Third

Common Review Mission

State Report

Orissa

SUMMARY

The National Rural Health Mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable and accountable quality health services to the remotest rural regions. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes.

3rd Common Review Mission visit to the States is based on the mandate of review and concurrent evaluation of Mission Steering Group.

A six member CRM 3 Team visited the State during 04th – 10th November 2009 with the following members:

1. Sri P. K. Hota, Director, NIPI, New Delhi
2. Dr. Ashoke Roy, Advisor, Public Health, RRC – NE, Guwahati.
3. Billy Stewart, Health Adviser, DFID, British High Commission, New Delhi
4. Dr Vijay Aruldas, General Secretary, CMAI, New Delhi
5. Ms Archana Varma, Director, Nirman Bhawan, MoHFW, New Delhi
6. Dr Shah Hussain, IDSP Division, NICD, MoHFW, New Delhi

The Team members (1, 2 and 3 visited Balasore district and the rest members (4 , 5and 6) visited Balasore district during 05th – 08th November 2009 after the state level briefing in Bhubaneswar on 04th November 2009. De-briefing was held in two phases on November 09th evening, chaired by Commissioner, H&FW and on November 10th, chaired by Mission Director, NRHM.

The followings are the observation:

a. Orissa seems to be maintaining the momentum of progress under the National Rural Health Mission, in its fourth year, despite bottlenecks of a very weak baseline and enormous disease burden. It appears to have made considerable progresses from the observations of the 1st CRM in 2007, which had listed absenteeism of staff, non availability of drugs, non functioning of facilities below district and sub district, as major constraints in care seekers accessing the health system.
b. Significant achievement in the interregnum between the 2nd CRM and the present 3rd CRM also seems to have been made, the most noticeable being the Gaon Kalyan Samittee mobilization effort for a ***"Sustha Gaon, Sustha Panchayat and a Sustha Orissa"***, streamlining of ASHA payment through ASHA Diwas, establishment of ASHA Gruhas as birth waiting room, bicycles and sarees to ASHA for identity, improvement in drug expenditure and availability, facility cleanliness, strong referrals through the Janani express, strong NGO partnership, excellent GIS mapping of facilities, prompt payment to JSY beneficiaries and in ensuring 24 hours minimum stay in facilities.
c. There is a general trend towards strengthening the services provided by the public health sector, with increasing access and improvements in quality, reflected in increasing utilization of the facilities.
d. An increase in attention to the functioning of public health systems is reflected by the fact that the systems functionality in Orissa and their bottlenecks are now receiving attention which is a major achievement.
e. The system continues to lag behind in fund utilization and there are challenges in both programme management and governance, which are to be overcome to absorb more funds and deliver better services are in place.
f. The improvement or system changes visible at the district level seem appropriate and welcome – but the scale of roll out and the rate of roll out seem inadequate.

Other initiatives under NRHM:

1. ASHAs in Orissa, a vibrant group of community health workers, highly dedicated however need to be handled /nurtured by the system carefully and mentored by people from outside the government functionaries.
2. Janani Surakshya Yojna (JSY) and Janani Express are the two welcome components, but are challenged by the slow rate of growth in infrastructure and personnel to meet the demand generated by the shift to institutional deliveries.
3. Utilization of Untied Funds, AMG & RKS funds has led to visible improvement of the public health facilities. The role of RKS however has been limited by the perception of RKS as an alternative financing structure than an institution for patient welfare.
4. A basic plan which can be subsequently revised and built upon is available at the facilities and at district level. Block plans are also available, but basically, these are restricted only to health sector, do not say much about the overall development of the community or catchment area, do not say much about the other related sectors beyond health. Village plans prepared based on household health data exist but involvement of PRIs are peripheral.
5. The Programme Management Support Units are successful in bringing the much awaited managerial skill in the health sector, but integration with disease control programmes has not been fully resolved.
6. There is considerable scope for improvement of fund flow from State to the districts and from district to peripheral health institutions. E – transfer of fund is only restricted up to the district HQ level, below that, at present, is generally missing, still dependant on the age old system of transfer of instruments. Sometime, it takes six to eight weeks of time to credit an amount.

Key Findings:

Strengths	Areas to Improve upon
Overall increased utilization of the public health facilities, lowering the work load at the referral facilities	H R planning for manning the peripheral facilities needs to be improved, especially in nursing cadre and in Lab. Technicians. No separate cadre is there for Public Health Managers to man the key posts at the State and or at district level.
	Infrastructure Upgradation works is slow due to multiplicity of agencies some of which are not working at the required pace. Civil Works now delegated to Zilla Swasthya Samitees but capacity of same in remote districts is limited. Construction of subcentres, drug warehouse and staff quarters need to be expedited. Some Primary Health Centres and Sub Centres remain weak, mainly due to human resource issue.
ASHAs are a vibrant group of community health workers working very diligently. They are seen to be the key motivators in immunization, ANC and institutional deliveries. Establishing "ASHA GRUHOs" and monthly ASHA Diwas on 10th of every month for streamlining of incentive payment and hand holding support along with provision of cycles, umbrella, saree go a long way to keep them interested and motivated with a sense of accountability.	Drug expenditure has improved from earlier years but needs to go up further to have a sizeable impact on out of pocket expenditure of the poor which remains high.
	Malaria and diarroheal status need more focus. All vacancies for the NVBDCP from District Malaria Officers to Lab. Technicians and MPW (M) need to be filled up. Laboratory services network needs to be expanded.

	
ASHA GRUHO in Kandhamal – an innovation	Vibrant enthusiastic ASHAs
	Nutrition and child health remains a cause of worry in this state. While the nutritional support system is well established, it does not have adequate impact on the nutritional status. Despite close integration with other developmental department technical expertise is wanting, eg. Technical support from H&FW dept. to WCD department for individualized tracking of children at the grassroots/community level to ensure their movement up the nutrition scale and focus monitoring on how many have moved up/ down/ static (results and not just inputs) is lacking
	Differential Planning for underserved difficult areas/communities needs to be prioritized and adequate resource flow ensured as health access and health seeking behavior remains difficult especially in tribal areas.
	Pro-active field supervision and hand holding support at all level is lacking. Regular monitoring and evaluation of the NGO intervention is need of the hour for hand holding support and optimal outputs.
People are conscious and aware of their needs in better districts; RKS & VH&SCs members are also pro-active. Proper and prioritized planning for utilization of RKS and VH&SC Untied Fund is leading to higher utilization and increased absorption of the fund in the current year.	ANMs and LHVs need to be trained in maintenance of Tickler bags, importance and utilization of the counterfoils of the MCH card, to follow up all children for immunisations.
NGO participation in NRHM activities for management of Janani Express and a few PHC (N) is commendable. VHSCs formed; PRIs, women's SHGs and ICDS are actively involved with the health system.	An integrated Mother & Child Health, FRU operationalisation, IMNCI roll out needs to be given high priority. Linking of TBAs with ANMs for underserved areas/ marginalized population groups is necessary for further quality services.
Dedicated peripheral staffs are trying their best to cope up with the increased load. Active tracking of targeted children and pregnant women by ASHAs, AWWs and ANMs is the key in improving Full ANC coverage, increased numbers in Institutional deliveries, awareness among the community and in Full Immunization status of children.	Weak Nursing Training Institutes need to be strengthened.
	All categories of paramedics and Gr. D posted in hospitals need to be trained in IMEP. Close supervision is also the need of the hour for proper implementation of the same.
Utilization of multi-skilled doctors for the expected output is found to be helpful in increasing the FRU network in the State.	
Excellent GIS mapping for the districts	

Bilateral donors such as NIPI and DFID providing technical assistance in the State	
Regular On line Test of Programme Management Support Unit (both for State and District level) ensure quality control of staff.	Inadequate co-ordination between the Finance division and Programme Implementation division is evident from nil to minimum expenditure in Child health, ARSH, Tribal Health & in Vulnerable Group related expenditures under Part A. No expenditure is reported under the head Training, New Initiatives Research Studies and Analysis.

Chapter – 1

3rd Common Review Mission Visit to Orissa

Some time-bound quantifiable goals need to be achieved through specific road maps with appropriate linkages and financial allocations for strengthening the health infrastructure as detailed in the State Programme Implementation Plan. The Common Review Mission Team should be able to see the changes in key aspects of Health delivery system including quality of services and outreach during this period. The progress of the Mission in Orissa was also assessed against the stated goals, objectives, outcomes, time lines and strategies.

The Teams

Balasore	Kandhamal
Sri Manish Kumar Verma, IAS, Dy. Commissioner **Dr. Braja Mohan Patra, I/c, CDMO**	**Dr. Krishan Kumar, Dy. Commissioner** **Dr. A. C. Sahu, I/c, CDMO**
1. Sri P. K. Hota, Director, NIPI, New Delhi 2. Dr. Ashoke Roy, Advisor, Public Health, RRC – NE, Guwahati. 3. Mr Billy Stewart, Senior Health Adviser, DFID, British High Commission, New Delhi **Members from State/ District:** 1. Dr. Braja Mohan Patra, I/c, CDMO 2. Dr. P.K. Senapati, Consultant, SPMSU 3. Sri Sisir Kr. Grahacharje, SPM 4. Ms.Soumyasree Mahapatra, DPM	1. Ms Archana Varma, Director, Nirman Bhawan, MoHFW, New Delhi 2. Dr Shah Hussain, IDSP Division, NICD, MoHFW, New Delhi 3. Dr Vijay Aruldas, General Secretary, CMAI, New Delhi **Members from State/ District:** 1. Dr. A. C. Sahu, I/c, CDMO 2. Dr. J K Pattnaik, ADMO (PH) 3. Sri Pranay Kr. Mahapatra, Consultant, SPMSU 4. Sri H. R. Kar, DPM
	
Briefing Session in Balasore on 05th November 2009	Briefing Session in Kandhamal on 05th November 2009

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.

Facilities Visited by the Teams

I. Balasore:

Sl	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	District Hospital	Balasore	District Hospital	Dr. Gitanjali Das
2	Basic Training Institute (ANM)	Balasore	ANM Training School	Smt. Ushamani Pati
3	Paschimbad PHC	Paschimbad	PHC – N (PPP)	Dr. A. K. Bera
4	Paschimbad S/C	Paschimbad	Sub Centre	Smt. Shantilata Das
5	Bartana S/C	Bartana	Sub Centre	Smt. Prava Rani Mahanti
6	Remuna PHC	Remuna	24*7 PHC	Dr. B.B. Das Mahapatra
7	Mandarpur AWC	Mandarpur	AWC	Smt. Pankajini Barik, ANM Smt. Sulata Pradhan, AWW
8	Somanathpur S/C	Somanathpur	Sub Centre	Smt. Sukanti Sahu
9	Basta CHC	Basta	CHC, FRU	Dr. K. R. Parida
10	Mukulish S/C	Mukulish	Sub Centre	Smt. Sukanti Dhar
11	Amarda Road PHC	Amarda Road	PHC – N	Dr. N. K. Pradhan
12	G. K. Bhatta Area Hospital	Jaleswar	CHC	Dr. Ganesh Pal
13	Rupsa CHC	Rupsa	CHC	Dr. Nabin K Behra
14	Gopalpur PHC	Gopalpur	24*7 PHC	Dr. S.S. Choudhuri
15	Iswarpur PHC	Iswarpur	24*7 PHC	**Not available**
16	Morigaon S/C	Morigaon	Sub Centre	Ms. Rangabati Nayek
17	Bahabarapur village	Bahabarapur	Village	M. Parida, Member
18	Marigaon village	Marigaon	Village	Smt. Rebati Biswal, Chairperson
19	Soro CHC	Soro	CHC, FRU	Dr. S.S. Achariyyaa

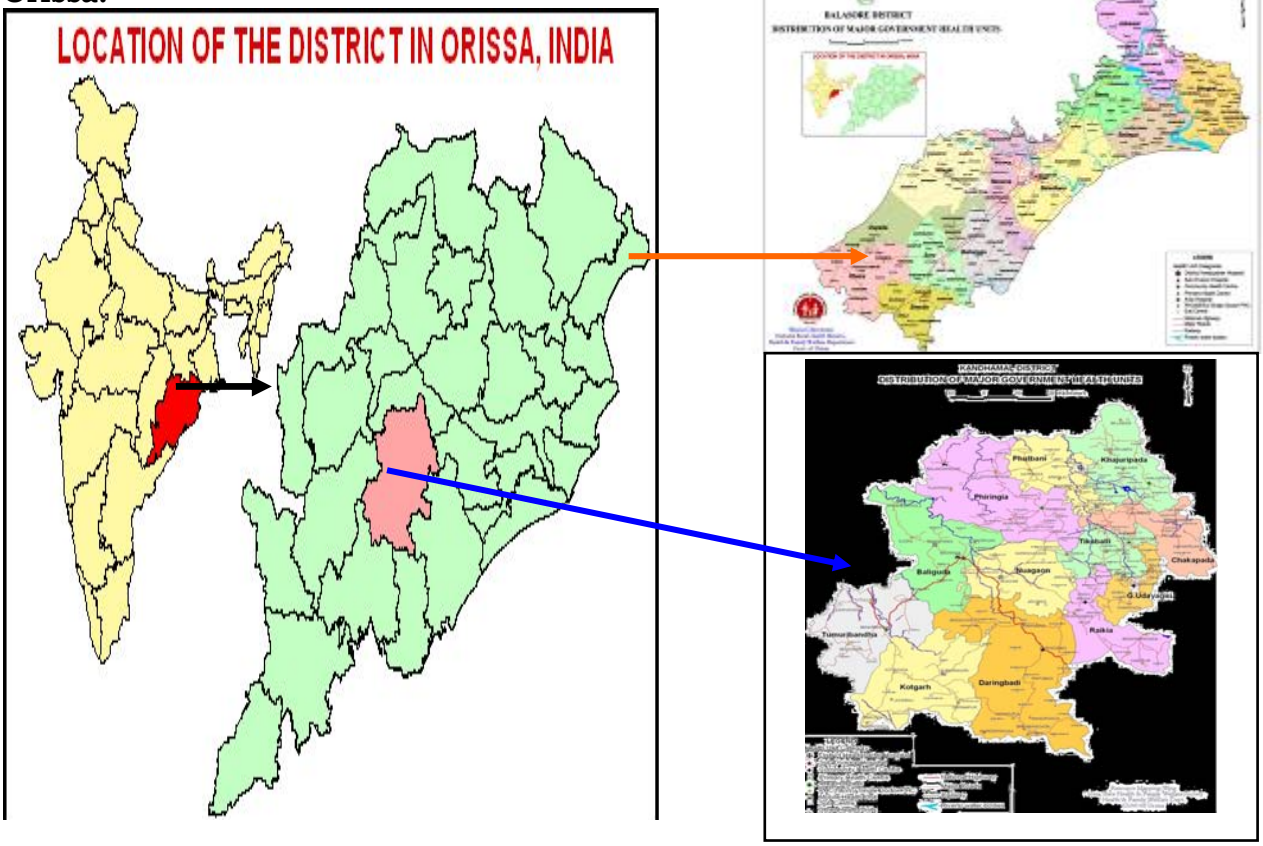
II. Kandhamal:

Sl	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	Deutipada S/C	Deutipada	Sub Centre	Smt. Sarla Naik
2	Deutipada village	Deutipada	GKS	
3	Govt. Girl Child School	Deutipada	School	
4	Khajuripada UPHC	Khajuripada	UPHC	Dr N. M. Mishra
5	Kandhamal District Hospital	Phulbani	District Hospital	Dr. A. C. Sahu
6	Tikabali UPHC	Tikabali	UPHC	Dr Sarangi
7	Rajnabadi PHC (N)	Rajnabadi	PHC (N)	Dr. Banjo Kr Roy
8	Ganjuguda SC			
9	Gardingia Relief Camp			
10	Talarimaha SC			
11	G Udaigiri CHC	G Udaigiri	CHC	
12	Gumagarh CHC	Gumagarh	CHC	
13	Kalinga PHC (N)	Kalinga	PHC (N)	
14	Bisipada PHC (N)	Bisipada	PHC (N)	
15	Ghutingia PHC (N)	Ghutingia	PHC (N)	
16	VH & ND Kalinga	Kalinga	AWW	
17	VH&ND Gardingia	Gardingia	AWW	Nirada Naik
18	Gardingia S/C	Gardingia	Sub Centre	Dr Subhashish Mohanty
19	Tikabali PHC (N)	Tikabali	PHC (N)	Sri Tilochan Pullai (Pharmacist)
20	Belghhar Area Hospital	Belghhar	Area Hospital	Dr Mrs Sarangi
21	Balliguda SDH	Balliguda	SDH	Dr Marandi
22-24	Bulughar, Budugudari and Bassinga	Bulughar, Budugudari and Bassinga	Villages	Discussions with women
25	CHC Gumagarh	Gumagarh	CHC	
26	Nuagaon PHC (N)	Nuagaon	PHC (N)	Group Discussion with the villagers, women groups.
27	Bilangal Village GP	Bilangal	GP	
28	Rangapada Village GP	Rangapada	GP	

Chapter – 2

Introduction:

Orissa:



The Profile – State:

Orissa, on the eastern coast of India is bound by Jharkhand on north, West Bengal on the northeast, Chhattisgarh on the west, Andhra Pradesh in the south and the Bay of Bengal in the east. It spreads over an area of 1, 55,707 square kms with a forest cover of 58,136.23 square kms. It is the 10th largest state in India. The rate of urbanization is 14.97%.

Orissa is prone to natural calamities. Floods and droughts regularly devastate the state and cyclones are common. Frequent occurrences of natural calamities stand as a barrier to overall progress of the state.

Facts & Figures:

Date of formation	1st April 1936
State Capital	Bhubaneswar
Area	155,707 square kms
Area under forest (total)	58,136.23 Sq. Kms
Literacy rate	63.61%
Per Capita Income (03-04)	Rs.6, 487.00

No. of Districts	30
Urbanization Ratio	14.97%
Religion	Hindu, Muslim, Christian and Buddhist
Official Language	Oriya
Temperature	Max 400 C (summer); Min 70 C (winter)
Annual average rainfall	150 cm
Population (2001) - Male - Female	3,68,04,660 1,86,60,570 (50.70%) 1,81,44,090 (49.30%)
- Rural - Urban	3,12,87,422 (85.01%) 55,17,238 (14.99%)
Scheduled Caste - Male - Female	60,82,063 (16.53%) 30,37,278 (08.25%) 30,08,785 (08.18%)
Scheduled Tribe - Male - Female	81,45,081 (22.13%) 40,66,783 (11.05%) 40,78,298 (11.08%)
Sex Ratio	972
Decadal Growth Rate	15.94%
Density of Population	236 per Sq. Km.
District Population - Highest (Ganjam) - Lowest (Deogarh)	 31,60,635 2,74,108
Total Literacy Rate - Male - Female	63.61% 75.95% 50.97%
Highest Literacy Rate (Khurda)	81%
Lowest Literacy Rate (Malkangiri)	32%
No. of C.D. Blocks - Tribal - Non Tribal	314 118 196
No. of Tehsils	171
No. of villages(inhabited)	47,529
No. of villages(un-inhabited)	3,820
No. of Towns	138
No. of Panchayat	6235

The ST and SC population constitute 22.13% and 16.53% respectively of the total state population; together they constitute 38.66% of the state population. This is comparatively higher than the All India figures of 16.20% SC and 8.19% ST population. It is important to note that the percentage of SC population has been increasing in the state while the ST population has been declining marginally. The ST population declined from 22.43% in 1981to 22.21% in 1991 down to 22.13% in 2001. Considering heavy concentration of ST and SC population in as many as 13 districts of the State, 44.70% of the total area has been declared as Scheduled Area, as per 1991 Census.

I. Existing Health Infrastructure in Orissa:

No. of Medical College and Hospitals (Government)	3
No. of District Hospitals (Capital Hospital, BBSR & R.G.H RKL)	32
No. of Sub-Divisional Hospitals	22
No. of Community Health Centres	231
No. of Primary Health Centres (Block PHC)	117
No. of Primary Health Centres SiD and other	1282
No. of First Referral Units(F.R.U)	96
No. of Rural Family Welfare Centres	314
No. of Urban Family Welfare Centres	10
No. of Postpartum Centres	79
No. of Sub-Centres	6688
No. of Health Posts (Revamping) (Bhubaneswar, Cuttack & Rourkela)	3
No. of Health & Family Welfare Training Centers (Cuttack & Sambalpur)	2
No. of Rural Health Centres (Jagatsinghpur, Attabira & Digapahandi)	3
No. of A.N.M. Training Schools	16
No. of M.P.H.W.(Male) Training School	3
No. of Ayurvedic Hospitals	5
No. of Ayurvedic Dispensaries	619
No. of Homoeopathic Hospitals	4
No. of Homoeopathic Dispensaries	560
No. of Unani Dispensaries	9

The infrastructure up-gradation has been assigned to 7 (Seven) executing agencies, projects worth 240 crores with only 78 crore utilization (33%), remain slow as elucidated in the table:

Agency	No. of Project	Completed (Nos)	Progress / Initiated (Nos)	Not started (Nos)
CPWD	17	3	13	1
OBCC	40	5	34	1
OPHC	108	14	82	12
PHD	27	6	11	10
PWD	296	153	85	58
RD	334	109	92	25
ZSS	3424	99	2028	1297
TOTAL	**4246**	**389**	**2345**	**1404**

The major pendency appears to be in sub centres, drug warehouse and staff quarter construction. The details are as below:

Major works	Total number	Completed	Work in progress
Labour Room (New Construction)	111	39	72
Labour Room (Repair & Renov.)	189	133	56
Sub-Center (New Construction)	304	2	99
Sub-Center (Repair/Renov.)	1171	116	40
Drug Ware House (Block Level)	61	0	28
Drug Ware House (District Level)	14	1	1
SNCU	17	7	10
Staff Quarters (D, E & F Type)	73	40	31

Baseline resource mapping:

The GIS mapping developed by Orissa is a landmark in resource efficient infrastructure planning. The mapping of health Institutions in Orissa clearly showed a dense concentration of health facilities in the eastern coastal districts, with sparse dispersal in the scheduled areas.

OBSERVARTIONS ON INFRASTRUCTURE UPGRADATION:

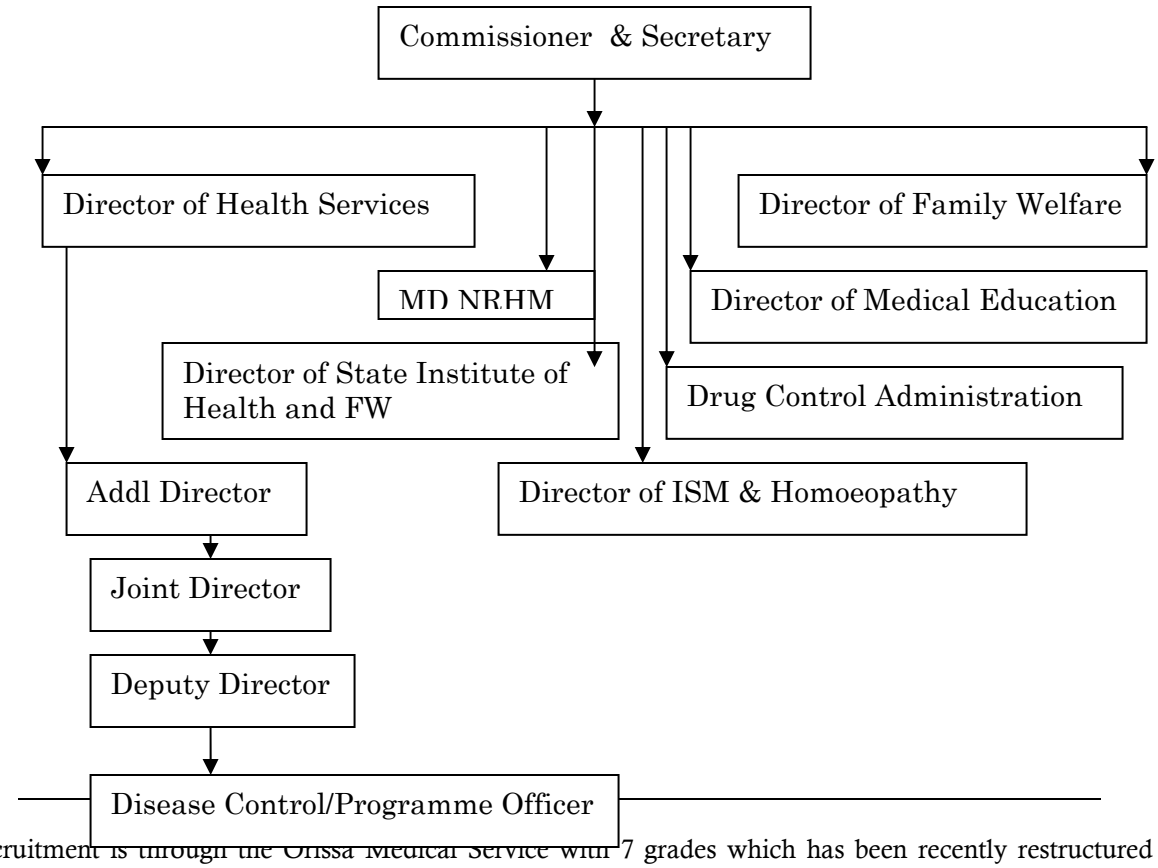
1. The GIS mapping provides a quick bird's eye view of distribution of infrastructure facilities in the government sector and is potentially a very important tool in resource efficient planning for infrastructure. But how far this mapping was translating into efficient allocation of resources as per need was not evident.
2. Civil Works now delegated to Zilla Swasthya Samitees but capacity of same in remote districts is limited.

II. Human Resources:

ORGANOGRAM OF STATE AND DISTRICT HEALTH STRUCUTRE

At State level, the organogram integrates at the level of Commissioner and Secretary with seven Directorates namely;

1. Mission Director who provides programmatic support for NRHM activities,
2. Director of Family Welfare with Joint Directors and Deputy Directors under him and incharge of the Family Welfare Programmes,. Also incharge of the ANM and Nursing Cadre.
3. Director Health Services with Joint and Deputy Directors under him and incharge of the various disease control programmes. He is also incharge of the District Medical Cadre.
4. Director Medical Education in charge of three Medical Colleges and Nursing College.
5. Director of SIHFW incharge of training,
6. Drugs Controller Administration,
7. Director of ISM and Homeopathy.



The recruitment is through the Orissa Medical Service with 7 grades which has been recently restructured and salary brought in parity with the sixth Pay Commission recommendations.

District level:

The Chief District Medical Officer (CDMO) heads the District Doctor Cadre and is supported by the Additional CDMO with ADMO Medical, ADMO Public Health, ADMO Family Welfare at the District level. They are supported by the Sub Divisional Medical Officers at the Sub Divisional level and Medical Officers at the CHC/PHC level. In addition there are facility specific cadres.

Major Initiatives Taken in HR Planning:

1. **Constitution of HR Cell to provide roadmap for:**
   - HR Human Resource Analysis and Audit
   - Preparation of Data Base for different cadres
   - Optimal utilisation and Equitable distribution of Human Resources
   - Filling of vacancy and reduce absenteeism
   - Attractive Packages, Better Promotional Avenues and decent career path
   - Transparent Transfer Policy(Proposed)
2. **Order for restructuring of Orissa Medical Service Cadre in May 2009,** with a revised cadre strength of 4258 doctors in 7 grades, amendments to rules regulating recruitment, promotion to be finalized within six months are definite steps to address the long pending stagnancy in the system.

3. Setting up of State Task Force on Nursing and realigning of Nursing cadre within Dept H&FW by an order in September 2009 also addresses a long standing need.

Availability of human resource and gap analysis

1. Availability of doctors is 1per 9825 population
2. Availability of Nurses is 1per 11000 population
3. Against the sanctioned strength of 4258 doctors, 3207 are available and 951 vacant with 22% vacancy. The maximum vacancy of 1381 doctors is in Class I Senior Grade with only 59 doctors in position, which definitely shows weakness in career progression . However there are 933 extra positions in Class I Junior Grade apparently to compensate for the vacancy in Class I Senior Grade.
4. Against the sanctioned strength of 7762 paramedics, 7736 are in position with 426 vacancies with only 5.5% vacancy at this level.
5. This is sought to be compensated through contractual engagement under NRHM elucidated below which clearly reflects the inability of the Government to recruit paramedical staff and hence the proposed strategy for augmentation of human resource esp paramedical described in subsequent paras is definitely step in right direction:

Category of post	Sanctioned	In position
Assistant Surgeon	18	18
Staff Nurse	1706	621
Health Worker (Female)	1861	877
Laboratory Technician	98	29
AYUSH Doctors	1476	1375

Recruitment and cadre management

Initiatives taken for doctors:

- Entry level post for doctors upgraded to Jr. Class-I
- Restructuring of OMS cadre
  - Specialist pay increased from Rs. 150/- to Rs. 3000/- per month.
  - Additional incentives for regular doctors working in KBK+
  - Specialists incentives to EmOC & LSAS trained doctors
- Age of engaging retired doctors increased from 65 years to 68 years
- Accommodation to health personnel up to block level.
- Increase seats in the Medical Colleges both in Under Graduate and PG courses.

