NATIONAL RURAL HEALTH MISSION

4th Common Review Mission

Orissa

15th – 23rd December 2010

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MANDATE OF THE 4TH CRM

- To review changes in health system since launch of NRHM through field visits and spot examination of relevant records.
- To document evidence for validating key paradigms of NRHM.
- To identify key constraints limiting the architectural correction envisaged under NRHM.
- To recommend policy and implementation level adaptations to accelerate achievement of the goals of NRHM.

CRM TEAM COMPOSITION - ORISSA:

- Dr. Sajjan Singh Yadav,Director NRHM, Govt Of India.
- Dr. Pradeep Haldar, Assistant Commissioner, Immunizatin, Govt Of India.
- Dr. J. N. Sahay, Advisor Quality, National Health System resource Centre (NHSRC)
- Prof. Dr. M. Bhattacharya, HOD Public Health, National Institute of Health & Family Welfare (NIHFW)
- Dr. Shyama Nagarajan, Health Specialist, The World Bank.
- Dr.Sanjay Pandey Chief of Party, Population Foundation of India
- DeepakTechchandani, Financial Management Group, NRHM, GoI.
- Hena Chakrabarty, Planning & Policy Division,NRHM,GoI

FUNCTIONARIES MET BY CRM TEAM IN ORISSA

- Smt Anu Garg, Secretary & Commissioner Health, Orissa
- Dr. P K Meharda Mission Director,Orissa
- Mr. P K Hota,District Collector Nuapada,Orissa
- Dr. Nishakar Hota, CDOM, Gajapati,Orissa
- Dr. B B Jagat, CDMO, Nuapada,Orissa
- Other State Government Officers & District Health Functionaries.
- GKS members, PRI Members, Village Health Functionaries etc.

FACILITIES VISITED BY CRM TEAM:

Type of Facility	Availability status in Gajapati	No. of Facilities visited by CRM team	Availability status in Nuapada	No. of Facilities visited by CRM team
District Head Quarter Hospital	1	1	1	1
No. of Blocks	7	4	5	
No. of CHC	8	4	4	3
PHC (New)	20	4	15	4
PHC	0	0	2	1
Sub-centre	136	4	95	9
Others(MHU, Maternity Waiting Hall & PHC(N) in PPP mode)	9	2	8	0

Facilities Visited by CRM team in Gajapati districts

- DHH, Paralakhemundi
- CHC Kasinagar,Gurandi,Raygada,Chandragiri,
- PHC(N) Hadubhangi,Garabandha,Ramagiri,G Udaygiri,
- S.C. – Haripur, Narayanapur,Uppalada, Machamara,
- Other Facility - MHU Point, Didinguda, Maternity waiting Home R.Udayagiri

Facilities Visited by CRM team in Nuapada districts

- DHC Nuapada
- CHC Khariar Road,CHC Komna, UP PHC/ CHC Kharia,Up PHC/ CHC, Bhella, Up PHC/ CHC Boden
- PHC(N) Biromal, PHC(N) , Tarbod, PHC (N), Domjhar
- S.C. – Parkod, S.C. - Samarsing S.C. Tarbod, S.C Bhojpur, S.C. – Bhulia. Sikuan, S.C. Nagpada, S.C. Khudpet, S.C. Bhainsadani, S.C. Sorbong

Name of Districts visited - Gajapati				
	Name	District HQ	Name of Collector	Name of CDMO
1	Gajapati	Paralakhemundi	Prakash Ch.Das	Dr.Nishakar Hota

Health Facilities visited

Sl.no	Name of the Institution Visited	Name of the Block/ Institution	Name of the In charge of the Institution	Designation
1	DHH, Paralakhemundi	DHH, Paralakhemundi	Dr U.S Mishra	ADMO(Med)
2	CHC Kasinagar	Kasinagar Block	Dr R.R Mishra	MO I/C
3	CHC Gurandi	Gurandi Block	Dr V.Rajesh	MO I/C
4	CHC Rayagada	Rayagada Block	Dr Manoj Kumar Behera	MO I/C
5	CHC Chandragiri	Mohana Block	Dr P.K Gantayat	MO I/C
6	PHC(N) Hadubhangi	Kasinagar Block	Dr Sunil Kumar Gantayat	MO I/C
7	PHC(N) Garabandha	Gurandi Block	Dr Biraja Prasad Swain	MO I/C
8	PHC(N) Ramagiri	R.Udayagiri Block	Dr Prabhat Kumar Mishra	MO I/C
9	PHC(N) P.Govindpur	Mohana Block	Dr Nirupama Jena	Ayush MO
10	Haripur SC	Kasinagar Block	Smt Sanghamitra Mahapatro	HW(F)
11	Narayanapur SC	Rayagada Block	Smt Kanakalata Mallick	HW(F)
12	Randiba SC	R.Udayagiri Block	Smt Mohini Devi	HW(F)
13	Machamara SC	Gurandi Block	Smt B.Jagadamba	HW(F)
14	Uppalada SC	Gurandi Block	Smt Sanjukta Mishra	HW(F)
15	MHU Point, Didinguda	Kasinagar	Dr Sachikanta Mahapatro	MO I/C
16	Maternity waiting Home R.Udayagiri	R.Udayagiri	Suhasini Nayak	ANM, Project Cordinator

Name of Districts visited - Nuapada				
Sno	Name	District HQ	**Name of DM**	Name of CDMO
1	Nuapada	Nuapada	**Sri.Pradeep Kumar Hota**	Dr.B.B.Jagat
Health Facilities visited				
SL No.	**Name**	**Address / Location**	**Level (SC / PHC / CHC/ other)**	**Name of the Person in Charge**
1	CHC Khariar Road	At/Po-Khariar Road, Dist-Nuapada	CHC	Dr.S.P Sathapathy
2	CHC Komna	At/Po-Komna , Dist-Nuapada	CHC	Dr.H.S. Sahoo
3	UP PHC/ CHC Kharia	Kharia	CHC	Dr. Mishra
4	PHC(N) Biromal	At/P-Biromal,	PHC(N)	Dr.R. Fandey (Ayush)
5	PHC(N) , Tarbod	At-Po- Tarbod	PHC(N)	Dr. U. Meher
6	Up PHC/ CHC, Bhella	At-Po- Bhella	PHC	Dr. D. Ojha
7	PHC (N), Domjhar	At-Po- Domjhar	PHC(N)	Dr. U. Jena
8	Up PHC/ CHC Boden	Boden	PHC (N)	Dr. Ranjan Khujur
9	S.C. – Parkod	At-Po- parkod	S.C	Smt Lilavati
10	S.C. - Samarsing	At-Samarsing, Po-Lakhana	S.C	Smt Rinki Panda Smt Sailabala Ghosh
11	S.C. Tarbod	At-Po- Tarbod	S.C	Smt Kanaklata
12	S.C Bhojpur	At- Bhojpur, po-Khariar	S.C	Smt Murchana Raut
13	S.C. – Bhulia. Sikuan	At-Po- Bhulia Sikuan	S.C	Smt Subhadra Dalpati
14	S.C. Nagpada	At-Nagpada	S.C	Smt Subhagini Panda
15	S.C. Khudpet	At-Khaira	S.C	Smt Christina
16	S.C. Bhainsadani	At-Bhainsadani	S.C	
17	S.C. Sorbong	Nuapada	S.C.	Anupama Mohapatra
18	S.C.	Bhella	S.C.	
19	DHC Nuapada	Nuapada	DHC	Dr. Nayak

BACKGROUND

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. Orissa is the tenth largest state in India with an urbanisation rate of 14.97%.Prone to natural calamities; floods, droughts and droughts regularly devastate the state. Frequent occurrences of natural calamities also stand as a barrier to overall progress in 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%
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

- ST and SC population constitute 22.13% and 16.53% respectively. **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.
- 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.**

EXISTING HEALTH INFRASTRUCTURE IN ORISSA:

Type of Health Facility	Status
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	377
No. of Primary Health Centres (New)	1212

No. of First Referral Units(F.R.U)	96
No. of Rural Family Welfare Centers	314
No. of Urban Family Welfare Centers	10
No. of Sub-Centers	6688
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

MAJOR ACHIEVEMENTS UNDER NRHM :

- State MMR has decreased from 358 (**SRS, 2003)** to 303 (**SRS, 2008) - <u>55 point decline</u>**
- State IMR has decreased from 75 (**SRS, 2005)** to 69 (**SRS 2008**) **<u>- 6 point decline</u>**
- **Full immunization coverage has decreased from <u>62.4% (DLHS-3) to 59.5% (CES 2009)</u>**
- Prevalence Rate of Leprosy is 0.87, 19 districts sustaining elimination level
- State API for Malaria reduced from 10 to 8.8
- Institutional delivery rate of the state is 76% (**HMIS -2009-2010**)-against Reported & 46% against Estimated Delivery (HMIS-2009-10)
- **<u>19.59 lakh mothers</u>** have benefited under Janani Surakhya Yojana (JSY) (between 2006-2010)
- 421 Ambulances deployed all across the state for providing 2nd referral transport services

