Third

Common Review Mission

State Report

Uttar Pradesh

Ministry of Health & Family Welfare

Common Review Mission – III

Uttar Pradesh: Report of Team

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B. Districts visited:

Allahabad, Kanpur City

C. Facilities visited

Sl No	Facility/Area	Allahabad	Kanpur
1.	District Hospital	Female (ISO-9000)	Male & Female
2.	CHC	Kohran, Karchana, Handia (FRU), Phulpur (said to be FRU)	Kalyanpur Bidhnu
3.	PHC	Saidabad (24x7), Mungrabadshapur (Jaunpur District),	Bithoor, Bhitargaon, Baraigarh
4.	HSC	Lediyari, Bheeti, Bodai, Samaudipur, Patherthal , Baraut, Purshottam pur, Kodapur	Mandhana
5.	Villages	Lediyari Bazar, Marichandpur, Puresudi, Jadipur, Sehla	Behatagambhirpur, Jurraiya

1. Introduction

Uttar Pradesh, with an area of 0.24 million sq. kms, accounts for approximately 7 percent of the total landmass of the country. As per Census 2001, the State had a population of around 166 million and accounted for approximately 16 percent of the country's population. The current population of the State, according to the population projections, is nearly 196 million.

For planning and development purposes, the State is divided into four distinct regions on the basis of homogeneity, contiguity and economic criteria. These regions are— Western, Central, Eastern and Bundelkhand. These regions are further subdivided in 18 divisions and 71 districts, Kanshi Ram Nagar being the newly formed district. The districts are divided into tehsils (304) and developmental blocks (820). In all, there are 107,164 revenue villages, approximately 682 cities and towns, 8135 Judicial Panchayats (Nyaya Panchayats) and 52,028 Gram Panchayats in the State (Census 2001)

Uttar Pradesh is the 9th most densely populated State with a population density of 689 persons per sq. km (Census 2001), as against the national average of 324 persons per sq. km. Out of the total population of the State, more than 79 percent (13.15 crores) live in the rural areas, while the remaining 21 percent (3.45 crores) live in the urban areas. Since the majority of the population lives in the rural areas, agriculture is the primary occupation of the people in the State. However, there are variations across the districts, with districts like Lucknow, Ghaziabad, Meerut, Agra and Kanpur having relatively large urban populations

Demographic Profile of Uttar Pradesh vis-à-vis India

Indicators	Uttar Pradesh	India
Population Density (2001)	689	324
Sex Ratio (2001)	898	933
Scheduled Caste (2001)	21%	16%
Scheduled Tribe (2001)	0.1%	8%
Literate Male (2001)	70%	76%
Literate Female (2001)	43%	54%
Life Expectancy— Male	65 Years	66 Years
Life Expectancy— Female	67 Years	66 Years

Out of the total population, 52.7 percent (8.75 crores) are males and 47.3 percent are females (7.85 crores). The sex ratio of the population is 898 females per 1000 males for the State, compared to 933 for all India (Census 2001). The population density is very high in the Eastern and Western regions and very low in Bundelkhand region.

Literacy rate in the State is 57 percent and there is a significant gap in literacy rates of urban areas (70 percent) and of rural areas (53 percent). As regards, the male and female literacy rates, the figures are 69 percent for males and 42 percent for females. Among the urban literates, male and female literacy rates are 77 percent and 62 percent, respectively, while for their rural counterparts, the proportion stands at 66 percent and 37 percent, respectively. The significant variations in the literacy rate imply high inequality in terms of access to education in rural and urban areas and between males and females.

2. Health Infrastructure and upgradation

The present public health infrastructure in the State, both in the urban and rural areas as reflected in the State PIP 2009-10, is shown below:

<table>
<tr><th>Urban Areas</th><th>No. of Facilities</th><th>Rural Areas</th><th>No. of Facilities</th></tr>
<tr><td>Super Specialty Institute</td><td>5</td><td rowspan="2">CHCs</td><td rowspan="2">426
(198 under construction)</td></tr>
<tr><td rowspan="2">Medical Colleges</td><td rowspan="2">7 - Govt.
2 – Central Govt.
3 –Private</td></tr>
<tr><td>BPHCs</td><td>397</td></tr>
<tr><td>District Male</td><td>61</td><td rowspan="2">Additional PHCs</td><td rowspan="2">2867
(In Govt. Bldg.- 1609)</td></tr>
<tr><td>District Female Hospitals</td><td>53</td></tr>
<tr><td>Combined Hospitals</td><td>20</td><td rowspan="2">Sub Centres</td><td rowspan="2">20521
(In Govt. Bldg.- 8289)</td></tr>
<tr><td>Urban FW Bureau</td><td>5</td></tr>
<tr><td>Urban FW Centres</td><td>61</td><td rowspan="3">-</td><td rowspan="3">-</td></tr>
<tr><td>Health Posts</td><td>288</td></tr>
<tr><td>District Level PPCs</td><td>61</td></tr>
</table>

The public health infrastructure in UP falls substantially short of the IPHS population based norms. Some up gradation of district hospitals and CHCs, construction of district warehouses, supply of electricity and construction of replacement for HSC presently operating in rented buildings has been initiated in this fiscal year. With the current, limited availability of human resources, the CRM team suggests that additional infrastructure only be sanctioned after adequate staff positions have been sanctioned, appointed and trained to staff the health facilities.

