had 2 ambulances

[63] In Chowgal PHC, it is being used for VIP duty

[64] At Kupwara SDH, there were 3 drivers and only 1 ambulance , at Teetwal MAC, there were two ambulances and 1 contractual driver in the MAC, one of which was not being used, at Tangdar CHC, there were 4 ambulances & only 2 drivers

[65] At Handwara DH, there are 4 ambulances and 3 drivers from block level have been attached. In Sarwal SDH there are 3 ambulances; while Kupwara SDH has only 1 operational ambulance

[66] At Kupwara SDH, ambulance charges of Rs.50 and POL expenses were being charged as the BMO stated that there were no funds for referral transport for the past two years.

[67] Posts of both State & Regional IEC / BCC officer and Audio Visual Officer are vacant; while there is an IEC/BCC consultant at the state level

[68] In one of the bordering blocks, in Baramulla district the hard to reach villages had been identified; among which few villages do not have any ASHAs or health facilities. However there appeared to be a lack of need at the block level to prepare a special plan for these areas. Outreach services consisting chiefly of immunization are being provided with the help of army and through male health staff in the border villages. ANC check-ups etc are not being done. Mode of transport to these areas is on foot. MOIC reported that 43 sputum positive cases were detected in Dudran, one of the villages. This is of concern.

service delivery of immunisation with maternal health and other child health interventions particularly at the sub-centre, anganwadi and community level (especially in HRA areas).

17. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health

What is the involvement of Panchayats/ Village Health and Sanitation Committees in processes of health system. Are there special convergent efforts at addressing malnutrition, vector-borne diseases, age of marriage, educational lunch etc. Are there any linkages with the HIV/AIDS; water and sanitation and Women and Children departments?

18. Nutrition

Nutrition is one of the most important collateral determinants of health. Poor nutritional status is known to contribute to the incidence, frequency and severity of most morbidities. Under the health sector reforms being undertaken under NRHM, steps to improve nutrition status of the community (including early childhood nutrition, adolescent nutrition and adult nutrition) are critical contributors to achieving the health indicator goals set under the Mission. Steps undertaken by the state/district in this regard and measure to improve the understanding of various aspects of nutrition including early & exclusive breast feeding, weaning, early age food items etc be looked at and what steps are taken to identify early malnutrition and remedial measures to combat the same. Steps taken to identify and manage moderate to severe malnutrition, continued monitoring and management of the cases, improve access to IEC material on nutrition be examined.

NUTRITION

The Village Health and Nutrition days are envisaged as platforms for integrated delivery of outreach MCH and Nutrition services and the success of which rests on the assumption of joint micro-planning and implementation efforts by the ANM, AWW, AW helpers, ASHAs, and the VHSC members. **Village Health and Nutrition** days (VHNDs) are not being organized as envisaged in the guidelines issued by Government of India. The services in these sessions are limited to immunisation only. Team visited Lonewala Anganwadi centre, district Kupwara, Kashmir division on Thursday and Gurah Talab Sub-Centre and Anganwadi centre, Jammu division. Some important observations based on interviews of ANM, AWWs, ASHAs are listed below:

- In the field VHNDs are still focused on immunization sessions, integrated range of RCH services is not provided. Immunization services are being provided on Wednesdays in Sub-centres / AWCs. At best, the VHNDs are immunization days only.

- In the Anganwadi centre in Kupwara district, supplementary nutrition activities such as distribution of take-home-rations for pregnant women and in-house feeding for children has not been carried out for the past 2-3 months as there has been no supply of food, while in the Anganwadi Centre Gurah Talab in Jammu, food for supplementary nutrition activities has been available from second week of October, prior to that no supplementary nutrition activities could be carried out for around 2-3 months as there was no supply of food.
- There is no advance micro-planning for these camps[69], due list of expected beneficiaries (children due for vaccination and ANCs) not being maintained by ANM at both places.
- Poor record keeping: counterfoils of immunization cards not retained[70], the registers and the immunization cards are sometimes not updated.
- Mobilization & convergence with ASHA & AWW is not adequate. No focus on preparation of micro-plan for each pregnancy & its tracking.
- TT inj. Is the only maternal health service provided[71], no weighing, BP measurement[72], ANC or PNC checkups & visits, ARSH counselling or services provided.
- No proactive plan in place to engage eligible couples and provide spacing services under Family Planning.
- Growth charts not maintained properly[73].
- Practices like keeping DPT/TT vials in direct contact with frozen ice packs and injection being given in gluteal region were observed. Training of Health Workers needs to be completed urgently.
- Monitoring of VHNDs is not being ensured.
- No evidence of systematic coordination between sub centre and AWC[74].

19. Non-governmental partnerships

What are the specific non -governmental partnerships? Are they effective? Do they lead to better services for people? How well is the state/district in implementation of the MNGO scheme? Numbers of accredited providers for JSY, MH and FP services. Is there a mechanism for performance based funding, effective contract management and robust monitoring mechanisms? Any Plan to expand PPPs for RCH services.