- 194 MHUs (target: 199) operationalised and catering to the need of inaccessible areas
- MHU – **Arogya+** a new initiatives in PPP mode for Naxal affected areas
- 286 Janani Express is engaged for promoting referral transport services.
- 22 PHC(N) of 13 districts are managed by the NGOs
- 40,526 (ASHAs) in place against total targeted 41,102 ASHAs.
- 44,929 GKS have been constituted in the State
- 32 ASHA Gruhas (DHH) made functional and 28 ASHA Gruhas made functional in FRUs
- **261, 24 X 7 facilities** operationalised in 30 districts
- Mamata Diwas(Village Health & Nutrition Day)- **3,94,565 sessions** held out of **4,34,and 300** planned (90% achieved).
- IMNCI (Integrated Management of Neonatal and Childhood Illnesses) implemented in 16 districts
- **1,62,477** Malnourished Children treated through Pustikar Diwas (During 2009-10) .
- 14 SNCU-II units operational in Mayurbhanj-4, Koraput2, Capital Hospital, Bhubaneswar-1, Kandhamal-1, Angul-1, Sonepur-1, Rayagada-1, Balasore-1, Sambalpur-1
- 234 New born corners established in 24 X 7 PHCs
- **141 YASHODAs are engaged** in 16 districts to support mothers during delivery.
- 5086 Medical and Paramedical personnel are trained on Skilled Birth Attendance.
- 58 MBBS Doctors are trained on Life saving Anesthetic skills (LSAS) and 27 MBBS Doctors trained on Emergency Obstetric Care (EmOC).
- All tribal residential Schools (1675) targeted for intensive school health programs through round the year interventions
- 1273 AYUSH Doctor, 17 Medical Officers, 760 Staff Nurses, 869 Addl. ANMs, 123 LTs are in position.

Crucial Indicators Health Indicators

INDICATOR	ORISSA			INDIA	
	Trend (*year & source*)	**Gajapati**	**Nuapada**	**Current status**	**NRHM (2012) goal**
Maternal Mortality Ratio (MMR)	303 (SRS 04-06)	188		254 (SRS 04-06)	<100
Infant Mortality Rate (IMR)	69 (SRS 2008)	21	62	53 (SRS 2008)	<30
Total Fertility Rate (TFR)	2.1 (SRS 2007)	2.1		2.7 (SRS 2007)	2.1

S. N.	Indicators (%)	Comparative Analysis of Health Indicators		
		Orissa	Gajapati	Nuapada
1	Improved Sources of Drinking Water	76.7	15.5	7.4
2	Have Access to Toilet facility	16.9	8.1	7.2
3	Any Modern method of contraception	37.8	30.1	31.1
4	Total unmet need	24.0	12.1	32.5
5	Mothers who had at least 3 Ante-Natal care visits during the last pregnancy	54.3	71.8	59.4
6	Institutional births	44.3	19.9	28.7
7	JSY Beneficiaries	31.9	50.72	
8	Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles)	62.4	42.9	57.4

9	Children breastfed within one hour of birth	63.7	69.1	49.8
10	Women heard of HIV/AIDS	47.4	16.3	6.0
11	Women heard of RTI/STI	14.4	7.4	1.6
***Source**: DLHS-3*				

MONITORABLE BASE LINE DATA FROM STATE HMIS

SN.	INDICATOR	2010-11			
		Baseline			
		(Apr-Nov 2010)			
		HF		State	
		Districts		TOTAL	
A	**Maternal Health**				
A.1	**Service Delivery**				
A.1.1	% Pregnant women registered for ANC in the quarter		89%		84%
A.1.2	% PW registered for ANC in the first trimester, in the quarter		30.80%		29.50%
A.1.3	Institutional deliveries (%) in the quarter (Expected)		55.50%		57.30%
	Against Reported Delivery		72.50%		81.60%
A.2	*Quality*				
A.2.1	% unreported deliveries in the quarter		23.50%		29.90%
A.2.2	% high risk pregnancies identified				
	(a) % women having hypertension		2.70%		2.60%
	(b) % women having low Hb level		15.40%		15%
A.2.3	% of Home Delivery by SBA (i.e. assisted by doctor/ nurse/ ANM)		24.60%		25.20%
A.2.4	C-sections performed (%)				
	(a) in Public facilities		4.09%		4.03%
	(b) in private accredited facilities		38%		36.80%

A.2.5	% of deliveries discharged after at least 48 hours of delivery (out of public institution deliveries)		63.50%		66%
A.2.6	% of still births		3.19%		2.69%
A.2.7	%age of maternal deaths audited		83%		80%
A.3	**Outputs**	**Current Year**	***Cumulative***	**Current Year**	***Cumulative***
A.3.1	% of 24x7 PHCs operationalised as per the GoI guidelines				
A.3.2	% of FRUs operationalised as per the GoI guidelines				
A.3.3	% of Level 1 MCH centres operationalised	110(50%)	350(78%)	223(53%)	623(76%)
A.3.4	% of Level 2 MCH centres operationalised	26(61%)	82(49%)	53 (35%)	261(73%)
A.3.5	% of Level 3 MCH centres operationalised	**9 (40%)**	43(82%)	20 (44%)	81(75%)
A.3.6	% ANMs/ LHVs/ SNs trained as SBA		33%		33.50%
A.3.5	% doctors trained as EmOC	3*	18(53%)	11(137%)	35(61%)
A.3.6	% doctors trained as LSAS	11*	24(42%)	24(66%)	83(71%)
A.4	**HR productivity**				
A.4.1	% of LSAS trained doctors giving spinal anaesthesia		24(75%)		52(83%)
A.4.2	Average no. of c-sections assisted by LSAS trained doctors		96		112
A.4.3	% of EmOC trained doctors conducting c-sections.		2(12%)		4(15%)
A.4.4	Average no. of c-sections performed by EmOC trained doctor		8		9

A.4.5	Average no. of deliveries performed by SBA trained SN/LHV/ANM/AYUSH Doctors		62		68
A.4.6	% of SBA trained ANMs conducting deliveries		31%		33%
A.5	**Facility utilization**				
A.5.1	% of FRUs conducting C-section		100%		100%
A.5.2	Average no. of c-sections per FRU		127		151
A.5.3	Average no. of MTPs performed in FRUs		68		105
A.5.4	Average no. of deliveries per 24x7 PHCs		421		443
A.5.5	Average no. of MTPs performed per 24x7 PHC		23		21
A.5.6	% of SC conducting at least 5 deliveries per month		85		140
B	**Child Health**				
B.1	*Service Delivery*				
B.1.1	Children 9-11 months age fully immunised (%)		78.90%		74%
B.1.2	% children breastfed within 1 hour of birth		60%		65%
B.1.3	% of low birth weight babies		19%		18%
B.2	**Quality**				
B.2.1	%age of women receiving PP check up to 48 hrs to 14 days		63%		66%
B.2.3	% drop out from BCG to measles		11.10%		11.10%
B.3	***Outputs***				
B.3.1	% of SNCUs operationalised	1 (17%)	8(53%)	1 (13%)	13(65%)
B.3.2	% of stabilisation units operationalised	4(12%)	17 (51%)	5 (9%)	25(33%)
B.3.3	% of new born baby care corners operationalised	215(29%)	248(34%)	371(27%)	454(33%)

B.3.4	% of personnel trained in IMNCI		43%		51%
B.3.5	% of personnel trained in F-IMNCI				19%
B.3.6	% of personnel trained in NSSK				14%
B.4	**Facility utilization**				
B.4.1	Average no. of children treated in SNCUs		1062		3759
B.4.2	Average no. of children treated in NBSUs				
C	**Family Planning**				
C.1	**Service Delivery**				
C.1.1	% of total sterilisation against ELA		26%		25%
C.1.2	% post partum sterilisation		4%		5%
C.1.3	% male sterilizations		5%		4%
C.1.4	% of IUD insertions against planned		40%		43%
C.1.5	% IUD retained for 6 months		39%		42%
C.1.6	% Sterilization acceptors with 2 children		NA		NA
C.1.7	% Sterilisation acceptors with 3 or more children		NA		NA
C.2	**Quality**				
C.2.1	% of complications following sterilisation		1.69%		1.54%
C.3	**Outputs**				
C.3.1	% doctors trained as minilap	15(50%)	119 (51%)	30 (33%)	234 (28%)
C.3.2	% doctors trained as NSV	13(68%)	34(55%)	19 (19%)	62(10%)
C.3.3	% doctors trained as laparoscopic sterilisation	14(45%)	16(30%)	30(50%)	52(22%)
C.3.4	% ANM/LHV/SN/MO trained in IUD insertion	94(49%)	146(32%)	192(53%)	459(7%)
C.4	**HR productivity**				

C.4.1	Average no. of NSVs conducted by trained doctors		21	19	
C.4.2	Average no. of minilap sterilisations conducted by minilap trained doctors		115	127	
C.4.3	Average no. of laparoscopic sterilisations conducted by lap sterilisation trained doctors		487	270	
C.4.4	Average no. of IUDs inserted by MO trained in IUD insertion		79	58	
C.4.5	Average no. of IUDs inserted by SN/ LHV/ ANM trained in IUD insertion		268	196	
C.5	**Facility utilisation**				
C.5.1	Average no. of sterilizations performed in FRUs		311	332	
C.5.2	Average no. of sterilizations performed in 24x7 PHCs		108	68	

PROGRESS AGAINST APPROVED PIP

Orissa has implemented the activities of National Rural Health Mission efficiently and effectively for attaining the goals and objectives of National Population Policy and Millennium Development Goals. NRHM has transformed public health service delivery in the State. The decentralization, responsiveness to local needs, paradigm shift in health system management and availability of untied funds has improved the facilities and their credibility among members of the public. The performance of JSY, community mobilization by ASHAs, proper referral transport, increased number of deliveries, OPDs and bed occupancy have significantly improved and a larger portion of community are getting benefit under Mission. Brief information on progress vis-a-vi issues have been highlighted which are as follows:

Status of Infrastructure:

Type of Facility	As per RHS 2008	New Construction	Up gradation / Renovation
Number of Sub Centre	6688	296	1529
Number of PHC	1279	0	428
Number of CHC	231	0	195
Number of DH	32	0	32

- ***No sanction granted to the State for construction of new facility for FY 2010-11.***
- ***Construction Approval provided during financial year 2008-09 for 3 major District Head Quarter Hospital viz. Malkangiri, Dhenkanal & Jharsugoda are yet to be started.***

Quality Assurance

Quality improvement systems has not yet been put in place though 3rd CRM has also recorded that the state "need to be put in place/strengthened".