Skill quality of health human resources

Efforts include:

DOCTORS

- Training of MBBS doctors in life saving Anaesthesia skills
- Training of MBBS doctors in Emergency Obstetric Care
- Training to Doctors on Public Health (1 year)
- Training to Doctors on Family Medicine (2 year)
- The AYUSH doctors are being trained (recently initiated) in Primary Health Care, Disease Control Programme, NRHM Initiatives, MCH and also in **Specialized Training** in Skill Birth Attendance , IMNCI and VH&NDs.

NURSES

- Skill Birth Attendance Training.
  - Equipping Staff Nurse to handle Obstetric cases.
- Integrated Management of New Born Care and Childhood Illness Training.
  - For better management of illnesses amongst new born and children.
- Skill based training
  - IUD insertion, facility based New Born Care etc.
- Exposure visits for staff nurses.

Plan for augmentation of health human resources

NURSING:

Private sector presence in GNM Training school (720 seats out of 980)and BSc Nursing (245 seats out of 265) while MSc Nursing (10 seats) only in Government Sector.Following measures are being taken to address Nursing Gap

- Opening of new courses
  MSc. Nursing Course introduced in MKCG Medical College.
- Management of nursing cadre.
  Establishment of a Nursing Management Support Unit.
- Public Private Partnership in Nursing Education
  Swasthya Sebika Nijukti Yojana
- Proposal submitted to GoI for setting up of 8 GNM schools in the State.
- Centre of excellence for Nursing Education.
- Development of MKCG Medical College into a centre of Excellence for Nursing Education.

Initiatives Taken for Nurses:

- Cadre re-structuring for Staff Nurses in process.
- Enhancement of remuneration for contractual Staff Nurses.

Existing	Increased
Rs. 4000/-	6000 (Coastal areas)
	6500 (Tribal & difficult areas)

- Regularization of services of contractual nurses after completion of 6 years of services .
- Walk in Interview to fill up the existing posts.

Initiatives Taken for ANM

Considerable presence of private sector in ANM Training Schools (1140 seats out of 1780) and the government set up are in dilapidated buildings with poor infrastructure.

Efforts to reduce ANM gap is through

- 33% increase of seats in Govt. ANM training schools.
- ANM being trained in Skilled Birth Attendance (Core & Non-Core).
- IMNCI training being provided to ANMs.
- Simple Accounting training provided to ANMs.
- Walk in Interview to fill up the existing posts.
- Regularization of services of contractual ANMS after completion of 6 years of services .

Initiatives Taken for Lab Techs and Radiographers

120 Seats of Lab tech and 60 seats of Radiographers are available in the Public sector in the State.

Augmentation proposed through

1. Doubling of seats
2. Private medical colleges have also proposed increasing of seats.

Augmentation proposed through increasing the ANMTC from 16 to 29 and additional seat capacity of 520 to the existing 640. GNM Schools from 3 to 11 with additional seat capacity of 470 to existing 200. Also one each in BSc Nursing , MSc Nursing and PBBSc Nursing are being proposed.

OBSERVATIONS ON HUMAN RESOURCE PLANNING

The previous paragraphs clearly indicate a comprehensive HR Plan with the right focus on Nursing, ANM and the paramedical cadre exist. The focus in HR Planning is perhaps rightly on filling gaps in numeric adequacy, equitable distribution and rational deployment of resources, transparent transfer policy (proposed). Due to the recent constitution of a HR cell, it is expected to be expedited. The formation of the HR cell is a promising innovation for taking the overview of policy and planning for HR.

However the challenge would be in implementing the recommendations. However quality of pre - service training and continuing medical education outside NRHM needs should also be the focus in HR Planning. The proposed incentives should try to build in more non monetary incentive packages for the remote and the left wing affected areas with possible preference in PG admissions, school admission, retention of living quarters in preferred areas, increase LTC etc.

Introduction of an integrated package including additional marks for "in-service" candidates (as is being done in some states) for post graduate courses (medicine and nursing) and a service obligation of 3-5 years would provide incentives for doctors and nurses to join government services and enhance the availability of specialists

III. Indicators:

I. Key Indicators:

INDICATOR	**ORISSA**		**INDIA**	
	Trend (*year & source*)		**Current status**	**NRHM (2012) goal**
Maternal Mortality Ratio (MMR)	358 (SRS 01-03)	303 (SRS 04-06)	254 (SRS 04-06)	<100
Infant Mortality Rate (IMR)	83 (SRS 2003)	69 (SRS 2008)	53 (SRS 2008)	<30
Total Fertility Rate (TFR)	2.6 (SRS 2003)	2.4 (SRS 2007)	2.7 (SRS 2007)	2.1

II. Important Outcome Indicators:

S. No.	RCH OUTCOME INDICATOR	ORISSA		INDIA*	
		DLHS–2 (2002–04)	DLHS–3 (2007–08)	DLHS–2 (2002–04)	DLHS–3 (2007–08)
1.	Mothers who received 3 or more antenatal care checkups (%)	41.7	54.6	50.4	51.0
2.	Mothers who had full antenatal check-up (%)	13.7	23.3	16.5	19.1
3.	Institutional deliveries (%)	30.8	44.3	40.9	47.0
4.	Children 12-23 months age fully immunised (%)	53.3	62.4	45.9	54.1
5.	Children age 6-35 months exclusively breastfed for at least 6 months (%)	20.7	42.6	22.7	24.9
6.	Children with diarrhoea in the last 2 weeks who received ORS (%)	48.3	49.0	30.3	33.7
7.	Use of any modern contraceptive method (%)	40.3	37.8	45.2	47.3
8.	Total unmet need for family planning - both spacing methods and terminal methods (%)	19.8	24.0	21.4	21.5

IV. PRI frame work in Orissa

The PRI involvement with the Mission is strong and supportive but not pivotal. Zilla Parishad Chairperson heads the District Rural Health Mission in the districts. Though, DRHM meetings are not happening as envisaged, yet, the stock of the health scenario and the progresses made under NRHM in the district finds its way in the monthly District Level Co-ordination Committee meetings. The Ward members/ members of the GPs are also concerned about the well being of the villagers, worried about the malarial situation and reluctance attitude of the villagers in using bed nets, frustrated over poor supply of toilet slabs under TSC, especially to the BPL categories. Though there may be differences within, but the people of Paschimbad GP are united for having an own exclusive PHC building. While discussing with the PRI functionaries of Bahabarapur and of Marigaon village of Balasore district, it was found that there is substantial amount of unspent balance, which means that there is no POAs for utilizing this fund meant for local health actions, though the pond located at the centre of the village needs immediate cleaning.

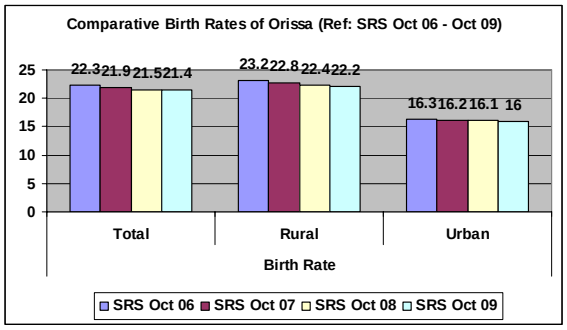
VI. Special Constraints:

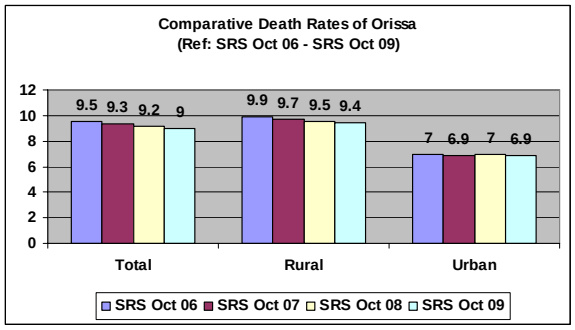
1. Vast areas with poor connectivity more than 50% blocks are termed as difficult blocks, either due to locations, habitants or due to left wing extremists affected areas.
2. No separate cadres for Public Health Managers to hold the posts of District or State level Health Officials, or public health requirement for postholders. Chief District Medical Officer is shifted as Surgeon or vise versa.
3. Newly qualified Specialists are not declared and posted as specialists.
4. Deficient staff accommodation with in the hospital campus
5. Poor nearly non – existent supervision and governance in district and in sub district level.

Chapter – 3

Desk Review

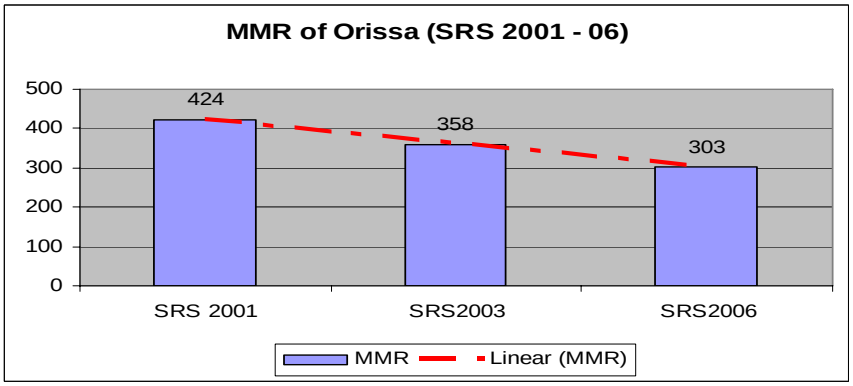
Birth & Death Rates:





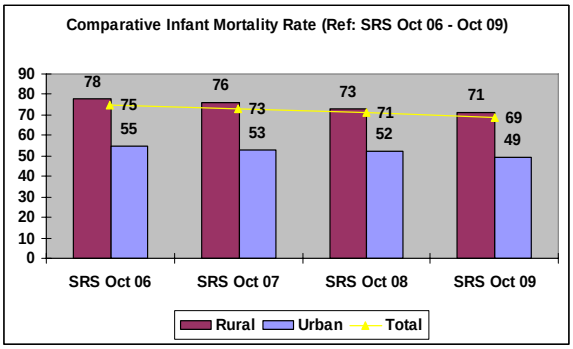
Sample Registration System (SRS: October 06 – 09) data are showing a mild downward trends in both Birth Rate and in Death Rate.

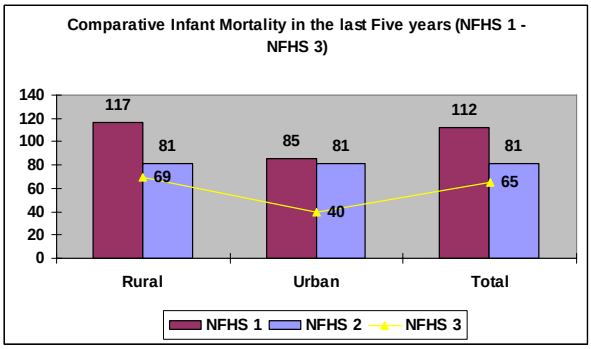
MMR:



Over the years, a gradual downward trend of MMR is being observed.

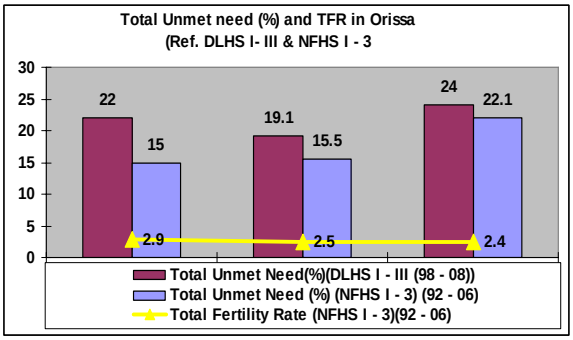
Infant Mortality Rate:

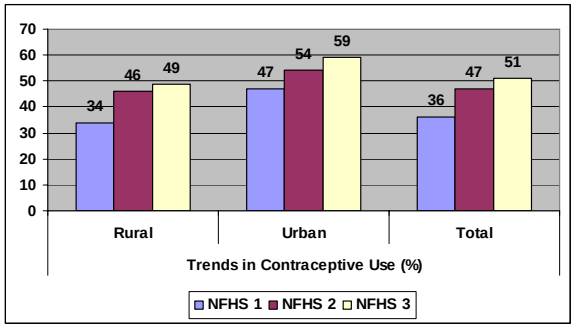


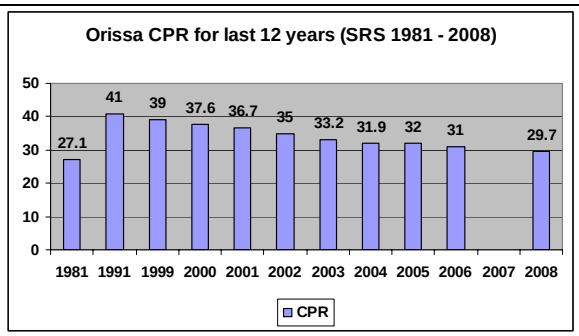


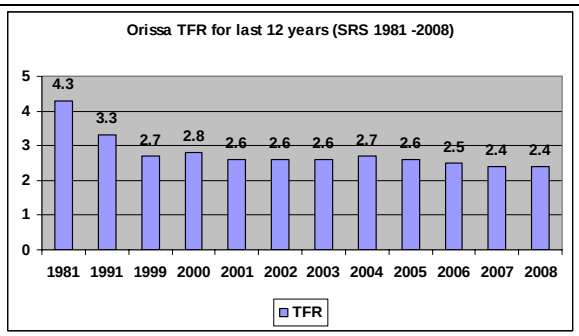
Sample Registration System (SRS: October 06 – 09) data are showing a down ward trend of IMR, decreased by seven points in rural Orissa, where as the fall is only six points in urban areas. This is consistent with the National Family Health Survey data, there is forty-eight point reduction in rural Orissa from 117 (NFHS 1) to 69 (NFHS 3) per 1000 live births & forty five point reduction in urban areas from 85 (NFHS 1) to 40 (NFHS 3) per 1000 live births, total reduction is by 47 ((From 112 (NFHS 1) to 65 (NFHS 3)).

Family Planning Practices & Total Fertility Rate:



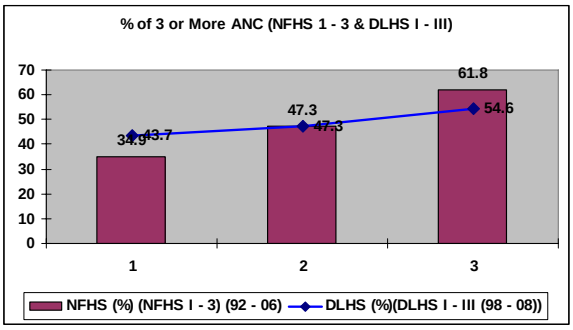


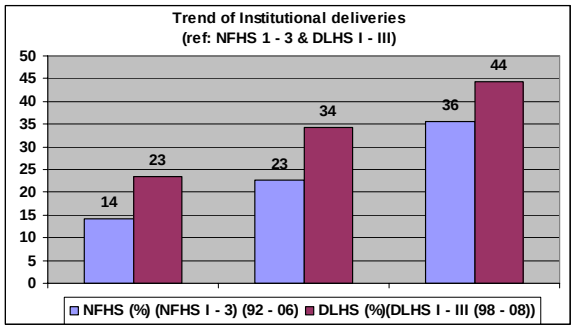




The Couple Protection Rate is increased over the years and the TFR also shows a declining trend, yet, the male participation in family planning is minimal (below 8% in sterilization).