20. Overall Programme management

Is a programme management system in place at State and district level? Does the district plan have adequate focus on planning for facility operationalisation and service delivery? Are they integrated with the mainstream? Are the new skills being

[69] In both sites visited there were no plans for VHNDs. At Gurah Talab HSC, MPHW (F) could not say as to "how" she was conducting sessions in the 10 Anganwadi Centres under her SC. It is doubtful, whether they were being covered.
[70] In Gurah Talab HSC
[71] IFA tablets were not in supply in Kupwara district
[72] At Gurah Talab HSC, weighing scale though found, was kept inside cardboard carton and was not properly calibrated; BP equipment was not found
[73] No baby weighing machine was found in Lonewala AWC
[74] In Gurah Talab AWC, AWW was not aware of VHND being held. She stated that MPHW (F) visited AWC but not on any specified day. ASHA did not necessarily come on that day

used? Any new skills required given the programme needs? Have Block level teams been constituted? Assess performance of programme management teams.

Program management
DPMU
(Districts: Kupwara & Baramula)

In Kupwara district, 5 out of 10 Block Program managers are in place. There is no district program manager (DPM) in place for last 4 months, no district data assistant (DDA) for last 2 years[75], only district accounts manager (DAM) position is filled. In Baramula district, the attrition rate in DPMU is high. DPMU did not have any DAM from May'08 to August '09 while there was no DPM and DDA from 1st week of July to 2nd week of October. RKS funds were released in the last week of September in Baramulla district. There has been restructuring in the pay scale of doctors and paramedical staff however this has not been implemented.

21. Financial management

Whether record keeping of finances is as per rules, and adequate staff provided for this. Whether the financial reporting is timely and accurate? Examine the system of utilization of funds and its reporting and the process of audit. Have the district and state level audit reports been timely and do they mention any adverse comments. Has action been taken on the audit findings? Record progress made on integration of FM processes with disease control programmes.

Financial Expenditure

While the expenditure has been increasing, state needs to take urgent steps to increase the absorptive capacity. Reported expenditure during 2008-09 is less than 10% of the allocation. Overall expenditure reported by the state in the 1st quarter is Rs. 3.52 crores (31.6% of the budget Q1 09-10): including Rs. 73.23 lakhs for base flexi pool (21.2% of the total base flexi pool budget), Rs 2.71 crores for JSY (38.7% of the JSY budget), and Rs. 8.28 lakhs for sterilisation compensation (12% of the sterilisation compensation budget). The state has reported nil expenditure on family planning and reported high variance from the amount planned for child health and Innovations / PPP/ NGO in Q1 09-10.

State had planned for Rs. 2.38 lakhs under family planning for Q1 09-10, including female sterilisation camps (Rs. 1.50 lakhs) and monitoring progress, quality and utilization of services by Quality Assurance Committees (Rs. 0.88 lakhs). The state has reported **NIL** expenditure for the 1st quarter.

22. Data Management

Whether the HMIS is effective? How is it being used? What is the level of data entry? PHC or Slack or District? What are the problems/constraints being faced? What are the steps being taken to improve the health MIS. Is the latest survey data being

[75] BMO, Chowgal PHC said the position of data assistant had been advertised in newspapers on 16th Nov, 2008 but Chairman DHS had not been taking interest.

used? Is disaggregated data recorded and used? What is the extent of integration of HMIS with IDSP? Measures needed to be strengthen the HMIS and increase of efficacy is suggested.

HMIS / Data management

There is a need to improve the recording systems at SHCs, monitoring of drug stock registers as well as the data compilation at district and State levels. Detailed record of patients in OPDs, IPDs, causes as to "why" they are undergoing the laboratory tests, ultrasound, X-rays is not being maintained in the registers.

The HMIS data is being uploaded at the district level and there is a need for verification of this data as more often the data is not correlated for the services utilisation including deliveries, out-patients and In-patients. While an HMIS is in place, systematic analysis and understanding of data & feed back to facilities or its use for planning or effecting corrections was not visible.

The monthly HMIS data for Jammu and Kashmir shows a 21.8% decrease in the total number of pregnant women registered for ANC from Q1 08-09 to Q1 09-10. However the proportion of pregnant women registered in the first trimester has increased by 5.8%. There has also been a 30.8% decrease in the number of deliveries conducted at public institutions and the proportion of such deliveries discharged in under 48 hours has increased from 7.5% to 44.6%. This is of concern. The number of newborns weighed at birth has decreased (in absolute numbers) by 22.4% from the corresponding quarter in the previous year; and the number of newborns weighed at birth has decreased by 22.4% and the number of newborns weighing less than 2.5 Kgs has increased to 21.7% in Q1 09-10 from 14.4% in Q1 08-09. The number of newborns breast fed within one hour has increased from 27% in Q1 08-09 to 39% in Q1 09-10. The state has also recorded a decrease in the number of live births by 21.2% between Q1 08-09 and Q1 09-10.

The HMIS data for the state shows several inconsistencies, e.g. total number of live births doesn't match the number of live births reported individually for males and females. Many such instances occur in the HMIS data and the state needs to investigate the reasons for the same so that the analysis can be made accurately.