2. Human Resource Planning

2.1 Availability of HR and Gap Analysis

During the field visit the team observed that with the availability of ASHAs in the field, the demand for especially RCH services has substantially increased primarily on account of the demand generation through JSY. At the village level there was general awareness of the

importance of immunization, ante natal care and institutional delivery. The HSCs visited were quite active with several facilities having women in different stages of delivery. While this is a very positive development, the current load of deliveries at the HSC prevents the ANM from leaving the HSC and carry out outreach activities such as immunization and VHNDs. This underlines the need for the 2nd AMNM and the Health Worker Male (HWM) at the HSC level.

The State had been using the 1991 population census figures at a population of 136 million when estimating their requirement for infrastructure and Human Resources. Since the 2009 estimated population is 196 million it is suggested this estimation be used when calculating the gaps and requirements.

The table below indicates that UP ranks substantially below the Indian average for availability of health staff per 10,000 population. Especially the ratio for nurses and ANMs is amongst the lowest in the country. The Health Directorate informed that they have taken up the matter of recruitment of nearly 4000 new doctors to the State Public Service Commission and requested them to process the same urgently. In addition they have requested for sanctioning of additional posts for nurses. The state has until now worked on a norm of 1 nurse/3 doctors. This has now been revised to 1 nurse/1 doctor. It should be noted that international norms are 4 nurses/1 doctor.

HR/10.000 population	Health HR	Doctors	Nurse & ANM
India	19.5	6.1	12.7
Highest	65	23	29
Uttar Pradesh	13	6	3
Lowest	10	3	3

Source: NHSRC 2009

The following table shows the shortfall of HR as per IPHS standards at PHC and HSC level in a sample district in UP.

PHC	Required No	Shortfall %
MO	408	79
AYUSH	136	82
Pharmacist	272	86
Staff Nurse	680	100
ANM	137	90
Lab Tech	272	96
SC		

ANM	1634	75
MHW	817	96

NHSRC 2009

The shortfall in availability of infrastructure in UP State, as per the 2001 Population Census norms is given below:

Infrastructure	Required	In position	Shortfall
Sub-centre	26,344	20,521	5,823
Primary Health Centre	4,390	3,690	700
Community Health Centre	1,097	515	582

Source: Bulletin on RHS-2008

Thus if one looks at the availability of various categories of manpower resources, based on the infrastructure in position, the following picture emerges:

HR Status - Based on Existing Infrastructure

Human Resources	Required	In position	Shortfall
ANM (SCs & PHCs)	24,211	21,024	3,187
SC - HW (Male)/ MPW(M)	20,521	2,097	18,424
PHC – HA (F)/LHV	3,690	3,509	181
PHC – HA (M)	3,690	4,294	-
PHC - Doctor at PHCs	3,690	2,001	1,689
CHC – Obs & Gynae	515	131	384
CHC – Physicians	515	186	329
CHC – Paediatricians	515	135	380
CHC – All Specialists	2,060	618	1,442
Radiographers	515	133	382
Pharmacist	4,205	1,954	2,251
Laboratory Technicians	4,205	1,085	3,120
Nurse/Midwife	7,295	3,340	3,955

2.2 Pre-service Training Capacity

As already mentioned, there is a requirement of a second ANM to meet the case load at the HSC level. Similarly, there are a large number of vacancies of MPW (Males). If one presumes, hypothetically, that all the 2nd ANMs and MPWs have been recruited and that they would also need to be trained, then considering the number of training institutions available in the State and their training capacity, the time required to train these additional recruits emerges as follows:

	Required	In position	Training Load (10% surplus)	Capacity (18 mths course)	Time required
HSCs	26,344	20,521			
ANMs (2 per HSC)	52,688	21,024	34,830	2,016	26 yrs
HW (M)	26,344	2,097	26,672	450	89 yrs

The above table and numbers clearly exhibits the inadequacy of the training capacity available and that the State needs to focus on increasing their training capacity.