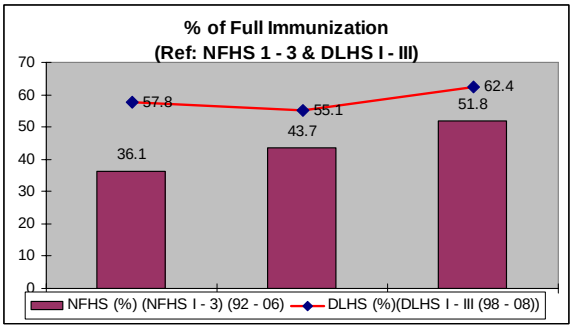
Trends in 3 or 3+ ANC

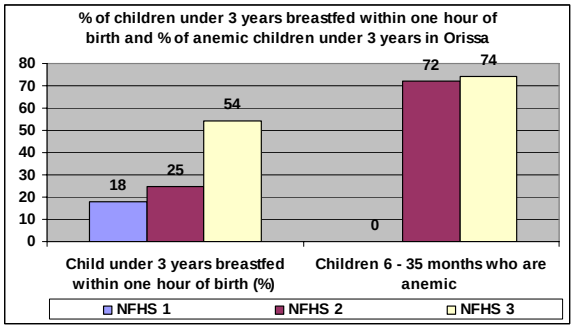




Trends in 3 or more ANC and % of Institutional deliveries are showing an increasing trend in Orissa over the years, which is quite appreciable. During the year 2008 – 09, there is 60% of Total deliveries were held at the health facilities in Orissa. 80%+ is the 3 or more ANC coverage in Orissa during 2008 – 09.

Immunization and Child Health:

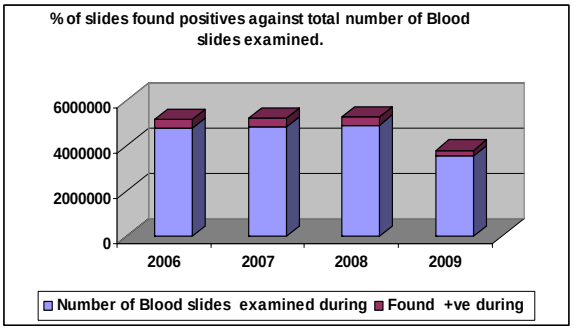


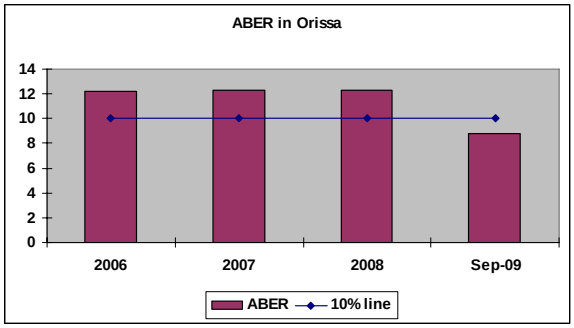


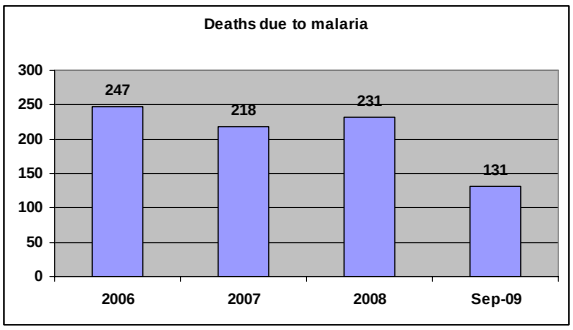
% of Fully Immunized Children in Orissa are gradually increasing in numbers, credit goes to the use of active tracking system by ANMs, ASHAs and by AWWs. In addition, there is less than 20% BCG to Measles dropout as per the HMIS 2008 – 09. Breast feeding practices is also showing a significantly increased trend.

Other Parameters:

NVBDCP

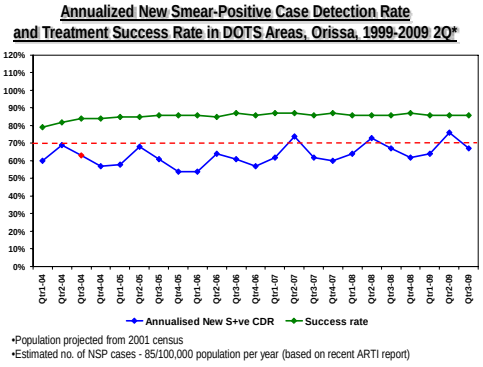


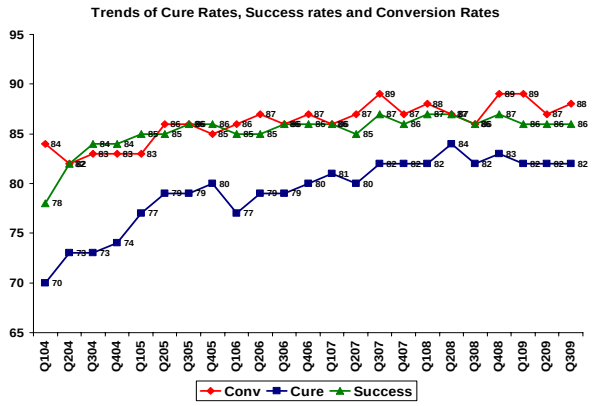




The malaria situation of Orissa is not improving over the years. The ABER over the years is above 10. The death due to malaria is also high.

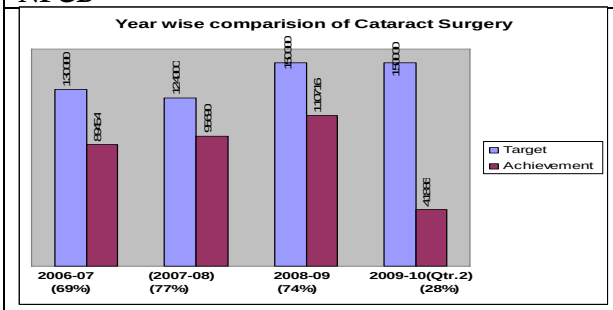
RNTCP





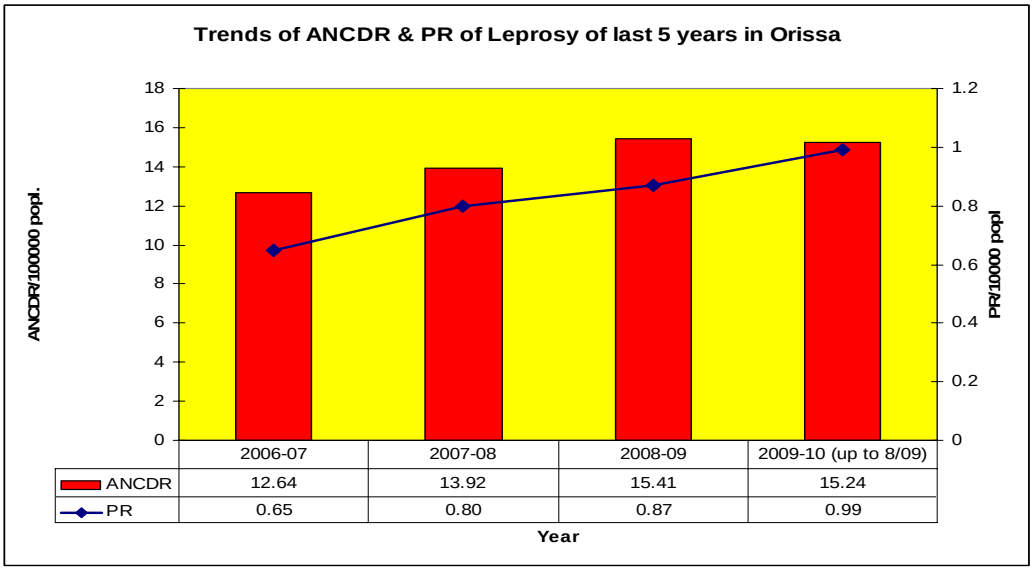
NSP Case Detection Rate in the State has followed a normal seasonal trend whereby the target of 70% has been achieved in the 2nd quarter every year with dips in the 4th quarter
The NSP Treatment Success Rate however has remained consistently around and above 85% since 2004

NPCB



The achievement of Cataract surgery against target was only in the range of 69% – 77%. The reasons of which may be analysed in terms of manpower and feasibilities.

NLEP



Annual New Case Detection Rate and Prevalence Rate for 10000 population are showing an increasing trend in Orissa.

Financial Management:

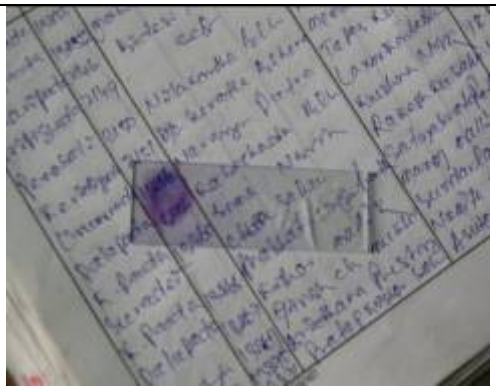
1. Under Part A, only Rs 119.74 Crore i.e. 54% of the approved PIP of Rs.221.01 Crore has been utilized by the state of Orissa under RCH-II as compared to National level expenditure against the PIPs approved is 71%. There is 26% increase in expenditure as compared to 2007-08.
2. Since the launch of RCH –II ,Rs 273.26 Crore , i.e. 85% has been utilized by the state against the release of Rs.320.60 Crores during the period 2005-06 to 2008-09.
3. Under Part B, more than 100% expenditure is shown under the head of Hospital Strengthening and Annual Maintenance Grants & Corpus Grants to RKS.
4. Expenditure under AYUSH, IEC/BCC and Additional Contractual Staff is more than 80% which is quite appreciable. As compared to 2007-08.
5. Expenditure reported under New Construction/Renovation and under Panchayati Raj Initiative is less than 2% of the amount approved in PIP.

Chapter – 4

Findings of the 3rd CRM in Orissa:

Change in key aspects of Health delivery system	
Item	**Observations**
1. Infrastructure Up-gradation	
Base Line Resource Mapping	Infrastructure varies widely in the State. Infrastructure in some facilities are adequate, in some, it is grossly deficient. Labour Rooms were found to be in construction but are frequently not connected with the main PHC building, making it difficult for the expectant mothers to access during rainy season & in darkness. In general, there is need of a comprehensive facility wise master plan. Kandhamal district is poorly developed in infrastructure and as such backward, roads are less, no rail connectivity, limited electrification, areas that are cut off for a large part of the year due to lack of connecting bridges and all weather roads. More than a quarter of the district suffered civil strife in the last 2 years and is a known bastion of ultra left. The private passenger transport in the district is underdeveloped and hiring of private vehicles for transporting patients to care centres is difficult in Kandhamal. Balasore is better developed in terms of infrastructure, road or rail connectivity, telecommunication network is strong, but there are certain areas, which do not have all weather roads (Paschimbad area).   Soro CHC, Balasore | A tiled labour table in Ishwarpur 24*7 PHC The Primary Health Care institutions are generally in old buildings and majority of the ones we visited had only recently received a fresh coat of paint. Several PHCs are without power supply, some CHCs even do not have a running water supply and consequent unused toilet system. Staff accommodation in the hospital premises is compromised.
Infrastructure Up-gradation	The health infrastructure in the State has been upgraded, building renovation, adding facilities and procuring to make up critical gaps was evident. Some of these processes has not been completed and are unable to provide full service. Kandhamal District Headquarters Hospital has been upgraded and services have been streamlined. Similar up-gradation was evident in several of the facilities visited. The 24x7 facilities have been made operational based on the up-gradation of infrastructure. There however remain issues regarding critical gaps in up-gradation hindering full utilization and also some issues regarding prioritization. If the toilet has been attached to the hospital, it is essential to make arrangements for running water to ensure its use.

	The facilities in Balsore district are in general having good infrastructure, and several PHCs had new construction in process for labour rooms. However the buildings were seen to be constructed in scattered manner in some of the facilities. Due care needs to be taken for staff accommodation with in the premise. A facility wise master plan would have been helpful for a better consolidated development. The district administration was of clear view that NRHM funds under the head support developmental spending that was restricted in procedural complexities in other funds. This has enabled the recent up-gradation of infrastructure.
2. Human Resources Planning	
Availability of Human Resources & Gap analysis	Though Medical Colleges and Nursing Colleges/ Schools are available in the State, both in public and in private sector, yet, there is scarcity of available manpower, both medicos and paramedics in the public sector, further coupled with inequitable manpower distribution. Available manpower scenario specially in Nursing staff, positioned in public health facilities is too less. The frequently encountered situation of one GNM manning a 24*7 PHC is compromising the quality aspect of service deliveries. Health Human resource in Kandhamal is scarce. The sanctioned strength is vacant 38% for Doctors; 20% for Nurses; 43% for HW(M) and 39% for Lab Technicians. Similar vacancies were seen in Balasore district, with particular vacancies reported for HW (M) and ANMs. The Nursing picture is grim through out the State. Facility wise manpower matrix, at least for the short listed FRUs and 24*7 PHCs, both for required and available, is yet to be done. The same exercise needs to be undertaken at the State level to formulate a road map to mitigate the gap, taking into account the annual manpower production of all categories of service providers from all the existing medical colleges, nursing colleges/schools, paramedics colleges/ schools.
Pre-service Training capacity	The Basic Training Institutes (ANMTC) in the State of Orissa needs revamping. The building, hostel accommodation, furniture and the library need strengthening. Class rooms and hostel rooms are poorly lit. The management of the ANMTCs (Principal & respective Chief Medical Officers) needs to be more pro-active in tapping the resources for strengthening of the Basic Training Institutes and in implementation.   Newly painted Poorly lit ANMTC, Balasore — Poor condition of ANMTC class room, Balasore Kandhamal and Balasore district each have an ANM training school in the DHH campus. NRHM has begun sponsoring 10 candidates from the current batch in Kandhamal. Up-gradation of the school is under active plan of the district to add GNM training and increasing the seats.