HMIS data shows 55 operational SNCUs in Q1 09-10, which has increased from 43 as at March 2009. However, according to the State PIP 09-10 submitted to GoI in March 2009, SNCUs were yet to be set up. As per the PIP, 14 SNCUs in district hospitals and 39 stabilisation units in FRUs/ CHCs are planned for the current year.

There is an urgent need for data verification both at district and state levels. State needs to put in place mechanisms to ensure quality of data entered on the HMIS web portal, including capacity building of data entry personnel.

23. Status of the progress of state against Specific objectives, expected Outcomes and expected Outcomes at Community level under NRHM.

The Framework for Implementation fo NRHM mentions the following objectives, and expected outcomes of the reform process envisaged under NRHM:

The Objectives of the Mission

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

The expected outcomes from the Mission as reflected in statistical data are:

- IMR reduced to 30/1000 live births by 2012.
- MMR reduced to 100/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.
- Malaria Mortality Reduction - 50% up to 2010, additional 10% by 2012.
- Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.
- Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
- Dengue Mortality Reduction Rate - 50% by 2010 and sustaining until 2012.
- Cataract operations-increasing to 46 lakhs until 2012.
- Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to less that 1 per 10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.

- Upgrading all Community Health Centers to Indian Public Health Standards.
- Increase utilization of First Referral units from bed occupancy by referred cases of less than 20% to over 75%.
- Engaging 4,00,000 female Accredited Social Health Activists (ASHAs).

The expected outcomes at Community level

- Availability of trained community level worker at village level, with a drug kit for generic ailments.
- Health Day at Aanganwadi level on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother and child health care, including nutrition.
- Availability of generic drugs for common ailments at sub Centre and Hospital level.
- Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level and assured referral-transport-communication systems to reach these facilities in time.
- Improved access to universal immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme.
- Improved facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidized under the Janani Surakshya Yojana (JSY) for the below poverty line families.
- Availability of assured health care at reduced financial risk through pilots of Community Health Insurance under the Mission.
- Availability of safe drinking water.
- Provision of household toilets.
- Improved outreach services to medically under-served remote areas through mobile medical units.
- Increase awareness about preventive health including nutrition.

The CRM team may seek to track progress of the respective state against the above objectives and expected outcomes under NRHM. The plans presented by the state before the Planning Commission may be examined to identify synergy of goals and objectives. The team may also comment on the overall pace of progress towards attainment of the goals & objectives and identify shortfalls which are likely. The team should also include clear and doable recommendations for accelerating the progress towards achieving the goals and objectives.

For each of these activities the report should be backed by empirical data as available from the records at district and state level as also based on feedback received in the course of focus group discussions etc. Special emphasis should be given to manpower needs, especially key areas like medical, nursing, other para medical staff (especially key skills like Lab Technicians, etc). The teams should also examine the progress against the time line of NRHM.

Part 2

Progress against the approved PIP of the state

Under NRHM, resource are allocated to states as flexible pools to states with decentralized programme Implementation plans being prepared by them for utilisation of the same. The PIPs are prepared in the states on basis of IDHAPs and Block plans. The National Programme Coordination Committee (NPCC) appraises and approves the state PIPs through a rigorous, two stage process where all concerned divisions of the MoHFW are associated and states Mission Directors explain their proposals in detail. All the state PIPs for FY 2009-10 were appraised and approved by the National Programme Coordination Committee well in time. Funds are being released to the states on basis of the approved plans and states are reporting progress against the key parameters. The CRM teams may seek to chart the progress of implementation of the initiatives which have been approved under the state PIP.

The decentralized planning process under NRHM has been in place for over four years and has been internalized by all states as the most appropriate route for accelerating health sector reforms. State PIPs have been appraised and approved by the NPCC for four complete years (2006-07, 07-08, 08-09 and 09-10). The Record of Proceedings (RoP) of the NPCC is a useful document for monitoring the overall direction of health sector reforms being undertaken by the states. The RoP have therefore been mapped across the years and themes for all the states. The mappings is useful tool to monitor the investments being made by the state in various major thematic areas of health sector reforms envisaged under NRHM. The CRM teams are expected to take up the monitoring of physical progress on the various themes mapped in the RoPs of NRHM for the past years. For this purpose, the states would prepare a statement of progress against the themes contained in the RoP Maps. The CRM teams may take up test checks of selected themes as deemed fit to track the consistency of strategy and adherence to plan by the state agencies. The change at the grass root level may be mapped against these test checks. As has been pointed out earlier, the review mission shall be expected to elicit objective / statistical data against the various parameters and also give comments on the quality issues.

24 oct order de]uting docs to other palaces
Lsas trained doctors should be poisted to remote areas . strengthen the remote facilities and close IPD services in suburban facilities. Allow th sub uran facilities to work as OPDs.

Pulwama DH (actually SDH not yet upgraded to DH) :Nine nurses and 33 doctors out of which there are 20 are specialists. 4-5 surgeons, five gynaecologist, two anaesthetists etc. At time of visit only 2 doctors are on duty and four are in their quarters for SOS use. Others are not around at this time. The pathway to the quarters is very very dark and dingy. A neighbouring PHC (rajpura) has 32 persons posted. Several can be posted to the DH. It is clearly irrational. DH has two ambulances, both not functional. The PHCs have two-three ambulances. But shifting them here leads the local MLA raising it as a political issue. The MO of the hospital says he is not allowed to post doctors from the PHCs to the DH and he has faced problems in the past. The anaesthetists are trained for LSAS buit are unable to work independently.