The state has proposed to set up a District Technical Team(DTT)[1] for MCH status maintenance. This would also support to develop a framework and institutionalization of quality assurance in the State,. NHSRC would provide technical assistance in setting up of a well-built QA cell is yet to be functioning as per guidelines.

[1] Reference : MCH Centre Status document

Financial Progress:

- Till 2nd quarter, under RCH Flexi pool The state has reported expenditure of Rs. ly Rs. 72.62 crore out of Rs. 258.37 crore, which is merely **28.11%.**
- The State has reported expenditure of 49.03% under Maternal Health (other than JSY) is satisfactory.
- The state has incurred only 5.07 % & 18.45 % expenditure under the heads of Family Planning Services (Other than NSV Camps & Sterilization) and Compensation & NSV Camps. The State's performance under these activities is not satisfactory. However, the expenditure under the head JSY of 36.21% is on an average level.
- The State has reported expenditure less than 30% of the approved annual PIP under the heads Child Health, Urban RCH, Training, and Programme Management. The State should take necessary steps to improve utilization under these activities.
- The State has reported expenditure less than 10% of the approved annual PIP under the heads Family Planning Operations (other than Compensation money), Innovations/PPP/NGO, and Tribal RCH. The State should take necessary steps to improve the pace of utilization under these activities with effective planning and monitoring.
- **NIL** Expenditure is reported under the heads ARSH and Procurement. The reasons of the same may please be clarified.
- There is no provision under Vulnerable Groups though expenditure incurred.
- The state has reported expenditure of Rs. 296.48 crore, till 2nd quarter from Mission Flexi pool i.e. **only 19.84%.**
- Since the launch of the programme, out of the total release of Rs. 608.16 crore under Mission flexible pool, the state has incurred 74.68 % expenditure i.e. Rs. 454.15 crore.
- The State has reported good utilization under the activity of Corpus Grant to RKS/HMS.

OBSERVATIONS OF CRM TEAM:

1. INFRASTRUCTURE & FACILITY UPGRADATION

- The State has established a State level engineering department to handle the infrastructural backlogs of the PIPs. However, there is no established Infrastructure Development Wing to handle up-gradation and development of infrastructure in the State Health facilities as per the principles of hospitals planning and designing to support functionality of the department.
    a. The OT in CHC Nuapada and Komna has no zoning, the OT has hanging tube lights and ceiling fans and suspended table fans, instead of shadow-less lamp and a/c facility.
    b. Hand taps have been fixed instead of elbow taps for scrub area.
    c. The new construction does not confirm to the spacing norms of indoor beds, for e.g. in Komna.
    d. Emergency room in the DHC does not have triage services; none of the CHCs had a facility for dental service. The inpatient area located in the 1st floor of one of the CHCs, is connected only by stairs, there are no ramps or lift to ensure easy shifting of patients.
    e. Similarly, the ward, casualty and OTs are not zonally located close to each other. This makes it difficult for transporting patients during summers/ rainy seasons across departments for treatment/ investigation, especially in the absence of shades in the connecting passages.

- Up-gradation/new construction formed a part of planning process with appropriate prioritization, rationalization of HR plan to ensure availability of staff in remote areas, utilizing resources available from other sources with specific strategies for addressing the needs of difficult areas. For example, The state has developed system to stage wise scale-up the new PHCs and CHCs in the districts, from L1 (delivery by ANM), L2 (delivery by doctor-MBBS/Ayush), L3 (Facility of CEmonC with blood storage and anesthetist to support C-section). The SCs are converted as a twin room residential accommodation to ensure availability of ANMs round the clock in the SC.

    - ✓ The Nuapada district has trained educated people within the tribal community (Mr Sukhal Sai Paharia and Basudev Gadtia) of Boden, as HW (Male) so that they can provide health services to the community, which are otherwise inaccessible through roads. The drugs and consumables are ferried to such remote locations on pony backs from the PHCs, such as the one in Boden once in a week.

- The health infrastructure in the districts have been upgraded to great extent, new buildings constructed, some buildings are renovated to make up critical gaps. Though in some cases**:**
  - ✓ Handing over of facility is pending since long.
  - ✓ Handing over of facility is done without completing final work and facility map.
  - ✓ Health Facility constructed without any technical inputs from health functionaries of the district/block/village.
  - ✓ Pending Construction.

  a. At Gajapti district , Raygada CHC has been handed over without handing over any map of the facility, there is no link between OT & Ward / Labor room & O & G ward.
  b. No toilet is attached to Labour room. Also the entrance and path ways of new building has to be construed for any patient to drop in.
  c. There are no connecting pathways between IPD and OPD section.
  d. construction is suspended over 3 years in Domjhar PHCin Nuapada district, thereby effecting the completion schedule.

- State level engineering department, envisaged to handle the infrastructural backlogs but has not established Infrastructure Development Wing to handle facility infrastructure as per IPHS norm.

- Quality of overall maintenance of infrastructure has improved, but there is no system for preventive and corrective management in place to identify facilities that need urgent repair.

2. HUMAN RESOURCES PLANNING

The scope and focus of our review was to do a quick dipstick analysis of the Human Resource planning and Organization Development related systems and processes. It involved structured and detail discussion with key officials and a cross section of staff. HR findings constitute a broad sensing of the above organizations based on data collected from various sources. The data provides insights into the strengths and weaknesses in the structure and delivery of healthcare services in the state and points to a range of possibilities and priorities in human resource management.

Availability of Human Resources & Gap analysis:

Category of Health Personnel	Total	Sanction	Position	Gap (As per IPHS)
AYUSH Doctors	1943	1476	1269	207
Doctors	11764	4258	3499	8265
Staff Nurses	15295	4335	4234	11061
ANM	20912	9351	9087	11825
Pharmacist	2207	2049	2004	2485
Lab. Technicians	2428	1593	1351	3453
Radiographer	530	162	133	821
HW(Male)	9442	4663	3456	6246

It could be noted from the above chart that overall a huge vacancy exist about 70% under doctors category. Following is our specific observations in two districts viz Gajapati & Nuapada.

The shortage of doctors in Nuapada District is to the extent of 50%, nurses 30%, paramedics 15%. In many hospitals critical and key position are vacant, such as the radiologist, gynecologist, anesthetist and Ophthalmologist. While some positions are being filled by contractual staff, there is only 1 Ophthalmologist in entire district, that too in the private sector, which makes it difficult to ensure the provision of such services. Therefore, there is a need to address the shortage of skilled manpower with other alternatives, such as sourcing from other parts of the State.

a. In Gajapati vacancy in doctor and specialist cadre 29.58%, Paramedical 38.30%,Group C staff 45.05%,grade D – 46.71%

Keeping in mind the HR gap the state has following points to implement soon.

1. Increase the sanctioned strength of Staff Nurses by 6963 posts
2. Increase 158 posts of Pharmacists as they are readily available
3. Increase the sanctioned strength of Radiographers by 368 posts
4. MPHW(M) vacancies can be filled by qualified Pharmacists
5. Campus recruitment for Staff Nurse and other Paramedics from private and public schools in KBK and tribal sub plan areas to facilitate better placement
6. Integrating and Multi skilling of Lab Technicians
7. Execution of bond to serve for five years in Govt paramedical institutions
8. Proposed to allow tribal ANM schools in the line of tribal Kanyashram with free education and execution of bond for 5 years in deficient areas

- HR positioning under SPMU/DPMU relatively better. It has only 13% vacant position as on November 2010.It is noted in Gajapati district that the BEEs are not optimally utilized where as BADA is over loaded in many cases.