2.3 Recruitment and Cadre Management

The state has developed a Personnel Information System which up till December 2008 had records (year of employment, specialist status, postings, courses undertaken etc.) for all doctors in the state and were in the process of entering similar information on paramedical staff. In addition two studies were undertaken on Incentives for Health service providers and Aspirations of MBBS and Nursing graduates. The initial outline of a Human Resource Reform Agenda has been prepared by a HR working group constituted in 2007. These documents should be reviewed as part of the HR review and taken forward for implementation.

2.3.1 Recommendations for HR augmentation - ANMs:

Based on the above, the CRM team recommends the following immediate measures for augmenting the number of **ANMs**:

- Contract ANMs from other states
- Purchase seats in ANM training schools from other states which have a surplus of training facilities. A possible language barrier may be resolved through arrangements for teaching in Hindi
- Increase the number of seats in existing ANM training schools and encourage the non-government sector to establish facilities for ANM training through PPP. The team understands that the state is currently in the process of contracting non government providers to manage district level hospitals. These providers could be requested/required to establish ANM and nurse training facilities connected to the health facilities they manage.

The following Medium Term actions are recommended:

- Sanction new ANM training schools and start training of the required numbers of tutors. The state should aim at having at least one ANM training school in every district. The District Hospitals could be used for imparting practical training to the ANMs.
- Encourage well performing ASHAs to apply for ANM training. Quite a number of ASHAs are graduates and ASHA experience could form part of the selection criteria. By encouraging qualified ASHAs to be trained as ANMs and placing them in their local area

they would demonstrate to future ASHAs and the community that ASHAs have career opportunities.

2.3.2 Recommendations for Augmenting other Human Resources:

- The IPHS norms and the current population increase in UP implies that the sanctioning of many more new posts (medical and paramedical) is required
- A major HR review, rationalization and reform is urgently required including plans for multi-skilling of doctors. This review should include all tiers i.e. specialists, general MOs, paramedical staff, ANMs and MHW
- A substantially increased number of MOs should be sent for multi-skilling
- Deploy AYUSH MOs in vacant positions. The team understands there may be issues of coordination between the Health and the AYUSH Directorates regarding provision of salaries, drugs and facilities for the AYUSH doctors. These issues could be resolved on priority so the AYUSH doctors who are available can be placed in vacant positions and serve the rural population.
- The number and capacity of nurse training schools should be increased - include PPP
- Arrange urgent refresher courses for ANMs to manage the increased workload (basic skills such as taking of BP, weight, testing urine for glucose and albumin and blood for HB etc. were found wanting) – this can be done through regular mentoring at the PHC/CHC monthly mtgs.
- Institutionalize Public Health Management and Health Facility Management training courses. Over the medium to long term public health managers at district and block level and facility managers at district hospitals and CHCs would free up doctors for clinical care – for which they have been trained and which they in most cases prefer over administrative work. These courses could be open to both doctors and other paramedical staff and could be offered in modules at both diploma and masters level. This would allow doctors interested in administration to be especially qualified for positions such as CMO and CMS.
- Strengthen regular technical supervision and monitoring; the newly established DPMU teams would be especially suited for this task.

3. Assessment of the case load being handled by the public system

The following table gives a good idea of how the health system is coping up with the increase in case load, especially with respect to the increase due to institutional deliveries/JSY.

Year	OPD Total (Average per Month)	Indoor Total (Average per Month)	Bed Occupancy
2005	325,007 (27,083)	2,146 (179)	19.2
2006	331,505 (27,625)	3,958 (330)	34.2
2007	384,350 (32,029)	10,922 (910)	52.5

2008	752,601 (62,716)	21,552 (1796)	73.6
2009 (Till Oct.)	534,528 (76,361)	14,124 (2017) (rise due to JSY; Post delivery stay to improve)	86.9

4. Preparedness of facilities for patient care services

The team visited the District Hospital (Female) in Allahabad. This facility received an ISO certification during 2008 and was a well managed and clean facility. The facility however has a shortage of staff (paediatrician and anaesthetist) and equipment (ultrasound) and does not receive the financial support required to maintain the ISO standard. Since most patients in this facility are women who deliver, recovery of user charges from patient fees is minimal. The team suggests that this certification experiences is used as a showcase to other DHs, CHCs and that the state considers provision of direct funding and/or special allocations to this and other ISO certified institutions of excellence to ensure that the quality is maintained.

The team observed that in most facilities visited, one or more requirements for providing FRU services would not be available. In fact no facility in Allahabad District fully complied with the FRU requirements. In addition it was found that there are issues of deployment of resources i.e. the ultrasound equipment and gynaecologist to be located in the same facility, X-ray and surgeon in the same facility, anaesthetist in facilities along with surgeons / gynaecologists etc.