PHC Chowgal
(Block: Handwara, District: Kupwara, Kashmir Division)

- Situated at a distance of 5kms from DH.
- General OPD, common for ANC check-ups (no weighing machine)
- No residential quarters for doctors
- No running water in LR[76], no designated newborn corner, no radiant warmer, weighing machine though available, kept on the floor, no medicines/emergency drug tray present in LR.
- Around 6-10 deliveries are conducted in a month
- No doctor/ANM/SNs trained in SBA in facility
- Most women are discharged 3-4 hours post delivery
- USG conducted at facility (27 in Sept, none in Oct due to doctors strike)
- HR: There are 4 MOs (including BMO), and a AYUSH doctor; 1 ANM & 2 Junior Nurses; 2 lab Technicians, 1 sweeper (& 4 are attached from Sub-Centres)
- There are 2 ambulances, one of which was being used for VIP duty
- There were infants who had not received any immunization following delivery in Handwara DH.
- No burial pit for placenta was found in the compound and a pit for sharps and needles was in the process of being constructed. Segregation of waste was not being done in the facility.
- Does not fulfil definition of 24x7 PHC as essential newborn services are not provided.

Anganwadi Centre, Lonewala
(Block: Treagham, District: Kupwara)

- Team visited the Anganwadi Centre in Lonewala. Following interview of the ANM, AWWs, ASHAs it was found that only immunisation services are being provided on Wednesdays. In the AWW Centre, supplementary nutrition activities such as distribution of take-home-rations for pregnant women and in-house feeding for children has not been carried out for the past 2-3 months as there has been no supply of food.
- No baby weighing machine was seen in the Anganwadi Centre.

Tangdar CHC
(Block: Tangdar, District: Kupwara, Kashmir Division)

- Located in the border area which is rendered inaccessible for 4-5 months during winter due to heavy snow fall cutting off the entire block and is the major health facility providing health services in the area.
- HR: 1 OBG specialist, 1 Anesthetist, 1 Physician, 1 Ophthalmologist, 1 Lady Asst. Surgeon[77], 1 Dental Surgeon; 3 Pharmacists, 2 Lab Technicians, 1 X-ray technician and 1 Sanitary Inspector.
- There is a shortage of Staff Nurses with 1 senior SN, 5 ANMs in the CHC (attached from adjoining PHCs). There are 4 nursing orderlies (who are untrained).

[76] Since BMO stated that repair work was being conducted
[77] 1 assistant surgeon posted in Garba PHC

- Diagnostic facilities of X-ray, ultrasound, ECG, laboratory was available. In X-ray room in Tangdar CHC, the walls were wooden and there is little protection from radiation leakage posing a hazard[78].
- There were 4 ambulances & only 2 drivers (1 regular & another contractual).
- There are no residential quarters for doctors.
- OBG specialist reported that 1 maternal death took place in the facility; he was however unaware of the definition of the same
- Doctors stated that while the BMO got 25% NPA, other specialists/MOs did not get any NPA.
- Doctors were found prescribing higher order prescription medicines instead of basic generic preparations leading to increased out-of-pocket expenditures for the patients.
- In LR, there is no designated newborn corner and newborns are not being weighed, standard protocols on BEmOC are not displayed and neither are they followed. Basic parameters are not recorded during course of delivery.
- There was no light in the toilets in both wards
- Newborn in the ward had not been immunized after 4 days. Mother admitted in the ward following C-section had not initiated breast feeding and was encouraged by the team to do the same.
- Most cases of deliveries were discharged after 2-3 hours post delivery and little efforts were made to keep mothers in hospital for at least 48 hours post delivery.
- There is little idea of biomedical waste management and there is no segregation of bio-medical waste; no hub cutters were available in the wards & LR.
- In the OT, there was Boyles apparatus with ventilator, OT table, OT lights (from NRHM funds), suction apparatus, Non Invasive Blood Pressure Monitoring Machine, Surgical Diathermy, Defibrillator.
- Colorimeter purchased from Hospital Development Funds.
- Temperature log books for Deep Freezer and ILR not being maintained and updated; and there was a thick layer of ice in the inner wall of Deep Freezer.
- Building had been damaged following earthquake; has been partially renovated but sections of it not safe due presence of cracks in the roof & walls.
- Does not fulfil the definition of FRU as essential newborn services and 24-hours blood bank / BSU not there.

Medical Aid Centre[79] - Teetwal
(Block: Tangdar, District: Kupwara, Kashmir Division)

- Located at Teetwal, at the border of India with Pakistan, a small river dividing the two countries.
- Human Resources: 1 ANM, 1 Pharmacist, 1 Basic Health Worker and 1 Nursing Orderly posted in Tangdar, CHC attached here.
- The ANM did not know how to use the BP instrument and no deliveries were being conducted, though a register had been prepared and shown to the team[80]. Delivery kit was not available. Items which can't be used here have been supplied; the store has a whole range of drugs ranging from Haemaccel, Roxithromycin, Theophylline and a several others. While oral pills & IFA tablets were not available[81]. There was a new vacuum extractor lying in the store.