HR POSITION AT DIFFERENT PMU LEVEL UNDER NRHM ORISSA				
Level of PMU	**Composition**	**Sanctioned Strength**	**In position**	**Vacancy**
SPMU	HR Cell, GIS Cell, HDT, PPP, M & E Cell, HP Cell, Finance Cell, Community Process Cell, Training, IEC & BCC, etc.	136	94	42
DPMU	DPM. DAM, DHIO, DMCH, WC, DAC, HM, Accountant, O.A, PM at SDH, etc.	491	384	107
BPMU	BPO, BADA	628	612	16
TOTAL		1255	1090	165

b. In both the districts availability of ward attendant, cleaning and security staff is inadequate, which has been addressed to some extent by outsourcing. It is not be note that funding for outsourcing is a bottleneck, which is generally funded through RKS that has many other contingent activities to address.

c. It is observed that the service provided by the house keeping out sourcing agencies in Gajapati district hospital is merely inadequate.

Assessment of case load being handled by the system

There is an increasing trend in the utilization of the MCH services in the hospitals in terms of Institutional delivery and ANCs. However, the trend of facility utilization in terms of OPD and IPD for other services has been static. There is also a rising trend in the investigation of lab tests. This increase is precipitating the HR crunch in the relevant services.

Pre-service Training capacity

Existing numbers and intake capacity of GNM Schools in the State

Sl No	Category of Institution	Number presently Existing		Present Intake Capacity	
		Before	**After**	Before	**After**
1	GNM Training schools	3	3	200	200 + 100*
2	GNM (Pvt)	32	40	1170	1430
3	GNM (pvt sector) Rourkela & Talcher	2	2	60	60
	TOTAL	**37**	**45**	**1430**	**1690**

**Intake capacity increased 50 each in VSS & MKCG*

To meet the noticeable need of nursing staff across the districts the State has increased the student intake capacity in GNM School by 18% where as ANM School by 24%.

Existing numbers and intake capacity of ANM Schools

Sl No	Category of Institution	Number presently Existing		Present Intake Capacity	
		As on Jun 2010	**As on Oct 2010**	As on Jun 2010	**As on Oct 2010**
1	ANM (govt old)	16	16 + 2*	640	640
2	ANM (Pvt)	35	48 + 39**	965	1365
	TOTAL	**51**	**64**	**1605**	**2005**

**** Approved by GOI ** NOC given***

a. In Nuapada & Gajapati there are no ANMTCs, Nursing schools, Paramedical training schools, and MPW training schools to meet the State's needs. Only one ANM training school in the private sector.

Existing numbers and intake capacity of B.Sc Nursing

Sl No	Category of Institution	Number presently Existing		Present Intake Capacity	
		As on Jun 2010	**As on Oct 2010**	As on Jun 2010	**As on Oct 2010**
2	Nursing College (B.SC) - Govt	1	1	20	20
4	Nursing College (Pvt)	12	12	600	600
	TOTAL	**13**	**13**	**620**	**620**

Though the state has taken corrective action during the current financial year, to fill in the HR gap of Staff Nurse which is more than 72% ,the actual out flow of passed out SN will join the service by 2015.

While Intake of student capacity has been increased the faculty positions remained unchanged, which call for quality of education/training being provided to the student will surely be a cause of concern. Following chart shows the faculty position for the GNM School and ANMTCs:

	Institution	Requirement Additional Faculty	Remarks
GNM	MKCG Nursing School	22	All Posts to be Created
	VSS Nursing School	22	
	New – Nawrangpur	19	
	Total	**81**	
ANM	1 in each 16 centers	16	
	New – Boudh ANM TC	7	
	Sonepur ANM TC	8	
	Total	**31**	
B. Sc Nursing	College of Nursing (Clinical Instructor)	**12**	

Whilst, in-service training for the above cadres is available, the quality of training needs to instill better skill development, which is evidenced by the fact that hand washing and universal precaution is not practiced scrupulously.

Recruitment and Cadre Management

a. While, the State is making efforts to expand the HR base by creating new post and recruiting against various cadre posts through contractual staff, the gap between "needed" and "available" Medical Officers, Specialists, Frontline health functionaries and Contingency workers, is still huge owing to the rising case load.

b. Most of the contractual staff-- DPM and BPMU is in place, except an Ayush doctor, a hospital manager, and four staff nurses. is contractual

c. The recruiting procedure adopted by the State especially for doctors and nurses have been decentralized and RKS is empowered to recruit critical personnel, as and when the need arises. This model in working satisfactorily. The State has provided incentives for staff working in KBK districts, however it is not attracting suitably qualified staff, in absence of a long term assured career progression opportunities.

Plan for Augmentation of Health Human Resources

a. Short-term and long-term plans with regards to recruitments are in place; however skill enhancement through capacity building and training is in early stage of development.

b. Need assessment and training of staff in continuing in the state, which is visible in the increasing skill sets of the ASHAs and the ANMs.

c. Differential remuneration according to the working condition (difficult, high focus…) has been put in place. However, special incentives (monetary and non-monetary) to the HR in the difficult/ most difficult/ inaccessible areas is not attracting suitably skilled staff in the absence of special rotational posting policies or workforce management policies, such as the compulsory service bonds, pre-PG rural service mandates etc. in place.

Skill quality of Health Human Resources

a. Comprehensive training calendar is available and during our verification it was evidenced that the training is provided as per the schedule. No training institutions of the Medical, Para-medical and other staff at District level in the public sector.
b. Trainings of ANMs and Nurses for SBA, and Doctors for LSAS, CEMONC, EmOC, BEMONC, communicable diseases, IMNCI and general administration is on as per schedule.
c. Trained personnel were suitably posted to utilize their newly acquired skills

3. HEALTH CARE SERVICE DELIVERY – FACILITY BASED - QUANTITY AND QUALITY CARE

a. The State has been guided to re-christened all its facility as Level 1, Level 2, and Level 3 depending on the service package provided. Nuapada district has one DHC, 6 CHCs, 15 PHCs (New) and 96 SCs. The PHCs have been Quantitative details regarding number of patients treated (both outpatient and inpatient), institutional deliveries and other RCH services like safe abortion services, RTI/STI, emergency care arrangements, investigations and infrastructure especially in the context of functional First Referral Units (FRUs) and 24x7 Primary Health Centers (24x7 PHCs)family planning in facilities visited as well as surgeries happening have been appended. The BOR of the facilities vary from 15-40% in L1 and L2, whereas in DHC the average hospital the average occupancy 60%. CHC Khariya Rd: 16 bedded level 2 (BMonC-- blood storage unit and anesthetic) supporting normal deliveries of 12-15 per month in the hospital with mothers being retained in the hospital for more than 2 days.

b. There is no provision for adequate number of hospital beds for the admitted patients, and the patients were put on floors. This arises from the fact that there is no clear understanding on what constitutes "hospital beds". The hospital ends up confusing observation, emergency, neonatal cribs, ANC, PNC and 1st stage labour beds as "sanctioned hospital beds"; thus always falling short of its actual bed-complement and reports a very high bed occupancy rate. However, the general BOR in the hospitals ranged from 25%-60% across district, except during disasters and epidemics, during which the hospital is supposed to make alternative and make shift arrangements to accommodate temporary increase in BOR.

c. There is need to develop system for clinical care management. Standardized printed clinical case sheets or labour room registers, treatment registers,

immunization registers are not available in the hospitals, BHTs are not available on the bed side, date and time of examination along with chief complaints and key findings are rarely mentioned in the clinical case sheets. In some locations, nurses were writing the clinical records and treatment instead of the clinician.

d. The medical records were not maintained as per the legal requirements in all the sites visited. The records were dumped in the ILR rooms or other storage areas of the hospital.

e. The labs and imaging services don't have provision for quality assurance (internal and external) and compliance to critical regulations related to BMW, AERB guidelines, fire safety and safe practices among others. Infection control and asepsis in the laboratories, safety measures for the laboratory technicians in terms of usage of gloves, handling sharps with needles cutters, segregating BMW, disposal of liquid waste is not adequate. Similarly, the use TLD badges for assessment of radiation exposure for the safety of radiographers is not practiced.

f. While the hospital has a set of essential drugs, and STGs have been made available, rational use of drugs is not in practice. While it is important to write the diagnosis, it is equally necessary to write the chief complaints and key examination findings before prescribing to ensure continuity of care.

g. There is no structured system for calibration and maintenance system of old equipment, however, the new equipment is provided under regular AMC. Even for the equipment under AMC, an established system of successful operational trail is yet to emerge. The vaccine carriers are broken. Despite the notification to the hospitals on electrical load-shedding for the next twenty days, there was no back-up arrangement to maintain the ILR and DF. Lack of maintenance of Oxygen cylinders makes it difficult for the nurses to open the cylinders in the newborn corner.

h. There is a need to operationalise the condemnation policy in a systematic fashion to ensure better utilization of the available space.

i. Similarly, the hospital stores in not maintained on the principles of inventory and stores management to ensure effectiveness for drugs and consumables, ensure safety, optimize the shelf life of the items stored locally and avoid expiry of items.

j. A provision for Rs 20/- per day for dietary supplement of the patients needs to be reconsidered given the rising cost of quality F&B products.

k. Laundry, sanitation, security are outsourced but there is a clear lack of comprehensive specifications and a system to manage the contracts. Patient

care amenities are under the focus of the district authorities, however, the resources for the provision of cleanliness in toilets, common areas, canteen services, telecom assistance, signage, areas for attendants are grossly inadequate.

l. Janani express is available to provide referral transport assistance for pregnant mothers.

m. Infection control, sterilization of equipment and biomedical waste disposal is conspicuous by its absence.

n. Lack of convergence amongst the executing agencies is the reason for poor maintenance infrastructure, equipment, electricity, water, sewer, toilet facilities, gardens, vehicle etc.

o. Resources spent on MCH services, have resulted in improvement in ANC services, institutional deliveries and FP services. The ANCs registration has gone up from 86% in 04-05 to 99% in 09-10 and in the current year is already at 72%. Full immunization has gone up from 45% in 04-05 to 91% in 09-10 and in the current year is already at 64%. Institutional deliveries have gone up from 9% in 04-05 to 52% in 09-10 and in the current year are already at 64%. While micro birth plan and immunization is available in all the visited sites the use of partograph was not uniform, owing to arrival of the mothers in the late stages of labour. Some partograph use was witnessed for primis and 48 hrs of stay was not being adhered to in most centers.

p. While most of the sites had new born care corners and the staff was skilled to handle the newborns, warmers were not there in all centers. Also because of lack of equipment maintenance, it was difficult for open the oxygen cylinders. The efforts on MCH care has reflected in the MMR and IMR, which has gone down from 43 in 08-09 to 25 in the current year, 782 in 08-09 to 379 till date respectively. However, most of the MMR in the DHC was due to severe anemia, owing to non mobilization of blood and blood products and IMR is due to high incidence of ARI owing to lack of awareness and lack of access to services during migration to other cities.

q. Progressively increased emphasis is being given to display of service guarantee and allied information; such as signages. However, concern for privacy of patients, especially women is no adequate—unrestricted access to the labour room, lack of screens and curtains to cover the labour area, labour room right from across the road in some sub centres, OBG OPD in the passage of OPD in CHC are some commonly seen examples.

r. Grievance redressal systems are currently scantly available, functioning for ASHAs, but not for patients. There is a need to increase the awareness of

public as regards building their expectation from the various levels of healthcare facilities, so as to avoid demonstrations and disruption in services owing to mis-match between expectation and service delivery.

s. RKS meetings are conducted regularly and key functionaries from panchayats, civil society groups, and user groups participate in the same actively.

t. Untied Funds and RKS funds and maintenance grants being used to strengthen service delivery and quality of care in terms of provisioning of non-planned and emergency infrastructure and contractual services, supporting increase in utilization during epidemics by procurement of additional drugs and consumables, providing transport services and managing the utility back-up services (diesels for DG sets, increased in electricity consumption).

u. GKS in Nuapda is operationalised. While in Gajapati district Regular orientation of the block level staff (ANM, ASHA it is one of the weak link, Anganwadi worker, Ward members) undertaken. Funds are used for cleaning the drains in the villages, making a garbage pit for the general wastes of the village, providing nutritious food to the TB patients, funding the mothers for blood transfusion, referring mothers to higher centers for delivery, the maintenance of cycles for ASHAs.

v. System for maternal and infant death audits are being conducted at the local levels, however the issues and concerns underlying the cause of death are not minuted, which makes it difficult to undertake actionable solution.

4. OUTREACH SERVICES:

a. Sub-center Functioning: The ANMs are undertaking outreach activities, such as immunization, home based new born care, advice on diarrhea and ARI, maternal & child nutrition and Vitamin A prophylaxis, participates in VHNDs. They monitor their progress through micro-planning of VHNDs however; BCC activities have not yielded the desired results in terms of handling ARIs.

b. Most sub-centers have second ANMs and MPWs and their support to the outreach activities.

c. Seven units of Mobile Medical Units (2 in pipeline)–Arogya are functioning, staffed with one MO, pharmacist, ANM and attendant provides services in the remote location.

d. VHNDs are being conducted regularly as per the micro-plan and the laid down guidelines. The VHNDs are organized along with the day for carry home rations for the families to ensure greater attendance.

e. Most of the registers that are used by the ANMs/ ASHA/ AWW need to be standardized and printed, so that they have more time for actual health care services instead of spending time to maintaining more than 25-35 registers, such as the delivery register, treatment registers, immunization register etc.

5. ASHA PROGRAMME

The district Gajapati, has taken steps to get involved the ASHA - Village health link workers, in the promotive and preventive health activities, since the beginning of the NRHM implementation. 755 ASHAs are in position till October, 2010 & they have been providing services like interpersonal communication related to pregnancy, care during pregnancy, ANC check up, delivery planning, escort to the expected mothers for delivery in Institution, supporting Angan wadi workers and ANMs for ensuring the ANC, Immunization services. They play key role in the successful observation of the VHND & Pustikar Diwas for availability and utilization of better health and nutrition services. All ASHA workers have been trained up to the Module 5.

a. Vacant Position of ASHA:

102 ASHA has left the ASHA group due to selection in the AWW position, or as a ward member etc.. as reported by the district team. Now the district has to take initiative to fill up this position and get the newly recruited ASHA oriented and trained, as soon as possible. As the GKS has given certain kind of resources to the ASHA workers. These resources needs to be optimally and rationally utilized, like if bicycle, ASHA kits and other equipments or resource materials have been given to the ASHA workers then ASHA should return back theses resources to GKS, so that the same can be made available to the other newly recruited ASHA.

b. Branding of ASHA:

We observed excellent branding of ASHA - uniform, apron, ASHA drug kit, caps, identity card etc. This has enhanced their self esteem as well as they got distinct identity and recognition in their community and Health department. This has helped to get a high morale of ASHA workers.

c. ASHA Drug Kits:

Wherever we visited, we saw the drug kits were available with the ASHA workers. They are also using it to perform their duties.

d. VHND:

Village Health and Nutrition Days are conducted in the district on Tuesday or Friday. Routine Immunization is conducted once a month on a Wednesday. ASHA workers help in

organizing these days by calling the eligible beneficiaries to the site, on site management and assisting ANM or AWW. She also helps ANM in conducting the antenatal care during the VHND.

e. **JSY**:

District has observed a significant rise in the Institutional delivery in the last three years i.e. ASHA is playing key role in escorting the pregnant woman to the institutions - L1 or L2 or L3. District has 31 % institutional delivery in the year 2007-08, which has been increased to 48% in the year 2009-10 and 93% and 99.22% institutional deliveries were covered under the JSY for the respective year. (Source : Gajapati District HMIS report) . Year 2010-11 is also witnessing the same trend. The same were concurred during the field visit. ASHA are playing critical role in this direction. District has realized the same and has take up some measures to provide more support to the ASHA workers. ASHA Gruha - managed by ASHA workers (for their night stay and as a rest room) at two FRUs (i.e. at DHH & CHC Chandragiri) are made functional.

f. Incentive to ASHA:

It was observed that incentive to ASHA varies from Rs. 350 - Rs. 3500 per month (Min.-max), as told by 30 participants ASHA workers in the sector level meeting in the Kashinagar on December 18, 2010. Their suggestion was to further rationalize the incentive process. Incentivisation is playing a critical role in getting them engaged in the prescribed role.

6. RCH II (MATERNAL HEALTH, CHILD HEALTH AND FAMILY PLANNING ACTIVITIES)

- Name-based tracking of pregnant women and children being started done as per the national guidelines, though there is a huge quality gap in filling up the data in the tracking sheets.

- As the service provision has improved in the PHC, CHC, DHCs and the ASHAs are serving as a link for creating demand and making referral to the facility for MH, CH and FP services, the service utilization has increased. There is a need to include all SCs for provisioning of delivery services to cater to the rising demand to ensure institutional delivery.

- Payments of JSY are functioning well and the patients are receiving money in time. However, the scope for private partnership is low in the district because of lack of quality prospective partners.

Maternal Health

- VHND days are observed in the district on Tuesday and Friday. During these VHND sessions anti natal checkup, TT to pregnant mother, IFA tablet distribution, weight, counseling etc are provided. The ASHA are also carrying out the pregnancy test by using Nischay Kit. However, child delivery plan was not visible in such VHND.
- Prevalence of moderate anemia is about 80% and severe anemia is about 20%. IFA tablet is supplemented.
- Intuitional deliveries are increasing each year for the last 3 years; though 48 hours stay is not maintained. Especially in SHC's delivery where after delivery mother are discharged within 3-4 hours. Also in some PHC (New) where delivery are conducted, the facility does not have beds to insure hospital stay. We understand that there are socio cultural issues and limitation of the facility but district can take a lead in this direction. It was observed that the L-1 facilities are not only recording the partograph but also are enclosing the same in case of referral.
    - Total Delivery : 7556(Till Nov 30th 2010)
    - Institutional delivery :4435
    - Cesarean Section in district hospital : 653 (as on 18.12.10)
    - Institutional Delivery Escorted By ASHA : 56% of total institutional delivery)

Janani Express

In a novel attempt to encourage institutional delivery and make available transportation Round the clock for pregnant women, National Rural Health Mission, Health & Family Welfare Department, Government of Orissa has launched "Janani Express".

- Transport availability continues to be a challenge and availability of money in advance with mother is a decisive factor leading to delay in reaching facilities, in addition to behavioral issues relating to tribal customs and tradition.

- Janani express is a referral transport system working in PPP mode. In this system the private service provider has purchase vehicle and provides the vehicle along with driver for use to transfer pregnant mother on fixed rate per kilometer rental basis. The maintenance of the vehicle is also being provided by the private provider. In the Gajapati district the system is working fine through SHG members and maintaining

the Inter Sectoral Convergence. As on November 2010 JE has supported 1934 cases which is 81% of total delivery in the district.

Name of the Block	Total case load up to Nov 2010	Month wise case Load
Gumma Block	241	30
Kashinagar Block	258	32
Garabandha (Gosani block)	188	24
Rayagada Block	401	50
Nuagada/ B.K. Pada	203	26
R. Udayagiri Block	201	25
Chandragiri (Mohana Block)	246	31
Total	**1934**	**30**

Case study

On 19-12-10 morning the day of our visit, Ms Chanchala got admitted to Chandragiri CHC; due to some complication in delivery she was referred to Berhampur district hospital which is 85 KM. The patient went home to collect some essential articles and spend about 30 minutes before proceeding for Behrampur. When they have traveled about 10 KM toward Behrampur her condition deteriorated and the baby head started presenting. The JE driver informed MOIC Chnadragiri CHC about the same and the MOI/c asked the driver to immediately return back. On arrival to the PHC, 3 doctors waiting outside the hospital immediately shifted her and saved Ms Chancala and her baby boy despite huge blood loss.

Child Health

- Nutrition and child health remains a cause of worry in this district. While the nutritional support system is well established, it does not have adequate impact on the nutritional status. Despite close integration with ICDS, technical expertise is wanting.

AWW records the growth chart but does not understand the gravity of children moving up and down the nutrition ladder of Grade I, II, III nutrition level. There is no effort by AWW/ ICDS supervisor to see movement up the nutrition scale and focus monitoring on how many have moved up/ down or remained static. A greater oversight of **Growth Chart Records by ANM** during VH&ND days is needed, possibly followed up by a joint disclosure in the GKS monthly meeting attended by ICDS Supervisor and ANM.

- The major issues impacting on less than 5 morbidity and mortality in the district are Malnutrition, Neonatal survival, Malaria, Anaemia. M*alaria is the principal cause of morbidity and mortality in the district, also leading to high childhood anemia*. As informed by MD NRHM Orissa the NVBDCP resources are not adequate to saturate areas to eliminate malaria.

- Pustikar Diwas for children are observed. Children falling in grade 3 and grade 4 in nutrition chart are referred to higher facility though in the districts no NRC is functioning.
- Around 35% babies born in facilities visited weighed less than 2.5 kg. Under 5 children seen suffering from repeated attacks of ARI, repeated Malaria induced fever. Going really difficult for single mothers who are daily wage earners.

- Total Sanitation Campaign is not doing well in the district

Immunization

- All the cold chain equipment both electrical and non electrical are functioning at various level. The Deep freezer at the peripheral level is being used for preparation of ice pack used in the vaccine carrier and the ILR is being used for the vaccine storage. Temperature of the ILR and DF are being maintained as per recommendation. No condemn ILR/DF seen in the periphery. The entire antigen is available except DT which has already being phased out. On random checking of the stock of vaccine the same matches with the quantity in the store. No frozen vaccine seen. The vaccines are store in the ILR.

- It has been observed that all the sub health centers that has been visited are having the tracking bag but they are not being used to track defaulter and for full immunization.

This could possibly lead to false reporting of full immunization coverage in HIMS. The sub health centers are maintaining excellent graph for the left out (who has not received any vaccine) or drop out but the same are not put to used when such drop out/left out numbers are large. The RI micro plans are made as a routine and in practice for more than two decade. Even villages with injection load of less than 20 which forms the majority are visited every month thereby there is increase vaccine wastage, increase manpower requirement and increase RI funds for alternate vaccine delivery etc. The micro plans needs rationalized so that the community with less injection load is visited at a longer interval with the bottom line as once in every quarter.

- In one of the PHC (new) in PPP mode the vaccination was carried out in the aganwadi center and not in the PHC which is also in the same village.

Family Planning

- The programme remains centered around adoption of permanent methods, with very little adoption of spacing methods
- Female sterilization continues to be the dominant family planning method.
- That promotion of spacing methods would not only contribute towards reduction in TFR, reduction of MMR and IMR but also lead to achievement of quality reproductive life is a notion not advocated either with the provider or the people.

ARSH

- Establishment of Adolescent Friendly Health Clinics (AFHCs) at DHH Paralakhemundi & AH Chandragiri.
- Training on ARSH to all the MOs, ANMs, LHVs, SNs & AWWs in the above 2 institutions & 2 Blocks (In & around Blocks).
- Sensitization on ARSH to the personnels from Education Dept, ICDS Depts, PRI functionaries, MNGO/FNGO involved in Adolescent activities and other stake holders.
- Monthly educative sessions on adolescent health issues at AWC by ARSH trained AWW
- Referral of the adolescents from periphery to the AFHCs (also referrals under School Health Programme). 40 nos of SSD School have been covered under school Health Program Untied fund @ Rs. 10,000/- have been released to the schoo.MHU team visiting the school fortnightly.

7. NUTRITION

- A Nutritional Rehabilitation Centers (NRCs) is envisaged in the DHC in the next PIP to manage Grade 3- and 4 malnutrition. Currently ASHAs, AWCs and ANMs are providing nutritional support through AWC, VHNDs and home based counseling and maintaining appropriate records. *In Gajapati district Block wise Micro plan for VHND has been developed.* ***6706 VHNDs*** *were planned till November 30th 2010 but* ***76%*** *of such VHNDs held.* However, the efforts on adolescent girls to improve maternal health are yet to be operationalised emphatically.

8. NATIONAL DISEASE CONTROL PROGRAMMES (NDCP)

The programs under the NDC are the following; RNTCP, NLEP, IDSP, NVBDCP,

NPCB

The programs have been implemented as per the national guidelines and have been integrated under the NRHM frameworks and the funds are being managed by the district health societies.
Blindness control initiative in the district is largely limited to Cataract surgery. 1488 surgeries have been conducted under NPCB program in Gajapati district which is 82% of current years target.

Since FY 08 there has been a reduction in the SPR from 26% to 16%, the no. of deaths from 25-12 and API from 42-20 in the NVBDCP, but there has been no change in the falciparum cases since FY 08 and continues to hover around 42-45%. The ABER is adequate around 12-13%.

The program is constrained by the absence of statistician and epidemiologist and entomologist in the district to support the specific needs of the national programs.

There is 50% shortage of LT in the Nuapada district; however, the programs are managed by the available LT in the facility for preparing the smears from sputum area available at the CHC and the PHC level. This may be because of the fact that the workload per technician on an average is not more than 30-40 tests/day for any LT. Currently, the services are being managed with adequate cross support between different groups of technicians however, and rationalization of the manpower can be considered owing to the changing demand in the current situation. Going forward into the future growth the demand has to be appropriately estimated and manpower is to be deployed accordingly.

Electrically operated electron microscopes have replaced the conventional microscopes in most laboratories, which make early reporting and treatment of malaria difficult in the district, given the long hours of load-shedding and lack of adequate power back-ups.

RNCTP

As per the records the case detection rate is more than 70% and the cure rate is >85% as per the objectives of the program. ASHAs support DOTs provision. However, she should be supervised that the drugs she provides to the patients is administered as per norms—consumed in front of ASHA. No shortage of drugs. Default rate is 1.7%. The LTs have not received the revised salary despite the approval of the same by CTD, 1-1.5yrs back.

NPCB

There is only one eye surgeon in the entire district and serves in the private sector, so the cataract surgeries are not being conducted in the public hospitals. However, the district authorities support the NGO initiative of camps for the same. There is an ophthalmic assistant available to help in the screening program for identifying refractive errors in the School children as part of the school health program. In spite of the constraints FY 09-10 witnessed 85% cataract surgeries.

NVBDCP

Efforts to control malaria are on, however, since the API is still around 20 there is a need to sustain and further strengthen the efforts. Community participation should be encouraged. Efforts like Nidhi Ratha Abhiyam, Moo Masari should be scaled-up and followed to assess the impact. ASHA are supporting the program efforts through providing testing services by RDK and providing treatment for the positive cases. They are also supporting as FTDs.

NLEP

Leprosy is still a problem at prevalence of 1.8 per 10, 000 population and the ANCDR is increased to 19.2 10, 000 population owing to increased efforts for detecting new cases, with high prevalence in children at 8.9, and deformity of 5.3 and MB at 48.5. There are only some blocks that are endemic for NLEP, like the Nuapada Block. Funds and drugs are available adequately at all levels. ANMs are trained to detect and report, but the efforts needs to be sustained and strengthened.

IDSP

Cases are being reported by ANMs on a weekly basis. S, L, P forms are being maintained as per guidelines. The district health authorities are aware of the issues related to IDSP, however, efforts are needed for improving networking of labs to ensure early detection and management of cases other than malaria and enteric fever and early detection of outbreaks. No value addition to the data generated in terms of its analysis, data triangulation and planning on next steps.

NIDDCP

Awareness campaigns are being held and iodized salt is available in the market.

- District of Gajapati is malaria as well as diahorrhea prone. These cases are handling by ASHA and MPW(M) for case detection in the peripheral level.
- Gajapati is a bordering district to Andhra Pradesh and it has been observed frequent cross referral movement. Though referral document is seen from AP but vice versa is not observed.
- Record at Raygada CHC depicts that Death due to TB in Cat I-1, Cat –II-1 and Cat-III-1 happened during current financial year. This needs attention of district authority

9. INSTITUTIONAL MECHANISMS AND PROGRAMME MANAGEMENT

Gaon Kalyan Samity:

Gaon Kalyan Samiti (GKS) were formed under the communitisation process of NRHM. This aims at enhanced community participation in planning, implementation and monitoring of the health and allied activities at village level. This also helps in building the awareness on maternal health services, child health services, family planning services, safe & healthy sanitary practices etc. amongst the village community. As per the achievements of the district it has already formed 1386 GKS in 1512 revenue villages. Out of 1386 formed GKS bank accounts have been opened in the 1323 GKS and fund has been transferred to them. (District report dated : December 17, 2010 for 4th CRM). Although the formation and functioning of the GKS's at the village level have been given due thrust under the NRHM programme by the District, but still certain push has to be given for their active meaningful engagement in the commoditization process.

i. Regular monthly meetings are held with good participation and minutes maintained and circulated at the State Health Mission (SHM) and District Health Mission (DHM) as required.

ii. The extent of utilization through Rogi Kalyan Samiti is improved but variable. The expenditures are backed by formal decision with due consent from the PRI members.

iii. The PRI participation varies from notional (only attends meetings) to considerable (supports up gradation of facility and service delivery).

iv. The District and Block Programme Management Units are in place and provide commendable support to the decision making at relevant levels with relevant information from the field through regular HMIS. The data received from the peripheral areas are fed to the district after due validation at the block level. It is further analysed at the district level to support planning and decision making. For instance the figures of immunization are checked and verified with the live birth data.

v. While the drugs and linen reach the district as per the plan of the district resulting in optimal utilization, the equipment is generally getting added to the system with or without a demand for the same because of lack of coordination between the various departments/agencies involved in program management. For instance while the DHC already has 2 Deep Freezers in the Blood Bank, out to which one is generally not in use because of fluctuating voltage in power supply; NACO has supplied two new such machines.

vi. Drug store not stocked and maintained, as per the principles of inventory management on the racks, resulting in stock outs.

vii. The supportive supervision activities of the PMU, needs to be strengthened for its capacity to supervise and assist the field workers on a regular basis.

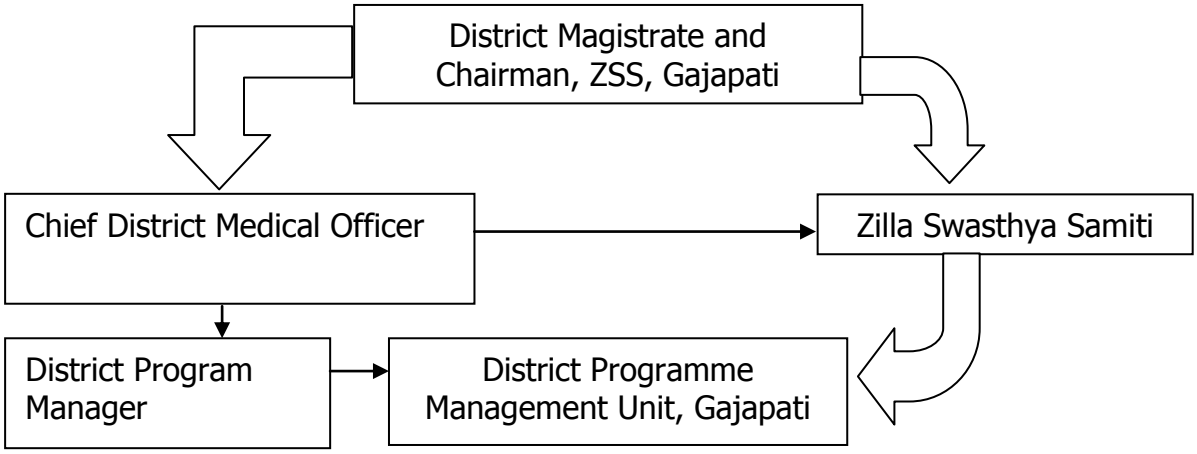
viii. System for accreditation of private hospitals for JSY, MH and FP services has been established.

ix. The completeness of data quality facilitates decision making at district level but data triangulation from different sources are not undertaken, to ensure authenticity of data. Also, the infrastructure and software systems has to be further strengthened to provide better connectivity of inter and intranet.

x. However, there is a need to standardize and rationalize the records being maintained by the ANMs, ASHAs and AWCs in a printed format to ensure that there is more free time to the workers for direct health and nutrition related interventions.

Zila swasthya Samity :

Zila Swasthy Samity (ZSS) under the chairmanship of the District Magistrate is functional and active. Its structure is as follow:



Also helps to get the determinants of health developed the convergent actions by way of effective convergence. It also identifies challenges and develops effective strategies to address them. Many innovations are promoted and managed by the ZSS. ZSS has also worked well in mobilizing resources through convergence like NBC equipment from the RSBY fund.

Rogi Kalyan Samity :

In Gajpati district 28 RKS are functional (8- at CHC, 19-at PHC and one at District levels). They are instrumental in taking initiatives in the management and good up-keeping of the facilities and its environment. RKS are functional and taking interest to perform its assigned responsibilities at the district and sub district levels. Rogi Kalyan Samity's Governing Body and Executive body are meeting regularly (as per our observation in two blocks of Gajpati). They mostly decide about the procurement issues, rate fixation of the services and renovation plans etc..It is good to observe that RKS has provided water filters, inverter and other useful services to each facility.

10. FINANCIAL MANAGEMENT

Following are the major observations during the visit of Gajapati District, Orissa:

Human Resources

State is having Joint Director – Finance on Deputation. Position of SAM & MIS officer is vacant. Earlier SFM position was vacant since January, 2009, now SAM has been promoted to SFM position and SAM position has become vacant. All four post of Audit Cell (two requested from C&AG & two other to be posted on contract) approved in PIP of 2010-11 are also vacant. Out of 30 one position of District Accounts Manager is vacant; State has placed one person from NIPI on temporary basis there. Out of 314 Block Accountant cum Data Assistants (BADA) 305 are in place.

In few places Accountants are handling some additional functions since long time and are quiet overloaded with the work, this should be avoided as this is affecting their performance in the role for which they have been appointed.

Funds Flow System

State Bank of India (SBI) is the lead bank in Orissa. State is using SBI for transfer of funds from Sate to Districts. Funds are transferred to all the Districts electronically. Out of 314 Blocks in 290 blocks funds are transferred through e-transfer. Currently State is not getting any MIS from the bank. Sate is aware of the benefits of e-banking and has shown interest in working with SBI for MIS generation.

Although the funds are transferred through e-transfer but time lag was found between the funds received by Districts from State & further funds transferred to Blocks. Funds under Mission Flexible Pool were transferred from State to Districts on 8th July, 2010 but the funds under the same head were transferred to District Hospital-Gajapati on 30th September, 2010 and credited to account on 13th October, 2010. As per District the time lag was because of finalization of sub district levels PIP on the basis of approved PIP of District.

Maintenance of Books of Accounts/Records & Submission of reports

Proper books of accounts were maintained at District and sub District levels. Even Sub Centre and Gaon Kalyan Samiti (GKS) is maintaining cash book. The records were updated and were properly kept.

Statement of expenditure is submitted by Blocks to District on monthly basis and further consolidated expenditure is submitted by District to State.

Accounting Software

State has decided to implement open source web based accounting software in place of Tally ERP 9. Procurement process of the open source software is at the stage of completion. As per State, most likely it will be implemented in January, 2011

Utilization of Funds

Funds are transferred from State to District as a lump sum amount under different pools and on similar lines District transfer funds to Blocks. District/ Blocks utilize this money on the basis of approved PIP. In few activities funds utilization was more than the approved PIP of 2010-11, District provided the reason that these funds were utilized in the first quarter when the PIP was not approved.

It was been observed that the utilization of funds under the activity of Untied Fund – Sub Centre & GKS (VHSC) is very low. In Gajapati District the utilization of untied fund – GKS till November, 2010 is almost 14% of the available funds; this is the situation when the funds for the current year (2010-11) have not been transferred yet. Similarly utilization under the activity of untied fund – sub centre was also found low. In year 2008-09 & 2009-10 equipments were purchased from District level for sub centre and CUG connection was provided by State to ANMs for sub centre activities which contributed to the major portion of expenditure happened in District under this activity.

Capacity building and sensitization of ANMs/AWWs/Ward members is required to improve the expenditure under the activity of Untied Fund – Sub Centre & GKS.

Diversion of funds

District is showing negative balance of Rs. 6.75 lakhs under the head of Immunization as on 24th November, 2010 which shows that the fund has been diverted from other Pool (RCH/MFP) to RI to perform the activities of RI.

Statutory/Concurrent Audit & Internal Controls

Although Statutory Audit for the year 2009-10 is complete but the audit report was not available with the District.