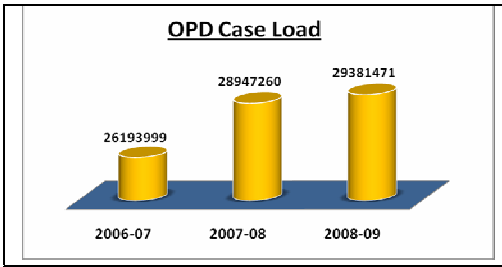
	The gap in Nursing category is being exploited by many private institutions without any facility offering GNM training in the district. At the same time there are good NGO institutions (reported in an NSHRC study of Nursing in Orissa) that need to be encouraged and brought in to further strengthen the government infrastructure The state encourages establishment of and enhancement of capacity of the existing institutions to fulfill critical health human resource gap. Some steps have also been initiated to lengthen stay of PG degree holders in rural health service. But the pace and output is short of the needs. Through NRHM the gap at the New PHC level is being fulfilled with AYUSH Doctors (75 posted in Balasore). This can give good results if the rationality of posting is decided on load of the institution and not on other considerations and also fully entrusting the public health activities to the AYUSH physicians. A contextual observation indicated patients were keen to consult AYUSH for chronic ailments in acute and infectious diseases they prefer a modern medicine pharmacist over an AYUSH graduate.
Recruitment and cadre management	Steps have been initiated to establish a cadre management structure for doctors and creating an appropriate cadre of Nursing service personnel. As the IPHS standards for HR has not been implemented in the state, the gap has not been ascertained yet. A large scale drive to recruit AYUSH physicians to staff the PHC (New) in the state has successfully been done. Most of these people are joining now populating unmanned health centers. The impact of the policy on overall health improvement can only be assessed after some time. About 104 AYUSH doctors are currently working in both the districts.
Plan for Augmentation of Health Human Resources	Mainly because of the civil strife and problems of ultra left activity certain health posts in Kandhamal districts are still vacant. In a bid to ensure that someone is there at the Sub Centre, the ASHA of the village in which the facility is located is designated HQ ASHA in Kandhamal district and given some incentive to keep the services going during the absence of ANM. This while keeping the SC running has made this ASHA unavailable to the village for a considerable period of time.
Skill quality of Health Human Resources	 SBA training at Kandhamal DH  Slides for MP found incorrect at Khajuria CHC in Kandhamal

	The team was able to examine quite a few personnel on a mix of skills during the visit. The ANM are generally well trained and are trained to collect malaria slide and finger prick blood for Hb estimation. The quality of slides they make is wanting and may allow more of false negatives. The lab technicians are good at their work but are used to take short cuts like making the thick smear and not making thin smear at all. Skills at all level for use of RDK was good. The physicians were not very clear about management of undernourished children –both modern medicine and AYUSH. Some senior physicians have their own perception on management of malaria cases and that in pregnant women, which is different from NVBDCP guidelines. Clear protocols for management of malaria were lacking. The Skilled Birth Attendant Skills (knowledge component) are of good order in ANMs and some of them are regularly using that skill for attended delivery at home. ASHAs have role clarity and are quite efficient in reaching the community, accompanying the mothers for delivery. But in skilled jobs they are slightly backward. ASHAs in the district do not have any grievances regarding total earning or timeliness of payments. In some villages there were some reports of ASHA eating into JSY payment to the mother, but it may be aberrations rather than rule
HR strategies to strengthen Physician specialists in a resource-constrained system:	<u>It is a fact that, in the present scenario:</u> a) There is a need to encourage those in government service to acquire specialist qualifications regardless of available positions, so that personal professionals aspirations are met b) A number of doctors have specialist qualifications, but are designated as general doctors because of inadequate posts of specialists. c) There is an increasing reduction in facilities and supportive human resources as one goes away from the HQ institutions (state / district), and doctors with specialist qualifications are often posted in facilities where they cannot practice their skills adequately. <u>In order to provide professional satisfaction, and also provide opportunities for skill development regardless of the facility at which they are serving, the following principles are, suggested to be followed:</u> a) those with specialist qualifications to be regarded as a precious resource who need to be developed in that specialist area, regardless of where they are posted b) Increase of access to specialist treatment facilities at least part-time to patients at DHH / SDH / CHC. This means not only specialist doctors but also the treatment facilities eg functioning theatre with instruments and anaesthetist. c) Ensure that these specialist treatment facilities, when available part time / full time at DHH/SDH/CHC , can be used clinically by those with speciality qualifications regardless of whether they are stationed at that facility or not, and are designated as a 'specialist' or not <u>Recommendations:</u> • Develop District Hospitals as teaching institutions: training facilities (conference hall, hostels, training co-ordinators), diagnostic and clinical upgradation • Regular "grand round" monthly, where a faculty from medical college comes on, say, a Saturday (or other light OPD day) and conducts teaching rounds so that doctors from the different levels in rotation have periodic CME at the DH. Can be linked with speciality – specific CMEs • Provide higher level of specialised care at DHH (or at SDH/CHC if this is available at DHH) eg visiting anaesthetist from medical college or private sector once a month for 1-2 days, and elective surgeries are listed from all facilities under that hospital, to be operated by the referring specialist. This referring specialist may be from any health facility centre in the district, regardless of whether he/she is designated as specialist or mot

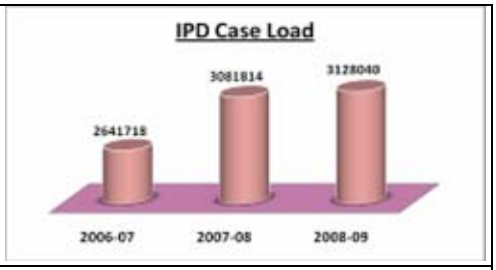
Similarly, attention needs to be paid to nursing and paramedicals professional development needs, career trajectory, and aspirations.

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

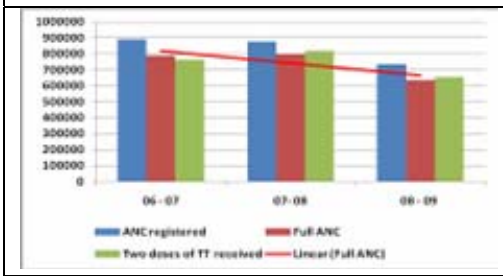
The OPD and IPD attendances in the State of Orissa are showing better utilization by the care seekers.



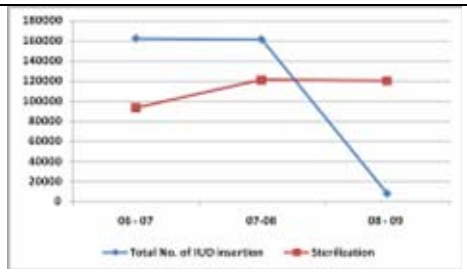
Increasing OPD attendance over the years



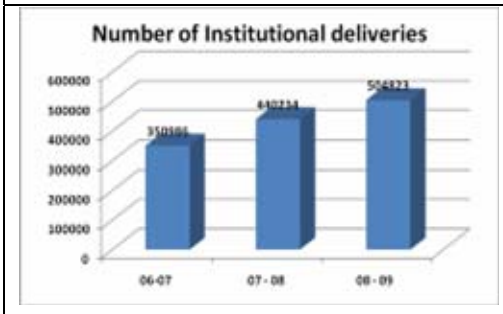
Increased IPD utilization by the Care seekers



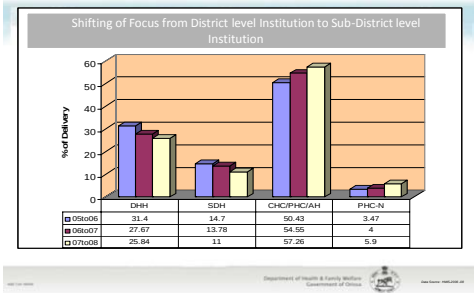
Year wise Full ANC with trend line against registered ANC cases and 2 TT



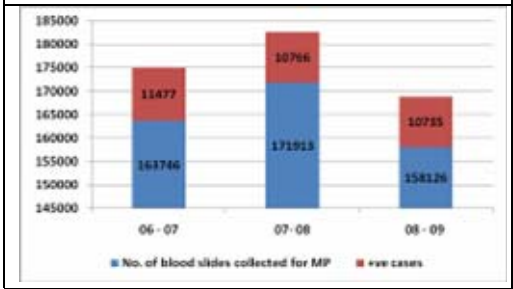
IUD insertion and sterilization

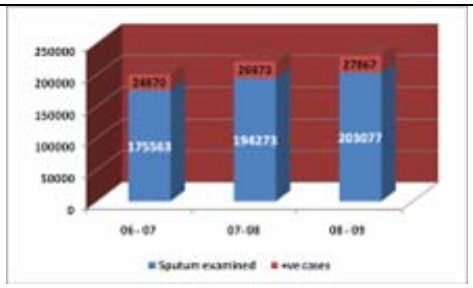


Increase in total number of institutional deliveries over the years



Better utilization of Sub District Health Facilities





Load on the laboratories

As a whole, the case load in the public health facilities is increasing over the years. Increasing trends are being observed for better utilization of the services provided at the health facilities,

with the exception of a declining trend for ANC and a flat trend for family planning. Institutional deliveries are happening in the sub-district facilities, thus the load on the district hospitals is reduced. Quality of the ANC data is questionable as TT2 shows a lesser figure than Full ANC in 2006 – 07.

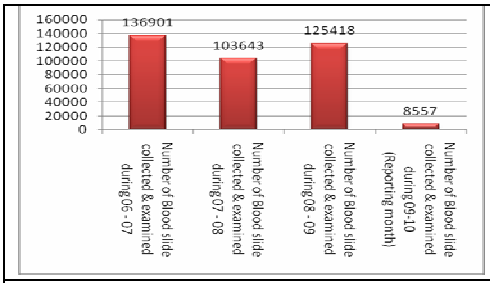
Majority of the health facilities are having functional laboratories, but unfortunately, routine tests, eg. Hb% estimation, Blood routine tests (TC, DC, ESR), Urine RE, Urine for sugar, albumin, etc. are not being done. Pregnancy Test is being done by using 'Nischay' kit, supplied by HLFPPT. Laboratory services in the public health facilities need immediate strengthening in terms of relocations of manpower, training, procurement, etc.

The Kandhamal District Head Quarter Hospital was attended to by 56082 patients at the OPD and 17157 at the Emergency Room from 1 April 2009 to 5 November 2009. During the same period Indoor admissions were 10430. Mean load on OPD/ER was Averaged that gives a monthly load on OPD of 10462; weekly 2362; 14% of them were admitted to indoor and 7% of them were categorized BPL. In the last completed week (24th to 30th Oct, 2009) the centre recorded 260 cases of Malaria (reported 202 in IDSP P form report).

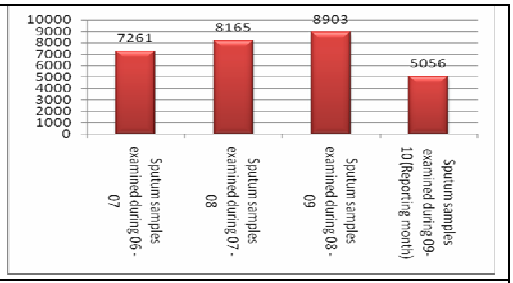
Khajuria is a busy hospital in the district and 24x7 facility with FRU services. The attendance at the centre was 15138 at the General OPD and 8000 for the Obs & Gynae OPD from 1 April 2009 to 5 November 2009. Taking the AYUSH OPD the load was 3648/m and 823/wk. The centre conducted 302 normal delivery during the same period -43/m; 9/wk.

Major contraceptive practice in the district is Female Sterilization. Condom and OCP are popular and in demand but there are supply problems making supply to client intermittent and ineffective. IUD insertion is picking up but the average duration of IUD in the client is 2 weeks. All IUDs are removed for some reason or other – wasting the investment and efforts.

In Balasore district, the OPD and IPD load have increased over the years. During 2008 – 09, the monthly inpatient load increased to 14411 from 6749 in 2006 – 07. Some of the other indicators are as follow:



Year wise blood smears examined for MP



Year wise sputum samples examined for AFB.

4. Preparedness of facilities for patient care services

Except in some of the district hospitals, preparedness of the facilities for holistic patient care services is limited. Quality of services is seriously compromised for want of adequate trained manpower, specially the nursing staff and the laboratory technicians. PHCs often only had one nurse limiting their ability to provide round the clock services. Laboratories are ill equipped, though, in many of the facilities, baby warmers, neonate resuscitation kits were available and are being used, yet, personalized care for the high risk neonate is wanting (GKB Area Hospital, Balasore). Citizen charter detailing the services available at the facility is seen in majority of the facilities visited. A map is displayed in Balasore DH for facilitating patients' movement. It is heartening to see compartmentalized cubicles in the labour room of Basta CHC to maintain the privacy of the expecting mothers in labour pain, effort of hospital authority of Soro CHC to inform the patients about the duty roster.

Signage and patients charter seen in facilities visited – need to be regularly maintained in all facilities. ICTCs operational in DH and CHCs, free condom distribution box and a complaint box at ICTC at Soro CHC.

Unattended premature twins (one is already dead) in baby warmer

Signage of Balasore DH

Ensuring the privacy of the expecting mothers in labour room at Basta CHC, Balasore

Duty Roaster of medicos & paramedics in Soro CHC, Balasore

Free Condom Box at the OPD, Soro CHC

JSY Complaint Box at Soro CHC

In Kandhamal, except the District Headquarter Hospital, the health care setting is poor and offer only limited services. The district does not have any Anaesthetist. So surgeries are limited to Caesarian Section under Regional Block Anaesthesia and small surgeries under local anaesthesia. At CHC Khajuria patients rarely spend a night. Generally everywhere the average stay of mother after child birth is one day. The assessment for improvement of facilities is limited by technical expertise.

5. Utilisation of untied fund

Utilizing various funds made available under NRHM the services has visibly improved. Gaps however remain. Huge unspent balance in the pass book points to poor utilization of fund in earlier years.

In Kandhamal district, CHC Gumagarh has added critical inputs like an arrangement for supplying meals to the inpatients and power back up for Labour Room, but procuring Urethral Catheters or a second set of instruments for the Labour room has not been planned.

In Balasore the availability of facility level plans in most facilities provided prioritized action for use of untied funds, though the monitoring of the plans could be improved as many of the activities listed for 2009/10 had yet to commence.

6. Outreach activities of Sub-centre

The sub centre provide outreach services. Generally, however the records on activities conducted at the farther villages from the centre are less compared to proximal ones. IEC activities like Village Kantha (Wall Writing with Health Messages) were evident, though recent in many places. VHNDs are planned in coordination with ICDS. But the coordination is limited to holding the event and not yet gelled into a system that takes care of the needy mother and children in festive mood for a gala event, nor does it reach out to the community other than those catered to by the Anganwadi. Thus, its impact on the community at large (men, adolescents, mothers not covered by the anganwadi) is limited, if any.

Expectant mothers in VH&ND

Wall Writing, displaying the list of VH&SC members, responsibilities and future activities in coming months.