78 Around 10 X-rays are being conducted in a day while a mobile X-ray machine is being used; the capacity of the machine is 100 MA.

79 The Medical Aid Centre (MAC) is of the level of a Sub Health Centre

80 Weight of neonates had been recorded as 10 kg

81 IFA tablets were not in supply in most facilities visited

- Vaccines were stored in the ILR however the staff said that there were frequent power failures. There didn't appear to be a system in place wherein the vaccine requirement[82] could be sent to CHC so that there would be no vaccine wastage. No counterfoils could be found, neither was a due list of beneficiaries to be immunized maintained.
- There are two ambulances[83] and 1 contractual driver in the MAC. The army ambulance is not being used.
- Medical Officer from Medecins Sans Frontieres along with their staff[84] are using the government premises to conduct OPD twice a week. Medicines are also provided by them free of cost to patients along with referral services.

Kupwara Sub District Hospital
(Block: Kupwara, District: Kupwara, Kashmir Division)

- Kupwara SDH is located at the district headquarters.
- It is a 58 bedded hospital with 12 beds in the Gynaecology ward and 15 in Paediatric ward.
- Human Resources: 21 doctors[85] including 3 surgeons, 1 ENT specialist, 1 Paediatrician (B grade) 3 OBG specialists (of which one is B-grade), 2 Physicians (including BMO) and 1 anaesthetist (B grade) of which 3 have been attached and 1 Dental Surgeon.
- There are 8 Pharmacists (of which 6 are attached), 2 theatre assistants (including 1 under NRHM), 2 ophthalmic assistants, 1 blood bank technician, 5 laboratory assistants (of which 2 are attached), 3 dental technicians (of which 2 are attached), 4 X-ray technician (2 are attached), 3 Junior Nurses (of which 2 are under NRHM), 7 FMPHW (5 are attached), 1 LHV, 2 Health Inspectors (1 is attached), 2 Health Educators(both are attached) 16 Nursing Orderly (of which 8 are attached) and 9 sweepers (7 are attached).
- There is a mismatch of drivers and vehicles with 3 drivers and only 1 ambulance in the facility[86].
- There is no block data assistant and an accountant has additional charge.
- Signages with services provided were displayed in the hospital campus along with user charges. In Kupwara SDH, ambulance charges of Rs.50 and POL expenses was being charged as the BMO stated that no funds for referral transport have been available for the past two years.
- Equipments available are not being optimally utilised[87]. The facility has no telephone facility/connection.
- There were television sets in one of the wards and also outside the OT.
- Toilets were without light and dirty. Hospital was dimly lit.
- Immunization clinic was located just next to the mortuary in Kupwara SDH.
- Several ILRs & DFs were in the district store, and could be seen as the window panes were broken. Key was not found and CMO of district could not say as to "why" the cold chain equipment are being kept in the store.

82 Calculated based on beneficiaries to be immunized

83 One of the Ambulances has been donated by the army (Sadbhavna)

84 HR: 1 MO, 1 drug dispenser, 1 registration person, 1 crowd puller and a sweeper

85 Including 4 under NRHM

86 Another ambulance in the facility is not functional

87 There were 6 radiant warmers, 3 Phototherapy units, 2 X-ray machines (one of 100 MA & the other 300 MA capacities) and an endoscope which is not being used as there is no skilled HR to operate it.

- There is no boundary wall. ***Blood Bank in the hospital is not registered*** and is not as per guidelines of Govt. of India
- Telemedicine unit has been installed in 2003 and was operationalised in 2005. It is connected with Govt. Medical Colleges Jammu & Kashmir, SKIMS, AIIMS, Apollo hospital, Delhi, Amrita Institute, Cochin, Fortis Hospital, Noida. 12 consultations were conducted in 2008 and 25 consultations have been held in 2009.
- Building for the emergency unit in Kupwara SDH started a year back, no work has been ongoing for 6 months due to lack of funds. Building for diagnostic centre is not operational and has not been handed over by the state health sector.
- Segregation of hazardous waste in coloured bags/bins is not being done as per bio-medical waste disposal rules. Manual segregation of waste is being done in the incinerator plant; sharps and needles are seen lying around the hospital campus.

Drugmulla PHC
(Block: Kupwara, District: Kupwara)

- Located at a distance of 5 kms from Kupwara SDH.
- Human Resources: 2 MBBS doctors[88] and a ISM doctor, 1 Staff Nurse, 1 FMPHW, 1 Nursing Orderly, 1 Medical Assistant
- 19 deliveries were conducted in the month of October.
- In LR, there is no designated newborn corner; no weighing machine, no oxytocin injection and no autoclave or sterilizer either. Little asepsis is being ensured in the absence of the latter.
- In the absence of skilled HR, microscope in the store in PHC is not used.
- New building is under construction for up gradation of the facility for the past 8 years and currently no work is going on.