Concurrent audit is in place in 28 District out of 30 as per information provided. As far as Gajapati District is concerned, in current year concurrent auditor has done the audit in two phases, one for the period April to June, 2010 & second for the period July to October, 2010. The report for both the phases has been submitted by the auditor in December, 2010. While going through the report it was observed that auditor has not given any quality inputs or no suggestions has been given by auditor to strengthen the internal control system. The report was yet to be analyzed by the District. As per the information provided by the District, a copy of the report is also provided to State by the auditor.

Internal control system needs to be strengthened. As per policy of State, few signed cheques (without putting names) in which the amount of Rs. 1000/- & Rs. 1400/- would be filled will be kept by the Senior staff nurse/ANMs so that the JSY payment to the beneficiary could be made even in odd hours if required, but in few facilities blank signed cheques (no amount filled) were found which expose the facility or State to a high risk. Strong monitoring is required to see that the policies framed by the State for the benefit of beneficiaries should be strictly followed as framed by the State.

Disease Control Programmes (NDCPs)

At District level there are separate Accountants for maintaining the books of accounts of disease control programmes. AT block level Block Accountant cum Data Assistant (BADA) only maintains cash book for NDCPs also. NDCPs at District level send the monthly expenditure statement to District Accounts Manager (DAM) for compilation and further DAM send the consolidated FMR (including NDCPs) to State.

Delegation of Financial and Administrative Powers

Financial & Administrative powers are properly delegated to perform the responsibilities effectively.

Monitoring & Evaluation System

State needs to strengthen the system of monitoring & evaluation. Although policies are laid down by the State to implement the accounting processes effectively but monitoring is not happening from State / District level to evaluate whether the policies are strictly followed or not at lower level.

Reconciliation of Unspent Balances

There should be a periodical reconciliation between State – District & District – Blocks for the unspent balances lying at each level. This will help the State to ensure that the releases done from higher to lower level and expenditure reported from lower to higher level are booked in books of accounts of each level properly.

Others

- Regular trainings should happen at State & District level for the capacity building of finance personnel at each level.

- Currently State is not uploading the FMR data in HMIS, this needs immediate attention.

- District – Gajapati is having unspent balance under EAG scheme, this should be refunded to GOI on urgent basis.
- District was keeping a track of unspent balances under untied funds given to CHC, PHC, HSC & VHSCs but periodical reconciliation should also be done for unspent balances lying at each level.
- District was using interest amount for some activities where the budget is not sufficient but this should be avoided as interest fund can only be utilized for approved activities only.
- District is filing the TDS return on half yearly basis where as it should be quarterly, it is a statutory requirement and it should be strictly complied with.
- Payments are made to ASHAs on 10th of every month through e-transfer
- Bank reconciliation is prepared in most of the facilities on monthly basis
- District Account Managers are doing the expenditure vs budget analysis regularly.
- State should organize some sessions where DAMs/Accountants could share their good practices.

11. DECENTRALIZED LOCAL HEALTH ACTION

NRHM has one of the major components of the decentralization and delegation of the authorities down the line up to the front line staff - ANM. The institutional mechanism of the decentralization is ZSS, BSS and GKS. In the district these functional institutions exist. GKS needs to be more involved; Village Health Plan can be a good tool to get the GKS actively involved and develop the ownership for the village community. Active involvement of the PRI members will be key to the success of the decentralization process. The resources like untied fund are made available for the best. Although plans are prepared the process involved can be elaborated. VHSC at village level are relatively weak and their capacity to develop and implement village plans needs to be strengthened. At the state level forming an advisory group on community action involving the component of planning. This will help to improve the community processes for improved health this will help to improve the community processes for improved health and link it with the state for adequate support mechanism.

Decentralized planning must involve capacity building of local NGOs, government officers and PRI members so that realistic plans can be prepared. Agencies working in respective districts can be given responsibility to them in order to facilitate the planning process and actualize government to do the planning.

District plans are being made to support planning, and strategize Up-gradation, with appropriate prioritization, rationalization of HR plan to ensure availability of resources in remote areas, improve accessible. However, there is no system at the state levels to ensure timely approval on all the plans. For instance the OT in DHC is virtually dysfunctional and the district plans for the same is yet to be looked into at the state level.

To confirm if the Village Health and Sanitation Committees (VHSC) for all villages are formed and their joint accounts are in place and whether the funds are being received by them timely. The funds are used for referral of mothers, cleaning drains etc.; however, there is a need for guidelines to ensure better utilization of funds.
Community Monitoring is in place, review is held at the ASHA sector meetings and at the higher levels to ensure better management of the services. **Capacity of GKS members is cause of concern in Gajapati though they are comparatively better in Nuapada.**

Other Activities:

RSBY

Currently RSBY has been implemented in 6 districts in Orissa in the 1st Phase. These Districts are Kalahandi, Nuapada, Debgarh, Jharsuguda, Nayagarh and Puri. 422629 families have enrolled where as 3889 families submitted their claims and Rs. 5,244,989.00/- has been settled till Sept 2010.

IEC

IEC has become of the strong point of NRHM Orissa. Messages displayed all over the State for bringing its population into institutional folds. Distribution of LLIN- ,Moomoshari Scheme, Hand Washing activity, Healthy Hospital seems a way head. The State needs to look into the utilisation of such excellent IEC materials at GKS and village level for local people to reap out of it.

Public Private Partnership

Public-Private Partnership (PPP) has emerged as one of the important strategies for health sector reforms in Orissa. Initiatives have been taken to meet the growing needs for health services including RCH-II and other national health programmes like Malaria, TB etc. The existing NGO Cell of the department has been revamped and strengthened to function as NGO-P3 Cell under NRHM, Orissa. Further to augment

the PPP initiatives, a Regional Resource Centre (RRC) has been established to provide technical support for PPP – NGO activities in the State. Orissa PPP policy in Health Sector has also been drafted besides guidelines on PPP in PHC management, PPP in Urban Health, and PPP in Malaria Control etc. Some of the on-going PPP arrangements are:

1. Contracting out Primary Health Centre (N).
2. Capacity Building of ASHA involving – MNGO / FNGO.
3. Urban Health Centres for slum population.
4. PPP in Malaria Control.
5. Janani Express.
6. Accreditation of Private NGO Hospitals for Institutional Delivery.
7. Outsourcing cleaning and security services at Health Institutions
8. Maternity Waiting Hall

BOTTLENECKS

• Difficult areas due to hilly terrain and Naxalite disturbances.

• Average population density varies density 84(Khandamal) – 236(Ganjam)

• Lack of interest in health by the PRIs

• Shortage of staff including specialists

• Tracking Bag not used for Full Immunization

• No Quality Assurance Cell in the State or District

• Weak Supply Chain Management of drugs

• Lack of comprehensive and sustainable plan for procurement of equipments

OVER ALL RECOMMENDATIONS

a. Development of state level hospital infrastructure development cell
b. To improve the service quality at public health facilities a State level nodal group for QUALITY should be formed, duly supported by a similar group at district level to do the mentoring and monitoring of services quality with respect to laid down standards i.e.IPHS,RCH service at different levels.

c. Develop crew of well trained alternate physicians and nurse doctors to manage un complicated cases and improving referrals.
d. Developing the health infrastructure however in fulfilling critical human resource gaps esp. in Nursing, anesthetists, lab technicians
e. Health human resource expansion to be need based. Career path to be well defined
f. Strengthen supportive supervision structure—standardize and systematize service delivery and reporting mechanisms.
g. Training of trainers to ensure better M& E and hand-holding at the field level
h. New initiatives to be evaluated and assimilated into the system for sustainability
i. GKS efforts to have strongly mentored to reap better fruit out of .

Recommendations in specific to ASHA Program:

After analyzing the overall performance aspects of ASHAs, following recommendations are being made:

- ✓ Encouraging peer learning process amongst the ASHAs during the sector meeting. This can be facilitated by good performer ANMs.
- ✓ Enhanced use of communication and job aid materials by ASHA workers.
- ✓ Rationalization of the incentive process for ASHA workers
- ✓ Exit policy for ASHA workers with the GKS, so that resources are optimally utilized.
- ✓ Regular replenishment of the ASHA drug kit and better monitoring of the drug kit supplies.
- ✓ Intra District and inter block exposure visit of ASHA workers.
- ✓ District level recognition of the better performing ASHA workers in the District ASHA sammelan or similar platforms.

Recommendations in specific to Decentalisation:

- ✓ GKS involvement in preparing the annual Village health, nutrition and sanitation plan by using the social map and other participatory tools (these tools are available with the ASHA, AWWs or ANMs)
- ✓ Sensitization & training of the GKS members on their active roles and responsibilities of GKS.
- ✓ Sensitization of PRI members (ward members) on GKS.
- ✓ Social audit by GKS members at the village level particularly on the issues related VHND, Pushtikar diwas, etc.
- ✓ Regular meeting of the GKS

- ✓ The district may need to sensitise the RKS members about their expected roles and responsibilities, so that they can take more interest in the functioning of the RKS as per the local need and challenges.
- ✓ RKS needs to have more interfaces with the District level functionaries for better planning, implementation, monitoring and capacity building of the Institution - RKS.
- ✓ Opportunities should be created by RKS to get the PRI members more involved and engaged in the activities of RKS. District may think to organise a workshop for the orientation and sensitisation of the PRI members at district, block and Gram Panchayat levels.