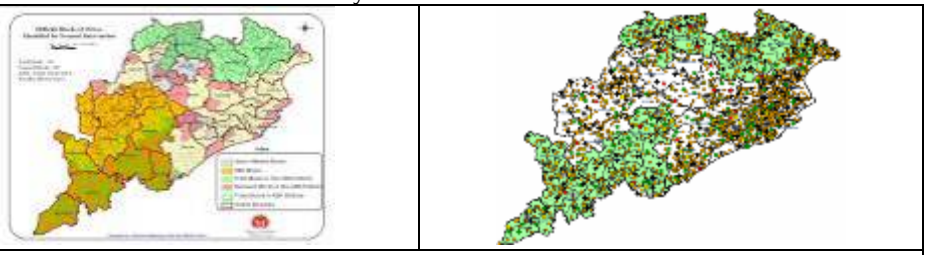
Outreach Immunization session in Kandhamal district

Regular VH&NDs, Jannani Express working well, referrals still a major bottleneck in under-served pockets, as observed in Kandhamal district. In Balasore vehicles were observed in most facilities. As observed at the Kalinga AWW, VHND on 6 November 2009, children who were sliding from Gr II to Gr III malnutrition were not getting attended to as to reverse the trend. Same was true of Mothers having low Haemoglobin. The intervention is limited to supplying Iron Tablets.

The MPW (M) are generally less available than ANM, wherever they are. Janani Express (exclusive ambulance services for transporting mothers for delivery to FRU/DHH) has been operational from mid August and since have transported 32% of such cases.

7. Thrust on difficult areas and vulnerable social groups

GIS mapping of the health facilities upto the level of sub centres has been done by the State for facilitating planning and implementing different health activities. The areas have been categorized as Left Wing Extremists affected blocks, KBK blocks, tribal blocks in non-KBK districts, etc. More thrust is needed in identifying pockets of PTGs (Primitive Tribal Groups) and LWE districts. **Project Arogya** for LWE steps in at positive direction. The state has begun to develop an **equity strategy** which would work with community leaders and traditional workers.



GIS mapping showing difficult areas and health facilities

Kandhamal district has a PTG population of 52%, Dalit population of 20 % and others settled mainly in the better communicated areas. The public health operational in the district have more vacancies and communication problems in overwhelmingly Tribal populated areas. The District has begun a programme to reach out to these people through Field NGOs operational in the district. In an interaction, these NGOs presented the main thrust of their activities as health service provision and identified language for communication and understanding of PTG customs and traditions as barriers to service. On a visit to such a village all under 15 children were found to be malnourished, having poor hygiene, giving history of monthly cycle of fever and splenomegaly.

The nutrition status in the community is poor. On a single family (of 42) random sample by 24 hour diet recall the calorie intake came out as 1600 K Cal. The diet pattern is almost wholly cereal (paddy, maize, jungle millet) based, no pulse, very small quantity of GLV and rarely pork. Food security is lacking.

In Balasore district, categorisation of the health facilities as located in difficult, most difficult or in inaccessible areas needs to be revisited. At present, all the health facilities in Nilgiri block and in Ishwarpur block under Balasore district are categorized to be in difficult areas, which may not be justified, where as Paschimbad area, which does not have all weather road connectivity, remains cut off for at least four months in a year during the rainy season, is not included. Considering the importance of the area and understanding the limitation, Paschimbad PHC (N) has been handed over to a NGO for rendering services to the community.

8. Quality of services provided

The hospitals and health centers are clean and utilize NRHM funds for up keeping the same. Drugs are available now, though there was evidence of gross irregularity in supply in the recent past. The OCPs are still in short supply; there is supply problem hindering consistent management of Falciparum malaria cases with Artesunate combination. Kit A and Kit B drugs are not fully available with the sub centers. Sub Centre is supplied with some antibiotics –which ANMs are not conversant with, like Cephalexin Capsules or Nimesulide tablets and also not eligible to use such drugs. Privacy is not always ensured especially in OPDs, with lack of screens/private areas.

There are 12 blocks in Kandhamal district and 5 FRUs running with limited criteria. Facilities like SNCUs are being added, two have been recently inaugurated at the G Udaigiri CHC and at the District HQ Hospital. Toilet and other facilities are not fully functional, unless improved they may not result in retaining the mothers for 2 days after child birth. Even within the logistic constraint of HRH, the facilities can improve service delivery by adopting good practices and scientific protocol of management.

There are five FRUs designated under Balasore district, which are functional with limited services. There is shortage of anesthetists, only 2 (two) are available and both at DH level, along with two multiskilled doctors in LSAS in Soro CHC and in Basta CHC. Niligiri SDH though designated as a FRU, no aneastetist or multiskilled MO in LSAS is there.

There are 11 (Eleven) SDHs/ Area Hospital/ CHCs in Balasore district, out of which, 4 (Four) facilities have been shortlisted to be a FRU and other 7 (seven) are functioning as 24*7 facilities. Out of these 24*7 CHCs, CHC Jaleswar and Baliapal are having only one Nurse each. CHC Khaira does not have a pharmacist.

Out of the 66 (sixty-six) PHCs, 6 (Six) PHCs have been short-listed to be functional 24*7 PHCs. In all these 24*7 PHCs, there is acute shortage of manpower, specially the nursing cadre. Quality of services is severely compromised. Laboratory services are also restricted.

9. Diagnostics

As a whole, the laboratory and diagnostic service is very poor.

At the PHC level, routine tests like Blood – RE, Hb% estimation, Urine – RE, Urine for sugar/ albumin, Pregnancy test, etc. are generally not being done.

At the CHC and some of the PHCs, diagnostic arrangement for malaria by Microscopy and Rapid Diagnostic Kit and Sputum AFB microscopy is available where trained Laboratory Technicians are available.

In X – ray rooms, lead shields are available but rarely used, but the TLD badges are conspicuous by their absence. Authority may take necessary action regarding the safety of the employees.

Diagnostic services for infectious diseases like Malaria, biochemical tests and routine clinical haematology support for indoor patients is available at the DHH. These are however very limited and the equipment here leaves much to be desired, and can in no way be said to be conducive to accurate results.

It is essential that a policy decision be made to provide each DHH and SDH with a semi-automatic analyser (and if possible at CHCs also). This should be accompanied by investigation protocols for common conditions, so that improved quality of investigations goes hand in hand with positive change in the investigation practices of doctors. At present, blood sugars are not estimated routinely for pregnant women even at the SDH and DHH, which reflects poorly on quality of care, especially when diabetes is increasingly becoming known as a prevalent public health problem affecting urban and rural areas, the rich and the poor.

Some ANMs and also some ASHAs collect malaria slides and send it for examination at the Sector PHC/CHC. The report feedback is patchy and slide collection also irregular and unsupervised. RDK is available at the Health Centres visited but are less used, mainly because of the 15 minute cycle necessary to complete the test. Both care provider and care seeker prefer dispensing the strip of Chloroquine rather than waiting for a positive report.

	During VHND days Hb estimation of mothers is conducted. ANMs are trained to collect blood on filter paper strip for estimation of Hb at the CHC, the service is sometimes used. Nischay, the diagnostic kit for pregnancy is rarely used. Kandhamal district hospital has one Medical Officer posted at the District Hospital in the lab headed by a specialist. She can be made instrumental to provide services for collection of sample for Blood, Sputum, CSF and Stool culture and Malaria microscopy with the team of Lab Technicians available at the DHH and other places. A linkage with a hospital in Bhubaneswar or a close by district lab would be very useful to diagnose outbreaks in the district early and avoid repetition of an outbreak situation like that of Chandipura Encephalitis in which several children died in the district in October 2009.
10. Logistics & Supply chain management	
	Logistic and supply chain management is a priority with the leadership in the state. Some streamlining of supply chain management is done and some more are in the pipeline. PROMIS is currently used by the Regional Vaccine Stores in the District for charging supply received from the state depot. Use of the software for Drug management has not taken off as the person trained for the job has left and a replacement not yet found. Drug supply is based on norms (80:20), patients still frequently required to buy in from outside, increasing out of pocket expenditure. Facility wise scale of drugs (2000) needs to be reviewed as there is considerable increase in utilization of health facilities by the care seekers. In most pharmacies, there have been persistent shortages (for over 6 months) of some medications from the essential drugs list, apart from the ones that arise out of poor stock management. Essential Drug List also asks for reviewing over the years. Introducing a locally-running software that can keep track of inventory and generate re-order forms should not be difficult to do, data from which can be integrated into a state-wide software when it is ready. It would also enable pharmacists to become familiar with use of computers, so that when the state wide software is installed, stock would have been already entered and pharmacists can quickly utilise it to its full potential. PROMIS could be extended to cover this function.
11. Decentralized Planning	
	The Perspective District Health Action Plan was not found available but Programme Implementation Plans for the districts visited was found available. During discussion it was learnt that, while formulating PIP of 09-10 FY inclusive process of planning had been adapted. The DPMU/BPMU and other Programme officers had participated in the process of planning. PIP preparation guideline dissemination to all stakeholders and extensive consultation were carried out for PIP preparation of 09-10. The Programme Implementation Plan for 2009-10 had been developed based on a series of consultative workshops held at different levels - block, district and state levels. It, therefore, incorporated recommendations and innovations made at the local level in all 30 districts. Using the bottom up approach to planning, village and block plans were consolidated to develop the district project implementation plans that further culminated into the State Plan for NRHM. At the state level, subject specific committees were made with representatives from development partners UNICEF, UNFPA, State & District level Programme Managers of Disease Control Programmes, Immunisation, Maternal & Child Health, Family Planning and TMST. The inclusive process of planning had brought issues and concerns from the village, block & district level as well as the other stakeholders to be reflected and addressed in the programme. It may be commented that progammatic priorities and activities highlighted in the PIP were based on health needs, priorities and gaps identified by all stakeholders taking into account, past experiences, successes of initiatives and projects.

	Block PIPs have been formulated based on a pre-designed format which also contained village level action plans for a few villages within the blocks. But the planning processes of the blocks were not mentioned in most of the block plans since it was not there in the designed format given by the State. In depth situational analysis in the form of topography, demographic profile, institutional structures & facilities, available human resources among all facilities, current situation of water & sanitation, educational situation are incorporated in most of the block PIPs. The district has a District Health Action Plan. But the processes of decentralized planning do not seem to have really gone into uniform practice at every level to reflect the felt need of the community. DHAPs are generally generic plans but facility based plan have mapped difficult areas . However pockets are still out of loop of health system due to inaccessibility of terrain in remote districts like Kandhamal. These pockets have to be identified for bringing within health delivery ambit. The ANMs and most of the in charge Medical Officers are not very conversant in use of the tools for Sub Centre Action plan or area health action plan. They depend on the Block and District PMSU for such outputs, this may be detrimental in the long run for the overall programme objectives. Even the District Blindness Control people are unable to justify fixing a target for cataract surgery, saying these are fixed by the state team. Evidenced based studies and group discussions are being undertaken while formulating some of the Block Health Action Plans (BHAP) , but a systematic use of these tools are still awaited. BHAPs are not the consolidation of the Village Health Action Plans. Facility wise health plans were observed in most facilities in Balasore, and were providing useful prioritization of available untied funds. However, periodic follow up to the plans was in need of strengthening.
12. Decentralised Local health action	
	Kandhamal district has begun an ambitious programme for reaching the unreached and back ward, difficult to reach areas through a decentralized service provision package initiated by Field NGOs active in the RCH sector in the district. This Programme known as "Arogya Plus" is currently covering the ultra left dominated blocks of the district and are likely to be spread to cover the whole district as the whole district can qualify as tribal dominated, extreme poverty stricken and difficult to reach. In Balasore one PHC has been contracted to an NGO for running and two NGOs are involved in slum outreach.
13. Community Processes under NRHM	
	Communitization in health sector has begun in the State. The Gaon Kalyan Samities in the villages have largely been formed. As they have been formed recently most of the times they are not attuned to hold a meeting with different groups to reach a community decision and implement the same. In the GKS meetings attended and in interactions with members it was found that most of the times health agenda do not go beyond a decision to support some ailing person with some money. Most GKS members are not clear, how many safe drinking water source like tube well is there. Some heard for the first time that there is scheme in which they can build their sanitary latrines themselves with implements from the Govt. The process has to go much further to address and reflect the felt needs of the community and to act as a watchdog on working of the primary health care system. Most of the GKS members are not clear about the holistic planning of the villages, majorities are restricted to plan for RS. 10000/-, the VH&SC fund. A holistic village plan may be beyond the Rs. 10000/-, fund sources and department wise allocation of works/ jobs may be done by the Block Level Development Committee.

14. ASHA	
	ASHAs are co-terminus with Anganwadi Centres (AWCs). Till date, 37510 out of targeted 41102 ASHAs have been selected, 33115 ASHAs (97.2%) have been trained in module I – IV. 129 NGOs along with departmental staff were involved in the training. ASHAs have received additional training in RDKs, Nischaya Kit. Training in PNC for 2617 ASHAs has been completed in 3 (Three) NIPI districts. 366 NGO trainers have been trained for module V training and is ongoing. 10th of every month is the designated day for discussion on ASHA programme at the block level - ***"Block ASHA Diwas***", where in analysis of the sector level reports, drug kit replenishment, incentive payment, address issues, grievance redressal, plan for next month are being done. Replenishment of the ASHA drug kits has been institutionalized. Out of the total 13 (Thirteen) items, 8 (Eight) items are supplied once annually by State, remaining 5 (Five) items like Tab. CQ, PCM, ORS, condoms & OCPs are being replenished by the health facilities. "ASHA Gruha" – Help Desk cum Rest House are being commissioned in District Headquarter Hospitals (30), Medical colleges (3), Rourkela Govt. Hospital, Capital Hospital, Bhubaneswar, which are being managed by ASHAs on rotation. Already operational in12 institutions. The ASHA recruitment in Kandhamal district is largely accomplished and has been trained upto Module 4. They are visible, known to the community and proving to be useful in providing select services to the community. Generally they are happy with the income they are being able to generate. The training level on Module 1 is clearly good; the same is not true of the other modules. Considering the generally low level of formal education, this vital health workforce needs to be handled with care for training to make them perform limited operations without error. In some villages there were some reports of ASHA eating into JSY payment to the mother, but it may be aberrations rather than rule . In Balasore district, ASHAs are a group of vibrant activists, proud of their social responsibilities. They are happy with their dress, but expressed that cotton saree would have been more comfortable and they can do away with the apron. Bicycles have not yet been issued to the ASHAs according to plans.