Handwara District Hospital
(Block: Handwara, District: Kupwara)

- District hospital is not located in the district headquarters. Location of facility is not rational; a number of facilities are clustered together[89]. It is a 100 bedded facility.
- MoIC was more concerned that there was a single clerk which led to delays in his administrative work; however there appeared to be an absolute lack of focus on "quality care" for patients and monitoring service delivery trends (IPD / OPD case loads/deliveries).
- Human Resources: 24 doctors including 4 surgeons (of which 1 is B Grade), 1 physician (of which 1 is B Grade), 5 OBG specialists (of which 1 is B Grade), 1 anaesthetist (who is B Grade), 2 orthopaedician (of which 1 is B Grade), ENT specialist and an ophthalmologist. Although several doctors are post graduates, they are not allowed to provide their skilled services if they are not "B" grade specialists. The anaesthetist stated that he is unable to attend emergency cases. 24-hours C-sections are not done in facility.
- Paramedical staff include: 1 Nursing Supervisor, 11 Junior Grade Nurses, 3 X ray technicians, 3 lab technicians, 3 dental technicians, 5 pharmacists, 1 LHV, 1 ANM, 7 Nursing Orderly and 3 sweepers.
- There are 3 functional ambulances, 4 drivers (3 of who are attached from blocks)
- A number of patients were seen in the Gynae OPD.

[88] One Lady MO has gone for training on USG

[89] SDH Langate (4kms), PHC Chowgal (5 kms), PHC Natnosa (5 kms), PHC Vadipora (4kms) from Dist Hospital Handwara

- Though there are 4 OTs, only one of them is functional.
- ***Blood Bank in the hospital is not registered*** and is not as per guidelines of GoI.
- Paediatric building with expensive equipment and wards have been donated by the army and another new building donated by local MP is lying unutilized. While the window panes of the wards broken during a snow storm have not been repaired. The window and part of the wall of the attached toilet in one of the wards, is broken.
- There are several wards in different buildings; however there are no nursing stations. Lack of ward assistants was observed.
- There were residential quarters for doctors.
- There has been no expenditure on compensation for sterilization. Expenditure for institutional deliveries till Oct-09 is Rs.7.01 lakhs.

Sopore Sub-District Hospital / Mother & Child Hospital
(Block: Sopore; District: Baramulla)

- Sopore Sub District Hospital, a 45 bedded hospital; is functioning in the OPD block. IPD block is under construction. The Mother and Child unit of the Hospital is situated 1 km away from the main hospital.
- Team found vaccine vials were kept in an open vaccine carrier in the immunization room in Sopore SDH. DPT, a freeze sensitive vaccine was found to be completely frozen. There appeared to be no system in place to store vaccines after immunization sessions.
- ***Blood Storage unit is not connected to UPS***. Emergency operations are not conducted.
- Residential quarters are under renovation
- Human Resources: 9 doctors including the Medical Superintendant, 2 OBG specialists, 3 Assistant Surgeons under NRHM, 5 Junior Grade Nurses, 2 OT technicians, 1 X-ray technician, 1 Lab assistant and 3 sweepers.
- Diagnostic facilities like X-ray, USG and Laboratory tests were providing services from 10 am to 4pm.
- In the OT, the probe of Boyle's apparatus was not functioning properly leading to error readings in the monitor. Both suction apparatus in the OT were not functioning properly.
- LR was located on the 1st floor.
- No payment for JSY has been made since 11th Oct '09 as adequate funds are not available with the facility.
- 1 maternal death was reported in the facility in 2009. 60 neonatal deaths have been reported from the period April-08 to August-09.
- There is no system of bio-medical waste & infection management. There is little / no segregation of waste and all hospital waste (including needles / sharps & placenta) are disposed by the municipality. The MoIC was unaware of the importance of the same.

Baramulla District Hospital
(Block: Baramulla, District: Baramulla)

- Baramulla District Hospital is located in the district headquarters. It is a 110 bedded hospital.
- In the LR, there were 3 phototherapy units, though only one was operational. There was no electrical connection for the other two. There was a single radiant warmer and no baby tray / baby weighing machine.

- Recording of vital information / important parameters in the register in LR like weight of baby was found to be lacking. The MO did not appear to know the significance of weight of newborn.
- In the ward, several mothers who had undergone C-sections were not breast feeding the newborns even 2-3 days post-operative, instead were bottle feeding. The staff in the hospital were aware of it, however no efforts in early initiation of breast feeding was visible. Team encouraged mothers to initiate breast feeding. ANC cards were not found with any of the cases admitted, though treatment sheets had advised USG, inj. tetanus toxoid etc. One of the mothers said that she undergone ANC check-up in the private clinic of one of the doctors.
- ICTC centre has 1 lady councellor and 1 technician. Absence of male counsellors in the STI clinic is preventing effective partner management practices.
- Blood bank is functioning 24 hours and has generator back-up. There are 4 OTs (Gynaecology, Ophthalmology, Orthopaedic & General theatres).
- Laparascope is available and only abdominal laparoscopic sterilisations are being conducted at the facility.