While a number of facilities were visibly better managed and cleaner than seen during earlier visits by some of the team members, there is scope for improvement in areas like reducing garbage around the compound/facility premises, preventing entry of animals/dogs in the premises, improving the cleanliness of toilets and repair of running/leaky taps.

The state does not have an emergency transport system and ambulances seen were mostly used for transport of drugs and supplies. It was observed that patients generally used any available private means of transport. The lack of an emergency transport service also affects the length of stay for pregnant women who deliver. In the case of JSY deliveries, as women arranged for to and fro transport, they stayed at the facility for only a few hours to avoid paying twice for transport. In other cases, a few ASHAs were enterprising enough to organise transport in such a way that payment was made only after the return journey transport was provided.

5. Outreach activities of Sub-Centres

VHNDs were being conducted but emphasis was largely on immunization. The ASHA plays an important role in organizing the VHND and in coordinating with the Anganwadi Worker. The large number of deliveries at the HSC limits the availability of the ANM for VHND; it was also found that the ANM does very little preparation for IEC activities. The role of the VHSCs is limited and there is scope for improving orientation and sensitisation of the committee members.

6. Utilization of untied funds

It was observed that untied funds were available at most of the facilities and the funds were being utilised on various activities. In certain cases, a major share of the RKS funds was being used for POL for generators & ambulances. The untied funds were also being used for funding the Health Mela expenses and this is likely to deplete the RKS kitty.

7. Thrust in difficult areas and vulnerable social groups

The state PIP did not have any special plan or budget for reaching vulnerable or tribal groups. No such initiatives were seen in the districts visited. However, the widespread availability of ASHAs is likely to improve access for vulnerable groups.

8. Quality of service provided

Where staff and equipment is available, the services provided were of apparently good quality. Use of partograph for deliveries was not seen although the team found that such training had been given at the district. The 48 hour stay after delivery was seen only in the District Hospital. At the HSC and PHC level, adequate facilities for patients staying were not available. At the CHCs it was reported that women leave with their families after a few hours of delivery. At the District Hospital women do stay the required time. Cleanliness in the facilities has generally improved but is still an issue in some places. MTP service were not found to be provided in any facility visited. Waste Management (segregation and collection) was functioning at the district and some CHCs but at the PHC and HSC levels there were no signs of improved infection control or waste management. The team was informed that there were issues regarding payment of the providers for collection of waste. The State Government had earlier entered into a contract with seven private providers to collect the waste and manage its disposal under the UPHSDP. After the closure of the UPHSDP project in December 2008 the state sanctioned funds to ensure payment till April when this expense would be covered under the NRHM. In the field it was noticed that there was delay in paying the providers, possibly due to the late approval of the NRHM PIP this year. It is important that this be addressed and any arrears be paid so the waste disposal system continues uninterrupted.

9. Diagnostics

Most facilities visited were performing routine tests (Hb, TLC, DLC, BS, MP, and Urine) but some shortage of reagents was seen in Allahabad. X-ray facilities were available at some CHCs but radiographer/x-ray technician has to manage without radiologist support. In one facility visited in Allahabad the X-ray machine was not functioning. At HSC level the ANMs were not using/able to use the BP-machine and the weighing scales for women and children. Urine is also not tested as part of the standard ANC. In one CHC in a high incidence HIV/AIDS location patients were, as far as possible, tested for HIV before any surgery or delivery services was provided. User charges were prominently displayed and investigations were free for BPL families.

10. Logistics and supply chain management

The State had outsourced the procurement to UNOPS, State Corp. A part of the procurement was being done on the recommendations of CPC and HPC. No shortage of medicine was noticed anywhere in the field. The State may like to introduce BIN card system to monitor the flows and stock outs. The States may also adopt a need/request based supply of drugs rather than adopt a thumb-rule approach so as to avoid wastages.

11 & 12. Decentralized Planning and Decentralized local health action plan

Though Integrated District Health Action Plans (IDHAP) had been prepared for the last two years, the administrative and financial approval of activities conveyed to the Districts was normative from the State level. This led to a feeling of de-motivation amongst the district staff that had prepared the plans. The State has been requested and they have agreed to include the district requirements in the State PIPs for 2010-11 along with priorities so that Fund allocation can be based on local need and priorities identified by the District authorities.

It was noted that there is still limited capacity to plan at the lower levels and that local – village - health action plans were not found during field visits.

RKS accounts are being maintained and show limited user charges which are mainly collected from the OPD and laboratory tests. The Regional Diagnostic Centre (TB Sapru) Allahabad claimed a monthly income of Rs. 3 lakhs which was used for general maintenance of the facility (which was excellent), X-ray plates etc

To respond to the mandate for micro-level planning in the public sector health system, it is essential that suitably trained human resources are available at the district level and preferably at the CHC. The role of CHCs needs to be seen beyond that of an FRU to being an institution to provide the first level of preventive and promotive supervision for the PHCs and HSCs in its catchment area.

13. Community Processes under NRHM

The central place given by the NRHM to the community involvement process including decentralized planning is the major difference between the approach adopted by the NRHM and other programs launched earlier. This is to be facilitated by ASHA, VHSC, and RKS. In the State, the process has been initiated and ASHAs are in place, RKS are functional but needs to be strengthened by increasing community participation. NGOs/Civil society members were not present even at the district hospital level with membership mainly confined to medical officers. PRI representatives need to be further strengthened. The PRIs had little understanding of NRHM. A three day training course for PRIs and VHSCs had earlier been developed and field tested in four districts by the SIHFW. This course could be very useful on a state wide scale. The Lalitpur experience could also be reviewed for scale up.

14. ASHA

ASHAs are now highly visible, motivated and effective, their presence in the village has substantially increased the awareness of service availability at community level and they are creating demand for both RCH and NDCP services – especially institutional deliveries. ASHAs were found to be generally satisfied with their job and they were receiving their payments on time. Most reported that they had received two training courses – no refresher training was observed. ASHA mentoring groups have been established at the state level and district meetings were reported to have been held. This has yet to permeate down to the ASHA level. ASHAs were found to be less well equipped for carrying out BCC and IEC activities effectively.

The State Government informed that following a recent GOI order, ASHAs were no longer being paid anything under the ***"Saubhagyawati Scheme"*** of the State Government wherein private health providers were accredited for undertaking JSY institutional deliveries**.** Similarly, mothers were also no longer being provided JSY benefits if they delivered at the accredited facility**.** The team observed that the ASHA, having motivated the JSY beneficiary for an institutional delivery, would not be incentivized if the beneficiary opted to deliver at an accredited private Institution rather than a governmental institution. This issue needs to be revisited in light of the case load at these facilities and the load in a government facility in the same catchment area. This issue was debated at the state de-briefing and it was felt that a distinction needs to be made where no public facility is available (eg Allahabad where only the Medical College in the city fully complies with the FRU requirements) women should be allowed to deliver in certified non-governmental facilities and still receive the JSY – and the ASHA should receive her incentive for taking care that the woman delivers in a facility. Alternative packages which cover ANC and post delivery care could be developed and a distinction between the package provided to a non-governmental facility which is a fully qualified FRU and one which is not.

To ensure sustainability of the valuable services provided by ASHA the CRM team suggests the following:

- Urgently establish ASHA mentoring mechanisms at the lowest level
- Ensure regular refresher training courses for ASHAs
- Provide career path for well performing ASHAs, where they could be given preferential consideration for the ANM seats. One could also arrange special pre-ANM catch up courses for the ASHAs to gain the required school qualifications; after completion of their ANM training, they could preferably be deployed in their local area and plan for attrition and corresponding trainings

15. National Disease Control Programmes

While the National Disease Control Programs (NDCP) are still implemented vertically, the team observed greater synergies at the field level with NRHM/RCH in terms of sharing resources and that ASHAs are also involved with implementing NDCPs – which enhances their compensation. The team noted that some ASHAs were serving as DOTS providers and were aware of leprosy

symptoms. The need for analysis of data at the State and District level was evident. In the case of TB, the team had requested for the scatter-plot for TB case detection and cure rates but it could not be presented at the State/District level. The level of record keeping for NDCPs was good in most places visited in the field.

16. RCH II

Most issues regarding RCH services have been commented on above. To summarize:

- There has been a substantial increase in institutional delivery at all levels.
- The increase in deliveries at HSCs underlines the urgent need for second ANM across the state. The gains from the introduction of ASHAs may not be sustained if the recruitment and placement of 2nd ANM is not addressed urgently
- Women stay up to 24 hours post-delivery at district level only
- Limited availability of FRU services (mainly blood supply issues persisted)
- 24x7 facilities functional for normal deliveries but stay at facility for more than a few hours is still an issue
- The increase in demand for RCH services has underlined the need to address issues of
  - emergency transport,
  - mobile vans
  - help-line service – for both providers and users of services
- MTP services and Maternal Death Audits are not carried out at the facilities visited.

17. Preventive and promotive health aspects with special reference to intersectoral convergence with social determinants of health

Though NRHM is envisaged as an umbrella programme encompassing different Health programmes like RCH, Disease control, etc it misses out on a crucial component required i.e. health promotion. In the complete framework of implementation there is hardly any mention about the need for systematic health promotion efforts. It is recommended that a structured health promotion strategy to be put in place. It should include components like physical activities, nutrition etc. Just provisioning of village health & sanitation days which has become a routine didactic affair will not be sufficient. There is also need to relook at the ways Health Melas are being organized. They should not looked upon only as means to provide secondary care services but also seen as opportunity for educating people & promoting health

18. Nutrition

Malnutrition including Anaemia is still a major challenge in the State. In the visited field areas the focus of nutritional intervention is on initiation of early breast feeding and exclusive breast feeding for first six month. This intervention is carried out very effectively through ASHAs. Women have started breast feeding within first hour especially in cases of institutional deliveries. However feeding after six months, is not receiving much attention. ASHAs and even ANMs don't have much knowledge on this issue. Anaemia among women and children is still a major issue and in the field area not much effort are being made to address this issue. During ANC

pregnant women are given only prophylactic dose of IFA. There is need to improve nutritional education especially with regard to introduction of weaning food and introduction of solid/semi solid. There is also need for growth monitoring of children in most of the villages weighing machine was not available till one or two months back. In many villages weighing machine had been bought using VHSCs funds.

19. Non-governmental partnerships

In Kanpur District, a slums pilot project was in place in collaboration with HLFPPT termed voucher scheme. This scheme was working in 390 slums covering around 500,000 population. Since its inception in November, 2008, the scheme was able to provide services to 11876 ANC, 2843 Deliveries, 2694, PNC, 287 Sterilizations, 269 IUCD & 1741 RTI/STI Services. Under "Saubhagyawati Scheme" 9 private nursing homes identified for referral of complicated cases for safe delivery and till now 450 women benefited. Overall very little systematic involvement of NGOs at the district level was noticed. The MNGO scheme was not being implemented. There is need to increase the NGO involvement in the implementation. NGOs could be involved in PRI strengthening in a variety of ways, including: consciousness raising, provision of technical advice, support in participatory planning, capacity building and facilitating monitoring processes, such as community and social audits to improve accountability.

20. Overall programme management

The staffing of the State, Divisional and District Program Management Units is in place – a big step forward for the state. The next step is to develop clear HR policies for TA/DA, performance appraisal and increments to ensure that there is limited attrition. While some team have been well embraced by the district administration a number of district teams are yet to be fully integrated in district level activities and their skills used effectively. The SPMU and DPMU teams can be very helpful both in planning and in target setting vis-a vis gaps in achievements, identification of underperforming district or blocks and general monitoring and supervision. Following the full integration of the district teams, block level teams need to be constituted. There were certain issues relating to disallowance of part of the salary (HRA component) need to resolved urgently.

21. Financial Management

Significant improvement in the financial management systems was observed and some highlights are:

- Timely reporting – both FMRs and Audit Report. In fact, this year UP has submitted the audit report by August 2009 inviting least audit observations.
- Timely & electronic fund transfer from State to districts
- Proper record keeping up to District level
- All payments were made by cheque
- Improved utilization
- Concurrent audit systems in place
- SPMU and DPMU in place (in almost all districts)

- Regular monthly meetings being held by Finance Controller with all DAMs at the State HQrs. This has made tremendous difference in ensuring compliance of various financial and accounting guidelines. Further, this also acts as a forum where individual districts share their problems. Best practices, way outs and clarifications are also shared by the various districts.

Some issues and areas of concern are listed below:

At Block and Below:

- Reports not flowing from the Sub-centres to the Block CHCs. This is resulting in reduced expenditure reporting even though the funds have been spent. This needs to be streamlined according to the Finance and Accounts Manual which prescribes quarterly reporting of SoEs from the sub-centres to the Block CHCs.
- Multiple bank accounts were noticed at the Block level
- Reports prepared at Blocks and sent to District Hqrs are not being prepared from the books of accounts.
- Accounts not being prepared at block level although all vouchers stay there.
- Health Assistants are writing the registers and do not have any knowledge of finance and accounts guidelines.

  Recommendations:

  These anomalies exist as the accounts are being handled either by an LDC or a Health Assistant; and not by the finance and accounts personnel. It is necessary that the State depute the Block Level Accountants with the knowledge of Tally software in all the blocks.

Stagnant/Decreasing State Budget support at District and Sub-district level: On scrutiny of budget support through the treasury at Kanpur CMO office, it was noted that State budget has almost remained stagnant. Further, below the District Headquarter, there is almost no State budget support except for the salary of health personnel. Once in a while they receive a meager POL of Rs 10000/- in a year. The State needs to increase their allocations for the District and sub-district health establishments.

The State Government has issued instructions for conducting Health Melas every month @ Rs 20,000/- per Health Mela but has not provided for any budget support, rather, it has issued orders for incurring this expenditure from the RKS funds. Further, it was seen that a major portion of RKS funds are spent on the POL for generators or ambulances, leaving a very little amount for use of improving the health facility. It was also observed that there is negligible support for incurring expenditure on POL from the state budget at the sub-district level. Thus the expenditure of RKS funds for Health Mela and POL strains the RKS kitty and it is likely that most of RKS at sub-district level will be heading towards zero balance.

Recommendation:

Health Mela is a regular activity and it must be budgeted in the State PIP. RCH-II programme has a similar activity of RCH Camps @ Rs 20000/-. State must project this in its next PIP.

Need to open bank account at new PHCs and additional PHCs: RKS grant of Rs 25000/- for new APHC and Additional PHCs are kept at the Block CHC and operated from there only. As a result, MO in charge of new PHC or Additional PHC has to approach MO of Block CHC for incurring any expenditure out of its own RKS grant. This is because the Bank Account of new PHCs and Additional PHCs have not been opened yet.

Recommendations:

The State needs to expedite opening of Bank Accounts of new PHCs and Additional PHCs so that concerned MO in charge can directly operate the RKS grant without approaching any higher authority. This will not only be in accordance with delegation of financial power under NRHM but also minimize operational inconvenience.

Concurrent audit systems not being utilized effectively: It was noted that concurrent audit system, though exists, is not effectively being utilized. State has sent instructions for appointment of concurrent auditor @ 4000/- per month. But, concurrent auditor is just reproducing the outputs of District Accounts Manager.

Recommendation:

Concurrent auditors should provide feedback on internal controls and submit the report to CMO & State Hqrs on other areas as mentioned in their TOR. They must also cover at least one sub-district facility in a month and suggest measures so as to strengthen their accounting and reporting system.

State Budget Allocation for Kanpur Nagar District (in Lakhs)

	2005-06	**2006-07**	**2007-08**	**2008-09**
CMO office	27.37	39	32.87	32.87
Main Centres	201.5	162.47	174	161.67
PPC	17.53	23.6	21.07	17.56
Sub-centres	315.7	416.25	420.74	400.24
Health Posts	90.2	182.66	157.66	162.66
POL	2.71	1.35	5.12	5.12
MCH	18.59	93.74	189	189
TOTAL	**673.6**	**919.07**	**1000.46**	**969.12**

22. Data management

It was observed that the Data uploading on HMIS Portal from the District level is good, however, the status of FMRs uploading on the HMIS Portal needs to be improved. The State needs to put in place systems for regular checking and validation of data. Some suggestions are that the Block, District, State Review meetings be based on data reported on HMIS and that the SPMU/DPMU be encouraged to present analytical reports & key findings to concerned

DHS/CMO/BMO etc. The State also needs to hasten Block/facility level data capturing and train the manpower on the use of data –from HMIS, DLHS and other sources.

23. Status of the progress of the state against specific objectives, and expected outcomes at community level

The team was not briefed on any initiative on community level involvement or expected outcomes. IEC activities were negligible in the field.

24. Innovations

A number of interesting innovations were seen during the field visits:

- JSY cheque with NRHM logo and 3 messages at the back: Breastfeeding for 6 months; 6 immunizations; spacing of 3 years for 2nd child
- SMS being used by District Accounts Manager in Kanpur for sending the messages for fund transfer and its utilization to all levels below
- Clear area demarcation of houses in the villages for ASHA
- Booklet for payment of incentives to ASHAs under 19 heads

The State also mentioned that they are having video conferencing facilities for all the 71 Districts and is being regularly used to monitor the progress in the Health Sector.

25. Additional Meetings

The Members of the Team had occasion to meet the following officials of Government of U.P.:

1. Chief Secretary, Shri Atul Gupta
2. Principal Secretary to Chief Minister, Shri Shailesh Krishna
3. District Magistrate, Allahabad

During these meetings the key issues relating to the Health Sector including Human Resources, Capacity Building and IEC were discussed at length.

26. Recommendations

The recommendations against specific issues have been covered in the main report. However, the following bullets could summarise the key recommendations:

- Human Resources & Infrastructure
  - Considering the HR and infrastructure crunch, the State needs to evolve and adopt a bold & dynamic strategy with time lines
  - Establish a Help-line for health providers/public to increase awareness of health issues and on the key features of various programmes

  - As a short-term measure, identify Nodal Facilities at the District and Sub-District level and fully opertionalise them at the Block level. A Block Team could be deployed to ensure full functionality of these nodal facilities
  - Improve referral transport to increase reach to the identified nodal facility

- Fund flows to the Block and below levels need to be faster and this could be achieved by a better coordination between the Main Bank and Lead Bank at the District level

- The State needs to put in place a closer monitoring system to get a grip on critical numerators, especially for ANC, Immunization, Deliveries, FP, Deaths

- The level of IEC activities was quite low and needs to be improved. Some of the key messages that could be conveyed are
  - Raising age at marriage
  - Education of girl child – the State could consider incentivizing higher studies for the girl child.
  - Family Planning – small family norm

- The meetings of State Health Mission need to be more regular and frequent to address all health related issues. This will go a long way in expediting the approval of plans, ensure inter-sectoral convergence and also secure political support and leadership

27. Views of State Government

The findings of the CRM Team were well received by the State Government and the other issues raised by them are bulleted below:

- The State Government was of the view that the increase number of Pulse Polio rounds (upto 10 per year) is diverting the scare resources and there is a need to merge routine immunization with Pulse Polio so that there is better utilization of the available resources. The State Government intends to propose incentivising immunization coverage in the next year's PIP.
- The State Government would be keen to adopt the 2001 Census Population norms for rural health infrastructure.
- The State Government is restructuring their HR Policy for deployment of doctors and incentivising them by offering salaries and allowances as per GOI norms. The re-deployment policy will aim to link doctors to functionality of the Institutions. The State is also putting up a case to increase the number of Nurses.
- The State is keen to operationalise the MMUs to increase the reach and penetration of health services in the rural areas.
- They would take steps to improve the sensitisation of MOs and ANMs on NRHM interventions and involve MOs in clinical activities.
- The State is making available the stock and flow of drugs to the Districts on the internet.
- The State mentioned that there has been a low allocation of budget for the health sector primarily because of the depletion on account of implementing the 6th CPC recommendations.

28. Additional comments of Shri T.V. Antony, Adviser (Population Stabilization) in respect of reducing IMR, MMR and TFR

Shri T.V. Antony, had occasion to meet Shri Babu Singh Kushwaha, Hon'ble Minister for Family Welfare, Government of U.P. to discuss the health sector issues and ways and means of reducing IMR, MMR and TFR in the State. The key strategies suggested are bulleted below:

- Supportive statements by all politicians periodically on family planning issues.
- Involvement of departments such as Women and Child Welfare, Education, Panchayati Raj, Rural Development, Information, Transport, ICDS etc. to be under the overall coordination by Collectors/DMs. This will increase the number of canvassers.
- As IEC activities were totally missing, the back side of all public vehicles be used to display messages as was done in Tamil Nadu with cooperation of transport department.
- All text books to carry health messages on their backside. School dramas to enact the 18 (Age at marriage) and 2 (Child) concepts.
- Panchayat Presidents to oppose child marriage particularly in their own panchayats.
- IEC to cover all aspects of MCH including need for regular immunisation, ANC, institutional delivery, spacing, ideal weight of the child, nutrition, contraception/sterilization, the planned family and need for 10^{th} class literacy for all.
- All CHC's to be **women friendly.** Electricity, light, water and clean toilets on a 24/7 days to be emphasized.
- Clean delivery rooms. Insistence on the delivery patient staying for at least 24 hours, so that any complications for the mother and child can be identified.
- As in Tamil Nadu provision of 3 meals a day for all delivery cases, as is now the case in district hospitals. A Birth companion of the choice of the mother to be available to hold the patient's hand even in the delivery room. This is being done in Tamil Nadu and Maharashtra.
- These improvements could be tried out immediately at least at Block level CHCs. This will be smaller in number, instead of trying to attempt to all Rural Health Centres of the state.
- All Panchayats should have 10^{th} class school. This alone can ensure that the girl child remains in school till about age of 16 or 17. In turn this will mean that the marriage age goes up to about 18 or 19.
- Repair of staff accommodation to ensure that atleast one doctor, one paramedic and one lower level staff would be available at health centre by turns, even at night.
- Strong monitoring of rural health programmes by Collector's. They should be requested to visit at least 4 rural health institutions every month. This monitoring should continue at least for the next 5 years.
- Recognition of good districts by a prize system (as in Rajasthan) with marks for immunization, ANC, institution delivery and for contraception/sterilization. Prizes to be given to the best districts, Panchayat unions and Panchayats. Prizes could be handed over by Chief Minister.
- Monitoring at state level of health district's IMR, MMR and TFR. It is to be remembered that the final objective of the NRHM is to bring down IMR to 30/1000, MMR to 100/1,00,000, and of TFR to 2.1 **by 2012.**

- It would also be ideal if at the State level every month, there is a measurement of performance at the CHC/PHC, in terms of OP/doctor, average daily bed occupancy, institutional delivery (with stay of the patient for at least 24 hours), and contraception/sterilization.

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