ASHA GRUHA @ Balasore DH

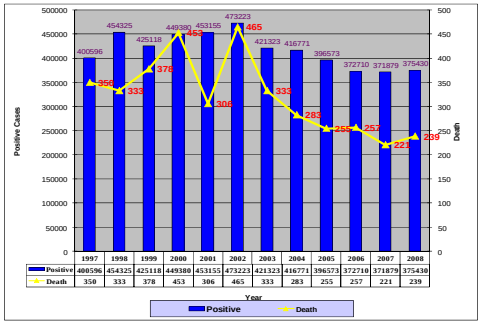

Interactive session with ASHAs

15. National Disease Control Programmes	
Overall	The disease control programme are known in the district and the presence of some were quite visible. The ANMs, Pharmacists and doctors are conversant with the IDSP, NVBDCP and RNTCP reporting system and some of them regularly generate report for onward transmission.

NVBDCP

Orissa is a high burden state in India with average Pf > 85%. Tribal population is 22% with high vulnerability to Pf exposure. ~ 60% reported malaria deaths occurs in tribal blocks.

20 High burden districts for Malaria.



Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Positive	400596	454325	425118	449380	453155	473223	421323	416771	396573	372710	371879	375430
Death	350	333	378	453	306	465	333	283	255	257	221	239

Cases & Deaths due to Malaria (1997 – 2008)

Anti – malarial activities include Indoor residual spray with DDT 50% WDP and SP5% WDP and distribution of Insecticide treated bednets (ITN) and Long lasting Insecticide treated nets (LLIN) to the villagers along with training of paramedics and ASHAs in use of RDKs, FTDs, etc. PRIs are involved in community monitoring of IRS.

Vector management intervention in Kandhamal district is limited to IRS spray and gambusia culture in water bodies. LLIN or any other bed net promotion has not started in the district yet. IRS spray was ongoing in the district during the tour of the team. The quality of spray was poor, patchy, not covering all the habitation rooms in households and there was no prior intimation to the community. The hatcheries for gambusia in several CHCs has been established, but follow up or coordination with other sectors and the community for ensuring that the seeds are actually charged in the water bodies and maintained is lacking.

In Balasore, it has been decided to distribute ITN to the pregnant women during their 1st ANC. In Bahabarapur village, no trace of IRS was seen in some of the rooms, visited and the some of the residents admitted that they do not like to sleep inside the bed nets as they feel to be suffocated.

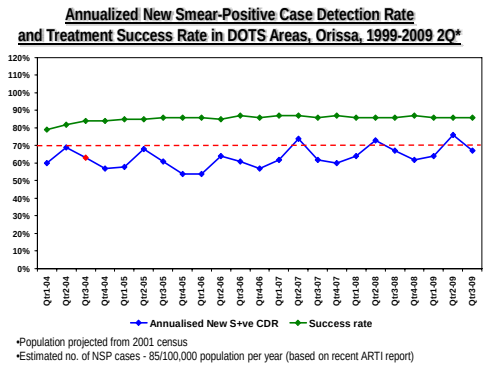
Balasore, one of the coastal districts of Orissa, is known to be filarial affected district. There was no mention of anti – filarial activities in the district presentation.

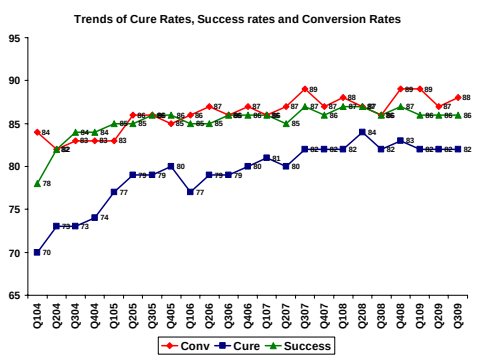
State has switched treatment policy to include artesunate, but clear protocols for use of artemisinin treatments were not evidenced from interaction with doctors in health facilities.

Breeding ground for mosquitoes at Balasore DH?

Inmates of the health facilities are not being provided with bed nets.

RNTCP

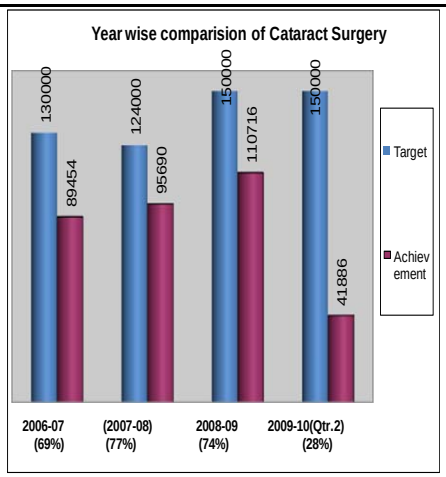




NSP Case Detection Rate in the State has followed a seasonal trend whereby the target of 70% has been achieved in the 2nd quarter every year with dips in the 4th quarter
The NSP Treatment Success Rate however has remained consistently around and above 85% since 2004

RNTCP presence in Kandhamal district was visible, but the data management and record keeping were found to be grossly sub standard at the G Udaigiri CHC, a key Microscopy center of the district.

NBCP



- The activities were mainly limited to cataract surgery at the district hospitals and reaching out to the community for transporting the patients for such surgery.
- In Kandhamal, the district capacity of a 20-bedded hospital with full-time eye surgeon and several paramedics were utilized to conduct 200 surgeries in the last one year, whereas the NGOs operating in the district conducted 600 surgeries during the same period.
- The payment to the NGOs, organizing the cataract surgery camps in earlier years is still lying unpaid and unadjusted.

A useful indicator to use here is CSR = Cataract Surgeries done per million population. In Orissa, the cataract surgeries done in 2008-09 show that the state achieved a CSR of 2,775. The desirable CSR to eliminate cataract blindness, assuming that population in the state >= 50 years is at least 11 %, is over 6,000 (figures of 2008-09 performance from NPCB, Ministry of Health & Family Welfare, Govt. of India, estimates of CSR linkage to > 50 years population from Vision 2020).

This emphasizes the need for a state-level strategizing on how to reach out to the largely unreached ,needy population in Orissa

NLEP

The data of newly detected cases reviewed from 2004-5 reveals a disconcerting recent increase in the ratio of MB to PB and the prevalence of disabilities in the newly detected cases. The NLEP officers in both the districts and at the state level demonstrated a clear understanding of the data, the trends and the issues. They are aware of this, and stated that this is more in the tribal (previously underserved) areas. Efforts have been made to step up the routine screening.

Year (Khandamal District)	Type	Detected	Disability Gr II	Disability Gr I	New Child
2008-9	PB	12	0	0	0
	MB	28	8	9	1
	Total	**40**	**8**	**9**	**1**
2007-8	PB	9	0	1	1
	MB	18	0	5	0
	Total	**27**	**0**	**6**	**1**
2006-7	PB	13	0	0	0
	MB	9	0	0	1
	Total	**22**	**0**	**0**	**1**
2005-6	PB	18	0	0	1
	MB	14	1	0	0
	Total	**32**	**1**	**0**	**1**
2004-5	PB	51	0	0	9
	MB	36	2	0	4
	Total	**87**	**2**	**0**	**13**

Therefore, it is highly recommended that, in a sample population, a screening survey (of the kind done earlier) be done, using leprosy paramedical workers still in service, in order to arrive at a epidemiologically valid estimate of the new cases, so that further strategies can be made on sound epidemiological information and principles. This is particularly important in view of the difficulties in healthcare access faced in many parts of Orissa.

NIDDCP

The SPIP for the year 2009 – 10 states that main NIDDCP activities are:

1. Observation of Global IDD Prevention Day on 21st October of every year and
2. IDD/Goitre survey in districts with the help of the three medical colleges and
3. Salt sample testing at entry points (road and railway), salt whole sellers and retailers.

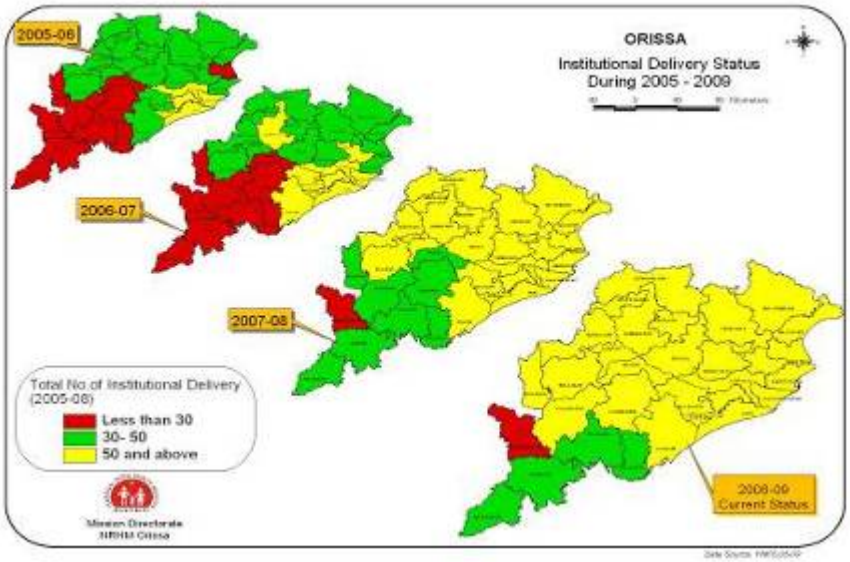
The survey, held during 2007 – 09 shows an incidence of 33.5% in Sundargarh district, 27.79% in Kandhamal district and 0.85% in Balasore. Survey was also conducted in 9 (nine) districts, report of which is awaited.

Though there is high incidence in some of the districts of the State, yet, there was no presentation /briefing was made either at State level or at Balasore district.

IDSP

Most of the health personnel examined are aware of IDSP and trained. The sub-centre level S-form reporting was poor and generally did not match the register. P-form reporting from PHC and CHCs (not new PHCs) were regular, but providing data which do not match records. Khajuria CHC reported 214 cases of malaria for the week 17th to 23th October 2009 in the P-form, during the same period OPD records showed 325 cases and lab record showed 34 cases.

16. RCH II (Maternal Health, Child Health and Family Planning Activities)



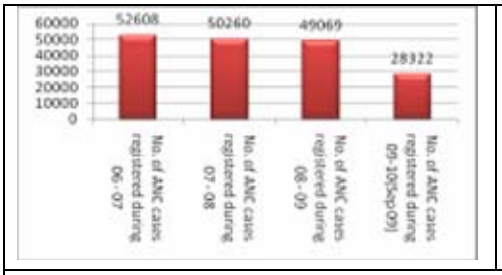
At the outset, it needs to be mentioned that there is considerable improvement in the field of Maternal and Child Health and in the field of Family Planning. Though the progress made is slow, yet, it may be said to be in the right direction. Over the years, MMR has reduced to 303 (SRS 2006) from 424 (SRS 2001), IMR is 69/1000 live births (SRS 2009) against 75/ 1000 live births (SRS 2006). Trends in 3 or more ANC and % of Institutional deliveries are showing an increasing trend in Orissa over the years, which is quite appreciable. 80%+ is the 3 or more ANC coverage in Orissa during 2008 – 09. During the year 2008 – 09, there is 60% of Total deliveries were held at the health facilities in Orissa. The above maps of Orissa clearly show the improvement in block wise number of Institutional deliveries over the years.

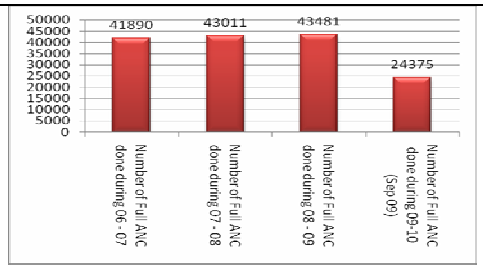
Demand creation though JSY was well promoted in Kandhamal and in Balasore districts and rate of institutional delivery as well as ANC coverage was steadily rising particularly over the last 2 years. JSY payments appeared to be made promptly and were update, an improvement over previous years. The quality of care however was not uniform and in some sub-centres was limited. Reach of MCH services to distant villages were poor. On an average one-third of new-born were low-birth weight and average maternal weight at first visit was 42 kgs in some centres. Care of anemia in pregnancy was limited to dispensing iron tablets and some ANMs were not very clear about danger signals of pregnancy. eg village in Ganjuguda SC: 2003-2008 shows the maternal weight tended to remain same; but birth weight of baby gaining over the years.

At G Udaigiri CHC, of 307 childbirths Jan to Nov 2009; 103 (33%) weighed <2500 G. At Gumagarh CHC, since 1st July 2009, of 40 childbirths, 13 (32%) weighed < 2500 G.

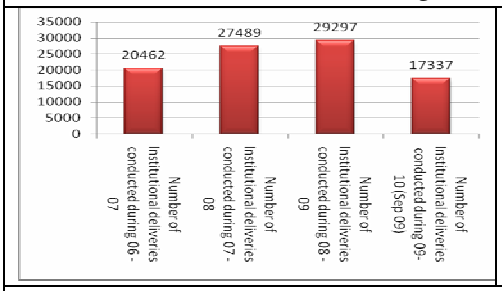
Record of birth-weight of new borns and maternal body weight at Goda Guda Village in Ganjuguda Sub-centre						
Median value for	2003	2004	2005	2006	2007	2008
Mothers weight at first visit in kgs	48	41	45	46	45	45
Birth weight of new born in gms.	2450	2450	2800	3000	2500	2900

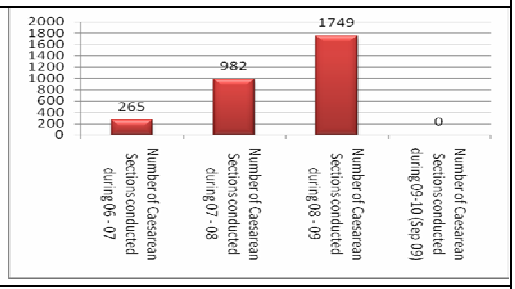
In Balasore district,





Year wise ANCs registered and Full ANCs in Balasore

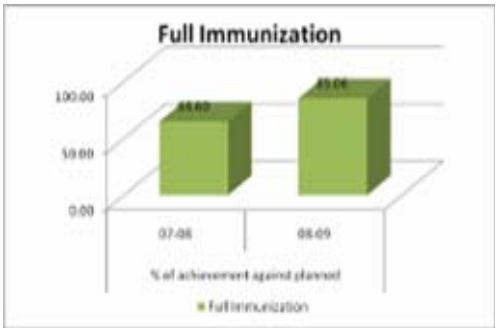




Year wise distribution of Institutional deliveries and Ceasarian Sections in the public health facilities of Balsore district

Full ANC is around 88.6% (2008 – 09) of the total number of cases registered against 79.6% in 2006 – 07. Facility utilization by the pregnant women is also increasing for deliveries over the last 3 (three) years. Increase in the FRU network in the district, two new FRUs in last year, led to 1749 (146 CS/month) ceasarian sections in 2008 – 09 against 265 (22 CS/ month) in 2006 – 07. More numbers of women are coming for ANCs and also completing 3 ANC, 2 TT and 100 IFA tablets. Number of PW, registered during the 1st trimester – a quality parameter, is also increasing and the pro-active role of ASHAs in the village in active tracking of PWs play a vital role.