PHC Boniyar
(Block: Boniyar; District: Baramulla)

- Signage with services available and user charges displayed outside the hospital
- It is a 12 bedded hospital. Number of deliveries in the facility ranges from 2 to 5 per month[90]; cases are usually referred to higher levels.
- Human resources: There are 3 doctors (which includes 2 from NRHM), 1 ISM doctor, 2 Dental Surgeons and 2 Junior Grade Nurses. Other paramedical staff include: 1 X-ray assistant, 1 Dental assistant, 1 Lab technician, 3 Pharmacists, 4 Nursing Orderlies and a sweeper.
- The facility has 2 ambulances and two drivers
- LR in the facility is located in the 1st floor has no attached toilet, no radiant warmer.
- Ultrasound machine is there in the facility but no skilled HR available to use the same. X-ray machine though installed 2 years back has been operationalised since the last 8 months.
- In the laboratory, electrical centrifuge was not functional.
- No meeting of the RKS has been held for more than a year.
- Among the 5 hard to reach villages identified, 3 villages do not have any ASHAs and no health facilities are in these areas. There is no special plan for the HRA areas. In border villages, outreach services, chiefly immunization are provided with the help of army. The services are provided by BHW & Health Educator (both male), hence ANC check-ups are not done. Mode of transport to these areas is on foot.
- Multi-coloured bins with no polythene bags were in the facility. However knowledge of staff on segregation of waste is limited.

Akhnoor CHC
(Block: Jammu, District: Jammu)

Akhnoor CHC was visited during CRM-1 in November-07. All specialities are available at the CHC and there is a lot of patient load. The following overall observations were noted:

- Co-operative medicine shop within hospital campus.

[90] In Jan-09, NIL deliveries were carried out

- All hospital waste (including placenta) is dumped in a vat, which is taken away by the municipality. Sharps were seen lying in hospital premises. No segregation of waste being done.
- Construction work for upgradation of the CHC is going on. There were half open manholes in hospital compound; display of user charges against available services was not properly visible owing to repair / renovation work that had been done. The same had not been painted again. Laundry plant is being constructed next to the mortuary. Dental section is being renovated.
- Human Resources: There are 20 doctors including 1 physician (B grade), 1 surgeon[91], 3 OBG specialist (1 of who is B grade), 2 paediatricians (1 of who is B grade), 1 radiologist, 1 ophthalmologist, 1 orthopaedician, 3 anaesthetists (1 of who is B grade) and 11 junior nurses[92]. Other paramedical staff include: 2 ophthalmic technicians[93], 3 Lab Technicians, 4 X-ray technicians 4 OT technicians and 7 pharmacists.
- The facility has 3 ambulances (one of which is donated by the local MP) and 3 drivers.
- There is no blood bank. Slit lamp in the hospital is not functional.
- Labour room opens into the Gynec ward. LR leads to newborn baby room with attached toilet. Among the 4 nursing staff posted in the LR, one is a man.
- Food is not provided in hospital to admitted cases and there is no room for attendants. There is no attached toilet with the ward on the 1st floor. There were only 4 patients were admitted in the 16 bedded ward.
- OT technicians and pharmacists were found in the nursing station, emergency room but didn't have any specified duties. In addition 4 pharmacists (under training) were in the emergency. Needles and syringes were placed in the dustbin following injection; hub-cutters though available in the emergency room were not used.
- The female OPD, a small room was overcrowded and provided little privacy. There were no screens / curtains.

Sub-Centre Gurah Talab under Akhnoor CHC
(District: Jammu)

- Sub-centre at Gurah Talab was visited. The building of the SC is two storied; the ground floor has three rooms with non functional toilet[94] as there is no running water or electric bulbs, the upper floor is not used; the walls are damp with seepage.
- There are 2 MPHW (F)[95], 1 pharmacist, 1 sweeper posted at the SC.
- BP equipment/slides were not found by team, though a register indicating slides made was in place. No counterfoils of immunization cards are maintained and no list of due beneficiaries are prepared. ANC examinations not being conducted at the SC. Weighing machine was packed in carton and though available was not properly calibrated.
- Drugs given to patient are not properly documented in the register and there is no means of monitoring their use. An approximate figure is written against each medicine at the end of the month.

[91] Conducts surgeries, though not a B-grade
[92] 3 are attached from PHCs; 4 from NRHM
[93] One from district Riyasi is attached
[94] Used as a wash room, with water stored in container
[95] One under NRHM

- MPHW (F) did not have any plan for VHNDs and could not say as to "how" she was conducting VHNDs in the 10 Anganwadi Centres under this SC. It is doubtful, whether they were being covered.

Anganwadi Centre, Gurah Talab
(District Jammu)

- Anganwadi centre, Gurah Talab was visited by team. AWW was not aware of "VHND". She stated that the MPHW (F) came to the AWC, however there was no fixed day in the month for her visit; immunization services were being provided in the SC. In AWC, food has been available since 09.10.09, supplementary nutrition activities could not be carried out for 3-4 months prior to this period as there was no supply of food in AWC. There appears to be little convergence in services between ICDS & Health. Child weighing machine was seen in AWC.

Mishriwala PHC
(Block: Kot Bhalwal; Dist: Jammu)

- PHC building consists of two quarters. No deliveries are conducted in this facility.
- Human Resources: There is a MBBS doctor, ISM doctor and a dental surgeon, 1 staff Nurse, 1 Health Educator, 1 LHV (who is attached), 1 Community Health Officer and 1 sweeper in the facility.
- The premises of the hospital are not very clean. No segregation of the waste takes place. All hospital waste including sharps / needles, syringes are dumped in a large pit just adjacent building where the female OPD is held resulting in flies in the OPD.
- The female OPD is small and there is much scope for improving the cleanliness in the premises outside. The cold chain equipments- the ILR & DF placed in the same room. ANC check-ups, immunization services and CuT insertion along with basic laboratory tests[96] are provided in the hospital. 18 laboratory tests had been conducted on the day of the visit. No deliveries are conducted in the facility.
- Of the 2000 OPD cases in the month of October-09, included 30-40 antenatal check-up cases.
- Hospital stores are kept in nearby school & Panchayat Ghar.
- There is a proposal for upgradation of the facility.

Sub-District Hospital, Sarwal
(Jammu district)

- The facility is being upgraded to a district hospital. Signages with services provided and user charges were displayed outside the main building.
- Multicoloured bins with polythene bags were in the hospital with instructions written above them; however in the emergency syringes and needles were found lying in the bin for general waste. In the ward, there was a mismatch in the placement of the bins aligned to instructions printed above.
- It is a 30 bedded hospital.
- Human Resources: There are 20 doctors including 1 surgeon (B grade), 1 physician (B grade), 1 OBG specialist (B grade), 1 paediatrician[97], 1 radiologist (B grade), 1 anaesthetist (B grade) and 1 orthopaedician (B grade). While an ENT specialist,

[96] Routine blood and urine tests and pregnancy tests

[97] Though not a B grade specialist, is providing specialist services

physician, 3 OBG specialists and 2 anaesthetists are working as assistant surgeons[98].

- The Gynae OPD remains closed on Tuesday as surgery is conducted by B grade OBG specialist on that day.
- There are 8 pharmacists; however no specific duty is assigned to any of them.
- There are no residential quarters for doctors; clerical staff lives in hospital quarters.
- There is a separate "Baby Resuscitation Unit" is equipped with a radiant warmer which is not functioning properly and a phototherapy unit and 10 beds[99], located outside the Gynae ward.
- LR opens into the Gynae ward. Sheets were placed over the windows in the LR for privacy. There is no attached toilet in the LR. Baby weighing machine in the LR was not functional. There is no designated newborn corner in the LR. A newborn with low apgar score was referred from the facility and died.
- Although there are only 10 beds in the Gynae ward, 12 cases had been admitted and two cases[100] were discharged in a short time. In the general ward there are 20 beds and only 4 cases have been admitted.
- Blood Storage Unit with UPS has been recently installed. In the absence of trained personnel; the laboratory technician looks after the BSU.
- In Sarwal SDH, Jammu no oral medications were available except Amoxycillin; while Cap Fegain was being prescribed though IFA tablets were available.

DPMU
(Districts: Kupwara & Baramula)

In Kupwara district, 5 out of 10 Block Program managers are in place. There is no DPM in place for last 4 months, no data assistant for last 2 years, only DAM (district accounts manager) position is filled. BMO, Chowgal PHC said the position of data assistant had been advertised in newspapers on 16th Nov, 2008 but Chairman DHS had not been taking interest. In Baramula district, the attrition rate in DPMU is high. DPMU did not have any DAM from May'08 to August '09 while there was no DPM and DDA from 1st week of July to 2nd week of October. RKS funds were released in the last week of September in Baramulla district. The amount for JSY had been released as a fixed quantum of Rs.40 lakhs in all districts not taking into account the population of the area. There has been restructuring in the pay scale of doctors and paramedical staff however this has not been implemented.

ANM Training Centre
(District: Kupwara; Division: Kashmir)

ANM Training School within Kupwara SDH was not functioning. Students in the institute being trained as Ophthalmic assistants / X-ray technicians / Dental assistants / Pharmacists and Staff Nurses were in the institute for more than 3 years and only 1-2 exams had been held as classes were hardly held. Students expressed their discontent over the time period that was wasted. The faculty consisted of 2 Junior Nurses Tutors; while 2 PHN tutors had joined last month.

ASHA
Interviewed ASHAs in District Kupwara

[98] Though skilled are working as GDMOs
[99] All of which were found to be empty at the time of visit
[100] D&C was done for a case

- Lonewala AWC
- Tangdar CHC

Interviewed ASHAs in District Baramulla
- Sopore Sub-District Hospital (Mother & Child Hospital)

- Few ASHAs were found to be unmarried and very young (around 18-19 years of age).
- JSY payments for ASHA are delayed (one of the ASHAs stated that she had received payments for only 6 cases while she has brought 23 cases for institutional deliveries).
- Drug kits provided to ASHA in 2008-09. ASHAs have undergone training in two parts.
- Knowledge of ASHAs on preventive & promotive MCH & FP services needs improvement.
- In many cases ASHAs pay for referral services to bring pregnant women to the hospital for deliveries / ANC check-ups.
- In most cases, ASHAs are doing their work with expectations that they will eventually be regularised.