Under child health, full immunization figures are being kept w.e.f. 2007 – 08 and the bar diagram shows that:



In Family planning practices, the trend is increasing, but while interacting with the PWs during VH&NDs, the followings were highlighted by the pregnant women:

1. The onus of family planning practices is on the women
2. Male participation in Family Planning practices is negligible
3. Women are less aware of IUCD Cu T 380 with 10 years life
4. Majority of the women are on OCPs
5. Though the ANMs are able to identify the PWs with danger signs, but not aware/ confident of how to refer the cases for medical intervention

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

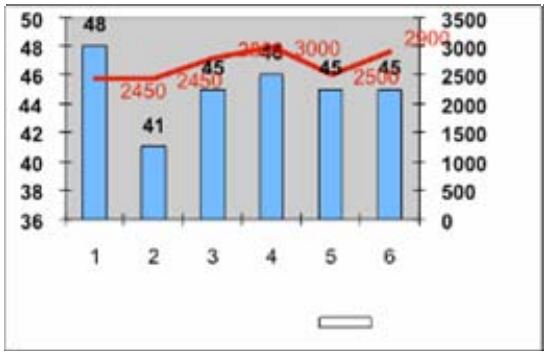
During the tour the team came across the case of 1 yr 10 month old Sanat Mallick (b/o Sulochana Mallick) suffering from Gr II & III malnutrition since birth at Kalinga Anganwadi centre. The child was in Gr III malnutrition for the last 3 visits and Gr. II malnutrition throughout. He was referred to CHC for care. His mother, single parent daily wage labourer was unable to provide him appropriate nutrition.

Cases like this call for an acute need of intersectoral coordination to combine the efforts of the women and child development sector and health sector synchronizing into sustainable community benefit. Most of the times this was not evident in the district. Nutritional deficiency is an important problem hindering healthy living in the district as most of the families do not have food security assured for several months in a year. This is particularly true of the Primitive Tribal Groups who are numeric majority in the district.

Similarly coordination with PHE, dept. of rural development, and safe toilet promotion are essential to support healthy living.

18. Nutrition

Low birth weight still remains a problem



While the nutritional support system is well established, it does not have adequate impact as the above table and observations in the field show : there is scope for significant improvements

A. **Nutritional supplementation for children**:

1. This is regularly prepared and provided in the anganwadis; referral takes place when there are downward movements in nutrition
2. It was observed that there was irregular attendance by children of other villages (other than the ones where the anganwadi was situated) and when mothers have other commitments eg NREGS.
3. There is Widespread Gr 1 and Gr 2 malnutrition; this tends to remain status quo in spite of the nutritional supplement
4. Movement of individual children up the nutrition scale needs to be incorporated at angawadi and supervisory levels as a desirable outcome, supported by statistical tracking of such movements (eg % age of children in gr 2 who moved to gr 1) and by family-based assessment and strategies for difficult cases.
5. Malaria needs attention on war footing for individual cases

The revised supplementary norms of Rs 4/5/6 per child per day is being implemented in pilot blocks as a state level initiative, using locally available foods including sprouted grams. Pregnant and lactating mothers are also included. To ensure that this effort gains the maximum benefit for women and children, the programme needs to be guided locally by

nutritionists aware of local food habits and customs, and have the stated target of developing locally relevant high-protein supplements. The plan is to set up mini factories managed by SHG federations with financial support from banks. And this will form part of the Mission Shakthi initiative of the department of women and child development, which aims to form, strengthen and sustain 3777 lakh SHGs (note: *to be verified)*

B. Pushtikar Divas:

Good programme: Provides separate track for Gr 3 and 4 Malnourished children with money for nutrition and treatment, which may be strengthened further by:

1. Monitoring indicators that give importance to tracking movement of children up the nutrition scale and community mobilisation for difficult cases
2. Monitoring focus on how many have moved up/ down/ static (results and not just inputs)
3. High protein nutrition supplement that can be prepared locally using locally available materials and prepared by women's groups

C. Nutritional support for antenatal mothers:

1. Stronger prioritisation required by identifying and targeting expectant mothers having anaemia or IUGR.

D. High protein supplement:

1. High protein supplement: from locally available foods; tailored for each area/ cultural group (esp on the case of PTGs)

E. **Village Based Feeding Centres** will go a long way in lieu of AWC based feeding centres, as it will bring the supplementary nutrition to the doorstep, and further reduce the barriers that exist.

The state plans to expand from 40,000 to 61,000 Anganwadis in the 3rd phase of expansion (universalisation), where there will be anganwadi centres on demand (serving min 150 population), as well as 11,000 Positive Deviance AWCs. The IMNCI and Positive Deviance will be a combined programme where the 'better' mothers will teach others.

There are as yet no specific strategies for PTGs.

Malnutrition and malaria are two major health problems in the district and make parts of vicious cycle of morbidity-lost wage-food insecurity. They needs to be addressed in tandem on a war footing, as part of a comprehensive community based action, with support from panchayat, agriculture, animal husbandry, and women and child development if we are to find sustainable solutions for communities.

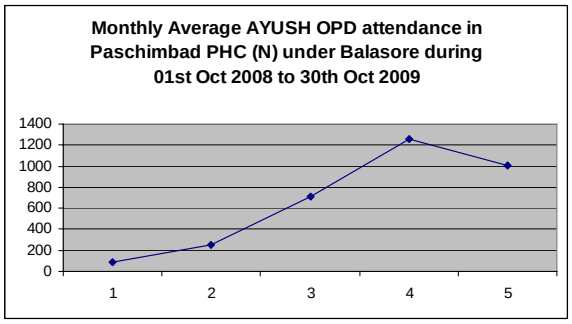
19. Non-governmental partnerships

Kandhamal is a backward district not blessed with the presence of large and resourceful NGOs. The Mother NGOs and field NGOs working in the district are mostly local groupings thriving-on and guided by Government sponsored programme. Moreover the operational NGOs do not have a tribal presence worth mentioning. In the backdrop of ethnic fault line separating dalits and tribals their reach into and rapport with PTGs is limited.

In Balasore district:

Management of PHC(N) by NGO- Paschimbad PHC(N) is managed by ARM, NGO since 24.12.2007. The services provided by the NGO includes OPD services, Laboratory services, Ambulance services, IEC activities in outreach areas, emergency health services during disaster situation. With all the limitations, with out a PHC building, Pascimbad PHC (N) is trying to render health care services to around 18000 population. District and State may take special initiative for this PHC.

Alternative For Rural Movement (ARM), a NGO, is managing the Paschimbad PHC at present w.e.f.24th December 2007. Average monthly OPD attendance increases from around 1100 in 2007 – 08 to 1928 in 2008 – 09 to 1983 in 2009 – 10. Average monthly institutional delivery increases from 1 in 2007 – 08 to 6.5 in 2008 – 09 to 12 in 2009 – 10. AYUSH OPD shows an increased average monthly attendance over the quarters.



Urban Slum Health Programme – Two NGOs May I Help You and Punaruthan Voluntary Organization are partners in Urban Slum Health Programe since March 2008. Under the Programme Urban clinics are being run for the Slum dwellers and RCH services are being given along with referral, lab services and immunization support. For community involvement and IEC activities Link workers are in position.

20. Overall Programme management

The PMSUs both at the State and at district level are a dynamic team of workers with high potential. The managers are good, dedicated, but lack of supervisory skills, which required to be supported by regular health services managers, both at the State level and at the district level. The gap between the Programme Managers (State & district) and the SPMSU/ DPMSUs was evident without any effort. BPMSUs are also active and some what found to be more accountable (MOI/C of Ishwarpur PHC was not available on the date of visit, but BPM was available).

The lack of regular appointees for programme management is a gap in implementing NRHM in general and the vertical national health programmes in particular. The block PMSUs were either absent or ha not taken roots yet.

As a result the health sector in the district has become collector driven who is an excellent and visionary leader. But so far as system strengthening and health sector reforms are concerned this has known pitfalls.

21. Financial Management

1. Under Part A, remarkable expenditure has been noticed under BCC / IEC head, state has spent 127% of the amount approved in PIP. More than 60% expenditure in MH and Programme Management is quite appreciable. 70% of total expenditure is reported under Maternal Health.
2. Under Part B, 83% increase has been noticed in expenditure during 2008-09.
3. State needs to improve expenditure in Child health, ARSH, Tribal Health & in Vulnerable Group related expenditures under Part A.
4. Under Part B, out of Rs. 182.81 Crores approved by the NPCC and Rs.123.44 Crores released, the state has utilized only Rs.66.79 Crores i.e. only 37% of approved PIP, while the national average of expenditure against PIP is 68.14%.
5. Since the start of the programme, Rs. 357.10 Crore has been released to the state but the state has utilized only Rs. 177.18 Crore (50%) and Rs. 179.92 Crore (50%) remains unutilized.
6. No expenditure is reported under the head Training, New Initiatives Research Studies and Analysis.
7. JSY and ASHA payments are made promptly, and monthly clearing of ASHA payments is helping to ensure that these are up to date.

22. Data Management	
	Uploading of data in web portal is more or less regular, but utilization of data needs to be more focused. Analysis and regular feed back to the facilities, generating these data, is not happening. It's more or less one way channel. During 2009 – 10 till October 2009, % of uploading of monthly district consolidated data is 87.14%, pendency is only 27. State forwarded only 68.31%. Baudh and Malkangiri district did not upload their data w.e.f. August 2009. The IDSP unit is fully manned and operational. The District Surveillance Officer is also trained and maintains continuity. But The Output Of The Programme Is Extremely Poor. Comprehension Of Data Points In The District Regarding IDSP Reporting Is Sub-Standard And Compliance Of Reporting Is Much Lower Than Oprtimal. In The Week Of 17th To 23rd October 2009, 58% Reported P-Form And 66% Units Reported In S-Form. Chronic Non-Reporters Included Daringbadi Where The AES Death Of More Than 10 Children Occurred In October 2009. NRHM MIS Monthly Reporting has better compliance, But Poorer Comprehension At Peripheral Levels Of Reporting. In fact The Comprehension Problem Does Not Have Something To Do With The Recent Change In The Reporting Format And Is Equally True Of Reporting In The Previous Format. Apparently Transfer Of Skill Has Not Happened From The PMUs. To The Respective Health Care Personnel. In The MIS, RCH Component Reporting Is Closer To Reality But Disease Control Reporting Is Poor. At Gumagad CHC the lab register shows 2000 blood slide examined for the month of October 2009. the relevant entry in MIS forms from CHC Gumagad puts five cases of malaria as total for the month.

Recommendations:

1. The meeting of State/District Rural Health Missions and State /District Health Societies may be streamlined so that these meetings are held at prescribed regular intervals. ASHA and GKS efforts to have strong mentoring support outside the government system.
2. Facility wise master plan along with provision of staff accommodation needs to be implemented in phased manner for optimal use of the available land to ensure services availabilities.
3. Facility wise Manpower mapping for ensuring optimal distribution needs to be done both at the State and at District level with some delegation to the district authority for relocating critical manpower with in the jurisdiction.
4. Laboratory Technicians from different sources, eg. Govt. system, RNTCP, OSACS, malaria, etc. are in some places underutilized. Optimal distribution of these Lab. Techs. may increase the laboratory services network in the State.
5. Model may be developed for:
    a. Strengthening of PHC New with trained AYUSH doctors, Staff Nurses, Pharmacist
    b. Multiskilling of staff may be promoted,
    c. PHC (N) functional only with Nursing Practitioners may be explored,
    d. Pooled Block-level CHC with full complement of MBBS and specialist doctors
    e. Well-equipped SDH and District Hospital (DHH as a training cum teaching centre)
6. As it is resource constrained system, professional development may be explored by:
    a. District Hospitals may be strengthened as teaching institutions in terms of training facilities, diagnostic and clinical up – gradations
    b. Monthly teaching rounds by faculty from medical college
    c. Visiting anesthetist from medical college or private sector monthly with elective surgeries from all facilities in district, to be operated by the referring specialist.
    d. Post training follow up tracking of the SAB trained personnel (Nurses, ANMs, AYUSH doctors, etc) needs to be done to ensure practicing of the skill learnt.
    e. Relocating/ granting study leave for technical personnel with out proper replacement may be avoided to maintain the strength in peripheral facilities.
    f. Principal of the Basic Training Institutes (ANM&TC) and district health authority need to be more pro-active for the improvement and functionality of these schools.

g. Regular payments of Salary of the peripheral staff including that of ANMs & LHVs need to be ensured. In case of any dislocation, the fund may be placed from the State exchequers for the time being, as it is reimbursed by GOI.

7. Supervisory structures to be strengthened by identifying Nodal officers for Districts at State level who would be responsible for all programs of the District and development of the District with specified visiting time schedule and feedback mechanism. Same for blocks. Monthly review meeting by Commissioner and Secretary of District Nodal officers may ensure the desired outputs.
8. Utilization of health facilities by clients, eg. OPD, IPD, lab. services need to be monitored at the district level for planning for future expansion. It can be further strengthened by:
    a. Co-locating AYUSH OPD at District Hospitals to promote clients preferences.
    b. As the utilization of the public health facilities by the care seekers is showing increasing trend over the years, availability of essential drugs in the facilities need to be ensured. The EDL and the facility wise medicine and other related consumables quota need to be revisited.
    c. Integrated Laboratory services should be made available. Routine services, like, Blood for TC,DC,Hb%, ESR, Urine – RE, including Urine for sugar and albumin, Stool for RE, MP, and sputum should be made available in all facilities up to the PHC.
    d. Privacy of services in OPDs needs to be ensured.
    e. Need to step up training of all categories of staff in IMEP. It is just not happening actually in the periphery.
    f. Ensure the hospital stay of mothers for 2 (Two) days after delivery, ensure home-visits by ANM mandatory at 7-10 days to assess the state of health of newborn
9. For strengthening the Supplementary Nutritional Services, Village based feeding Centres, at least in the villages (and for PTGs) not having AWCs, will go a long way by improving the accessibility as well as acceptability of the supplied foods. High-protein mix to be developed from locally available foods in each area with the guidance of nutritionists for supplementary nutrition.
10. Monitoring to focus on the upward movement in nutrition scale, and family-specific assessment for difficult cases. Malaria and malnutrition to be tackled in tandem on a war footing with full community mobilization and commitment and multi-sectoral coordination, if impact s to be felt.
11. All the facilities need to be classified in terms of located in difficult , most difficult and in inaccessible areas, for formulating differential intense local specific plan of action. Linkage of postings in underserved areas (KBK + areas) for certain tenure may be linked with career progression (PG study for medicos and nurses), better postings, etc. Financial incentives may be considered for a complete package of services.
12. New initiatives to be evaluated and assimilated into the system for sustainability

Some cherished moments: