



National Rural Health Mission

Key findings

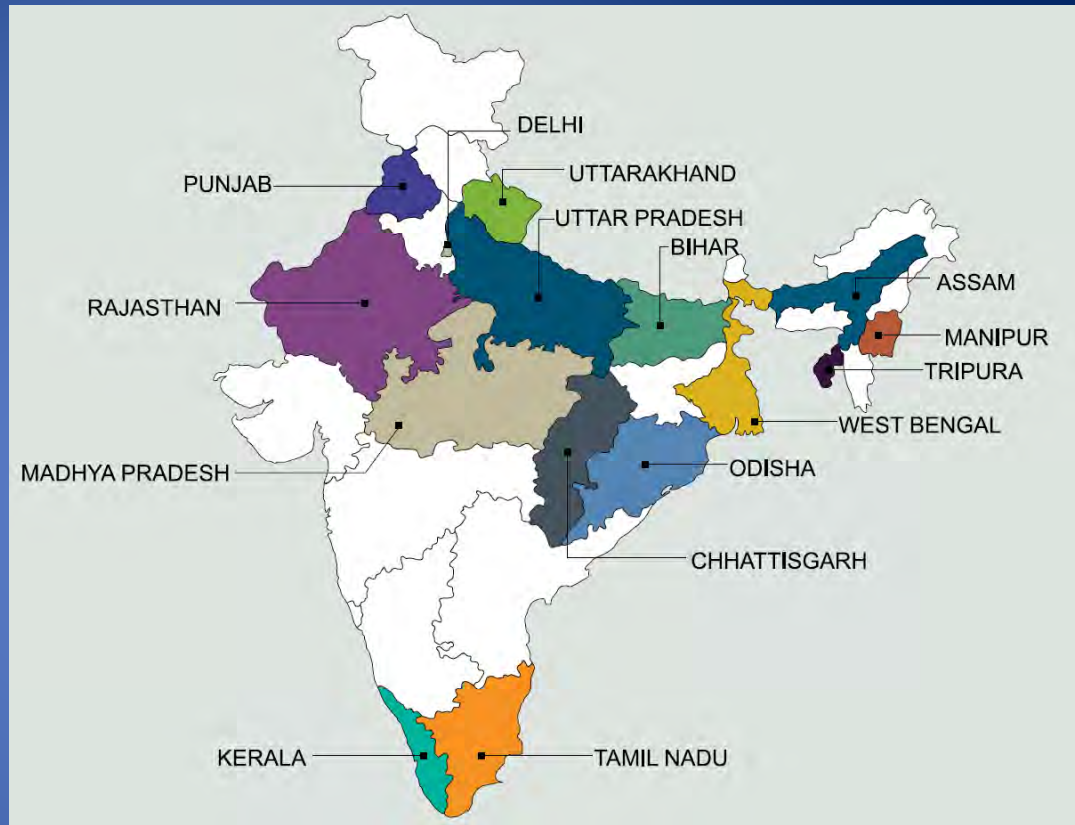
6th COMMON REVIEW MISSION

CRM visit

□ November 2nd - 9th, 2012

□ 15 states visited-
Seven High Focus,
Three North Eastern and
Five Non High focus States

□ 171 Team Members
including Government
officials, Public health
experts, civil society
representatives,
Development partners,
MoHFW consultants



Themes - 10x10 matrix of process & output elements

- I. Progress in Improving Facility based Curative services- Access, Equity, Affordability, Quality.
- II. Progress in increasing Coverage of Outreach Services- Sub-centres, Mobile Medical Units
- III. Human Resources for Health-Adequacy in Numbers, Skills and Performance
- IV. Reproductive and Child Health Programme
- V. Disease Control Programme-Communicable and Non Communicable Diseases

Themes - 10x10 matrix of process & output elements

- VI. Strengthening Community Processes- the role of community organisations- PRIs, VHSNCs, NGOs and Community Health Workers – ASHAs.
- VII. Action on Social Determinants and Equity concerns and Promotive Health Care
- VIII. Programme Management: Institutional capacity for professional and participatory management
- IX. Knowledge Management: Training and Technical Assistance Institutions and Partnerships.
- X. Financial Management-especially Absorption, Fund flows, Accounting.

I. PROGRESS IN IMPROVING FACILITY BASED CURATIVE SERVICES

Key Findings

- ❖ Increasing trend in public facility utilisation – (Source – HMIS)
 - OPD utilization – up 46% from 2009- high in TN, Kerala and Delhi. Very low in UP, MP and Chhattisgarh (0.65 visit per capita nationally as against 5.1 in Sri Lanka).
 - Utilization of IPD services- up by 86% since 2009- high in TN, Kerala, Odisha and Delhi (33/1000 as against 280 per 1000 population in Sri Lanka)
- Further, not uniform across states and districts and these figures mean high Out Of Pocket (OOP) expenses.
- ❖ <1/5th of facilities cater to the increased case load at district levels and higher, leading to overcrowding in those facilities. Also, reflects lack of access in many areas.

Key Findings

- ❖ Package of health care services now includes wider range of communicable and NCDs in **non high focus states, but largely RCH services in EAG states**
- ❖ Some successful PPPs models across states include – dial 108 ERS, outsourcing of maintenance services and Bio-Waste Management, Accreditation of small nursing homes in backward areas for JSY also has reasonable outcomes.
- ❖ Interrupted supplies of drugs- a problem in all states except Tamil Nadu, Kerala, Delhi and Rajasthan.

Key Findings

- ❖ JSSK helped foster the perception of health care as an entitlement in the public system. But Still High OOP - Assam, Tripura, Manipur, Delhi, UP, MP, UK, Chhattisgarh and Punjab.
- ❖ Infection control is a problem in all states except Tamil Nadu and needs immediate solutions for infrastructure design, infection control practices, sterile supplies and specific technical monitoring.
- ❖ Lack of privacy for women patients continues as a concern in many states.

Recommendations

- District Health Action Plan (DHAP) must be strengthened as the road map for achieving NRHM goal in the 12th Plan period of Universal Health Care.
- DHAP must clearly specify service package to be delivered by each facility within a time period and specify public facilities where emergency services would be made available - to match the growing presence of Dial 108 ERS.

Recommendations

- New facilities should be proposed where access to existing facilities is sub-optimal due to geographic considerations. In the remaining contexts, more bed and HRH may be added to existing facilities.
- Display of information on entitlements and services must be ensured at strategic locations and responsive grievance redressal system to be put in place in every facility.
- Quality Assurance, facility wise performance audit and supportive supervision must be taken as a priority.

II. PROGRESS IN INCREASING COVERAGE OF OUTREACH SERVICES- SUB-CENTRES, MOBILE MEDICAL UNITS

Key Findings

- ❖ Adequacy of SHCs – In Six states (Assam, MP, Odisha, Punjab, UP and West Bengal), SHCs cater to a much larger population.
- ❖ ANM Availability - At least one ANM per SHC is present in Assam, Kerala, Tamil Nadu, Manipur and West Bengal; whereas MP, Punjab, Rajasthan, Uttarakhand have only a few vacancies. Assam also has Rural Health Practitioner (RHP) at SHCs.
- ❖ Immunization - SHC and VHND provide adequate immunization services in most states , Functionality of the cold chain has improved across states.

Key Findings

- ❖ However, Counselling, health education and promotive health care is usually not a part of the services provided during VHNDs.
- ❖ Quality of ANC in terms of Hb estimation, BP measurement, abdominal examination, urine albumin is unsatisfactory. Gaps in skills of ANMs also noticed. Privacy for examination of women during VHNDs is a problem.
- ❖ Use of MCTS & line listing of severely anaemic pregnant women poor.

Recommendations

- ❖ Policy move is required for adequately staffed SHC to act as the 'first port of call' into health care system.
- ❖ Based on local context state should decide, whether the SHC would be –
 - ✓ a site of institutional delivery,
 - ✓ have a mid- level care provider,
 - ✓ have one or both female workers playing a role in disease control,
- ❖ Institute Standard treatment guidelines and the training programmes for SHC cadre to be based on the service package and redefined roles including that for NCDs.
- ❖ Package of services to be delivered by the MMU and its role needs to be defined depending on the context and performance regularly assessed.

III. HUMAN RESOURCES FOR HEALTH - ADEQUACY IN NUMBERS, SKILLS AND PERFORMANCE

Key Findings

- ❖ Service provider vacancies (MBBS MO, AYUSH MO staff nurses, ANMs and paramedics) have reduced due to innovative HRH strategies.
- ❖ Various incentive schemes for HRH introduced in Orissa, U.P, Bihar, Assam, Chhattisgarh, Kerala and Punjab.
- ❖ Performance appraisal for contractual employees on annual basis initiated in Bihar, Chhattisgarh, Kerala.
- ❖ Online HRMIS in place in Orissa, Tamil Nadu, Assam and Bihar

Key Findings

- ❖ Specialist vacancies still remains a critical issue in all states.
- ❖ Performance monitoring of regular/ contractual HR poor
- ❖ Despite high demand of AYUSH services, they are yet to be properly mainstreamed. Lack of AYUSH IEC, AYUSH pharmacists & irregular supply of AYUSH medicines were reported as common reasons.
- ❖ Lack of parity in remuneration between contractual and regular staff resulted in attrition in Punjab, Uttar Pradesh, Madhya Pradesh and Manipur.
- ❖ Fragmentation of training on skills for service providers (SBA, NSSK, IMNCI etc.) is a problem.

Recommendations

- Need to develop a comprehensive human resource policy which specifies a clear plan of action for meeting public health workforce requirements and ensuring performance.
- Establish and strengthen the HRH cell for all contractual staff
- Service Rules, particularly in relation to specialists, need to be aligned to HR need- IPHS norms could form the basis. Facility Wise positions of gynaecologists, anaesthetists, paediatricians, surgeons, medicine etc should be created which could be filled up by them only either through regular or contractual employees.

Recommendations

- More seats for government doctors in medical colleges in those disciplines where greater shortage of specialists exists.
- Utilise the flexibility available in contractual payments to make higher/differential payments for hard and remote areas and for specialists that are in short supply.
- Basic plus performance based payments to encourage performance- ensures regular performance monitoring and alignment of incentives to performance- build a culture of accountability to outcomes- use opportunity to improve regular systems and regular cadre
- HRH database on web portal linked to facility HMIS to facilitate rational deployment

Recommendations

- Ensure quality in recruitment through rigorous selection e.g. Competency assessment based recruitment of Nurses, paramedics & ANMs and attractive remuneration
- State should establish/ improve the standardization of performance appraisal systems with built in mechanisms for performance measurement.
- To address knowledge and skill gaps amongst all categories of clinical service providers (Medical officers, AYUSH MOs, Rural Medical assistants, nurses and paramedics), states should institute Standard Treatment Guidelines (STG) and base assessment of training needs, training plans and performance on the STGs.

IV. REPRODUCTIVE AND CHILD HEALTH PROGRAMME

Key Findings

- ❖ Total number of FRUs increased from 955 to 2536 after launch of NRHM. However, still well below WHO benchmark.
- ❖ 24 X 7 facilities grew seven fold. However, more than half the PHCs are not 24 X 7.
- ❖ Mapping of delivery points and segregation into L 1, 2 and 3 facilities is complete in all states.
- ❖ SBA trained personnel
 - ❖ posted adequate- Rajasthan, MP, Bihar, West Bengal, Orissa and Assam
 - ❖ *Not adequate- Uttrakhand, UP, Tripura, Delhi and Chhattisgarh.*

Key Findings

- ❖ Publicly financed emergency response and patient transport systems are functional in all states except Tripura and Manipur .
- ❖ Substantial increases on HBNC noticed in most states except Delhi. Facility based newborn care is yet to start in Chhattisgarh while Tamil Nadu, MP, Assam and Orissa are among the best performers (SNCUs) .
- ❖ In all high focus states, EmONC or fixed day FP services and even MTPs below the DH level still remains a challenge.
- ❖ Uneven case loads across facilities with normative allocation of human and financial resources is one of the key problems.

Recommendations

- Linkages with technical partners to build the capacity to quickly roll out SNCU/NBSUs, and strengthening the referral link between home based and facility based newborn care are the need of the hour.
- Quality of clinical care in RCH areas must remain a priority. Immediate action needed on three dimensions: better training to carefully prioritized service providers, better logistics to ensure uninterrupted drug supplies, and good quality supportive supervision.
- Complementarity between the 108, the 102 and the local tie-ups would be key to ensuring assured referral transport and efficiency of its provision.
- Sensitizing service providers to the concept of health care entitlements is essential.

V. DISEASE CONTROL PROGRAMME

Key Findings

- ❖ Horizontal integration of disease control programmes has improved at district and state levels, and peripheral workers and community levels. But Integration at the level of data management and use, is weak.
- ❖ Distribution of Long Lasting Insecticide Treated Bed Nets (LLIN) and the Indoor Residual Spray (IRS) programme is good in Odisha, West Bengal and Chhattisgarh with a decrease in positive cases and deaths.

Key Findings

- ❖ Case detection and treatment for TB improved in Chattisgarh, Tripura, Assam, Delhi, Madhya Pradesh, Rajasthan and Odisha
- ❖ Close coordination of NPCB with school health programmes was observed in Delhi, Odisha, MP, UP, WB and Tripura
- ❖ Punjab, Tamilnadu, Kerala and Odisha have instituted programmes for NCD. In Jorhat (Assam)- the pilot project on National Programme for Prevention and Control of Diabetes, Cancer and Stroke (NPCDCS), all sub-centers maintain relevant records.

Key Findings

- ❖ The Disease Surveillance Units (DSUs) under IDSP are not optimally operational at several places, particularly remote areas mainly due to vacancies, high turnover, and lack of training and support for contractual epidemiologists.
- ❖ Timely supply of antimalarials and RDK to ASHA, MPW and ANM and locale specific intensive operations in areas with very high API are essential to reduce malaria deaths.
- ❖ Programmatic Management of Drug Resistant TB cases (PMDT) has been implemented only in Odisha and UP

Recommendations

- The IDSP programme needs re-orientation to emphasize immediate and appropriate district and facility level public health response to disease outbreaks and use of IDSP information for local planning.

VI. STRENGTHENING COMMUNITY PROCESSES

Key Findings

- ❖ ASHAs have consistently been described as “vibrant” and “enthusiastic”.
- ❖ Home visits as per HBNC guidelines have started in Assam, Chhattisgarh, Orissa, MP, Punjab, Manipur, Tripura and Uttarakhand.
- ❖ Best Practices –
 - Odisha is a best practice example on payment,
 - Bihar on development of training sites,
 - Assam and Chhattisgarh on welfare measures, and
 - Bihar and Chhattisgarh on basic education up-gradation.
- ❖ Active VHSNCs were reported from Chhattisgarh, Orissa, Uttar Pradesh, Punjab, Kerala, Tamil Nadu and Tripura.
- ❖ Mechanisms of payment, drug logistics, supportive supervision and performance assessment remain a challenge.

Recommendations

- ASHAs and ASHA facilitators should be sensitized to ensure reach to the most marginalised and vulnerable.
- Improve training quality – by accrediting training sites and trainers. ensuring availability of books, equipment and communication kits during training
- National Guideline and best practice compendium for VHSNC - as a minimum package in training VHSNCs is required .
- ASHA should be supported to play a leadership and capacity building role for the VHSNCs and work in close coordination with PRIs.
- For implementing and scaling up community based monitoring across states and districts, additional technical capacity of NGOs is essential
- Creating career opportunities for ASHAs is essential at this stage – which can be achieved through certification and supporting participation in literacy, equivalency and nurse education programmes.

VII. ACTION ON SOCIAL DETERMINANTS

Key Findings

- ❖ Support for water and sanitation activities through ASHA and VHSNCs correlates with strong VHSNCs, as seen in Orissa, Chhattisgarh and Tamil Nadu
- ❖ Innovations like - ASHA Sahyogini of Rajasthan, software bridge between MCTS and AWW in Assam, and interdepartmental overlap for training in Tripura.
- ❖ Operational NRCs at district and block levels present in Assam, Bihar, Chhattisgarh, Orissa, MP, Rajasthan and UP - correlating with systematic referral of cases at the community level in these states.
- ❖ Increased awareness on girl child protection has led to a reduction in reports of mobile ultra-sound machines across states.

Key Findings

- ❖ Extensive coverage of school health programme seen in Tamil Nadu, Orissa, Chhattisgarh, Punjab, Delhi and Kerala.
- ❖ Delhi and Tamil Nadu have an effective birth and death registration systems.

Recommendation:

- ❖ Need to integrating information systems and tracking the respective contribution of convergent partners e.g. MCTS could be used for civil birth registration and for monitoring nutrition status child-wise and delivery of WCD services to target group
- ❖ Provision of birth certificates within 24 hours of birth to be viewed as an entitlement and a measure of quality to build system for universal civil registration at birth.

VIII. PROGRAMME MANAGEMENT

Key Findings

- ❖ Program Management Unit (PMU) is managed by multidisciplinary professionals in all states except Tamil Nadu and Kerala - where medical doctors with public health qualifications are posted as DPMs.
- ❖ Many states have made progress in reforming procurement policies but logistics remain poor.
- ❖ High attrition rates and vacancies of contractual staff in UP, MP, Rajasthan, Uttarakhand and Chhattisgarh are noted due to lower salaries and lack of career progression.

Recommendations

- ❖ Building Institutional Capacity for decentralised Planning and Programme Implementation remains the key.
- ❖ Establishment of a procurement and logistics system benchmarked to TNMSC
- ❖ A regular schedule of supportive supervisory visits by directorate and program management staff using checklists and follow up action plans
- ❖ An HR policy for programme management staff which includes periodic capacity building efforts needs to be established.

IX. KNOWLEDGE MANAGEMENT

Key Findings

- ❖ State level training institutes – SIHFW or equivalent are in place in all states visited except Delhi and Manipur, Tripura is in the process of establishing an SIHFW.
- ❖ SHSRCs are in place in Chhattisgarh, Odisha, Rajasthan, Uttarakhand, Punjab and Kerala; and have been approved this year for Tamil Nadu and Uttar Pradesh. RRC-NE provides technical support to all NE states.
- ❖ All states except Assam and Odisha have inadequate human resources in SIHFW
- ❖ States have developed a wide variety of local decision support data analytics, such as for human resources in Bihar, Assam and Odisha. Tamil Nadu reports over 30 systems in use.
- ❖ States are making a sincere effort to improve the MCTS despite constraints of poor internet connectivity, insufficient staff, system design issues etc.

Recommendations

- ❖ The Centre should issue a national guidelines on a minimum staffing pattern to establish a viable SPMU, SIHFWs, SHSRCs, ANMTCs, RHFWTCs and DTCs – similar to IPHS for facilities.
- ❖ Development of training capacity in high focus states through revitalization of existing institutions and leveraging of partnerships with other state level institutes specially medical colleges and schools of public health for training, technical support and mentoring should be the main focus of the first two years of the Twelfth Five Year Plan.
- ❖ States need to ensure the use of MCTS and HMIS information by program managers for planning, review and ensuring delivery of services and publishing the information annually.
- ❖ HMIS systems should be able to share data electronically with databases of disease control programmes, MCTS, etc.

X. FINANCIAL MANAGEMENT

Key Findings

- Increase in public expenditure on health care consequent to NRHM and the stimulus to public health sector growth led to an increase in public share of total expenditure on health from 19.1% in 2005 to 30.3% in 2009, with further increases likely.
- Fund absorption has improved but not to desired extent. Systemic reasons for poor absorption of funds relate to long time cycles for infrastructure development and the problems of normative allocation of untied funds.

Recommendations

- States need to persist with and build on accounting reform measures like use of Tally-9 at all levels, clear guidelines, electronic transfers of funds, and concurrent audits.
- Absorption of untied funds should be expedited by the use of clear guidelines .
- Inter-facility allocation responsive to case loads and usage at facility level including a normative payment should be provided to each facility.

A photograph of a group of people outdoors. In the foreground, a woman with dark hair and a light blue shirt stands on the left, smiling. In the center, a man wearing a grey beanie and a grey jacket is seated in a wheelchair, looking towards the camera. To his right, a young girl with dark hair, wearing a black and white striped shirt, stands with her arms crossed. In the background, a white van is parked, and a young man is visible near its open side door. The scene is set against a backdrop of green trees and foliage.

Thank You

Summary of Key Findings

- Accelerated progress in achievements of key health outcomes-maternal and child survival, population stabilisation.
- Considerable increase in outpatient attendance and in-patient admissions
- Package of health care services in non high focus states has expanded to wider range of communicable and non communicable diseases
- Significant progress in the creation of new facilities and infrastructure at sub-centers, CHC and DH levels.
- Availability of drugs has increased at all levels, but gaps are observed at sub-center and ASHA levels. Improved availability of diagnostics is seen at the block PHC, CHC and district hospital.
- With the launch of JSSK, Out of Pocket expenditures have declined but still average is about Rs 500 for an institutional delivery

Summary of Key Findings

- Dial 108 emergency response services – one of the most successful PPPs while outsourcing of maintenance services and Bio-Waste Management, also appear to be successful.
- Considerable increase in attention to quality of care but with considerable fragmentation.
- Service provider vacancies have decreased due to HRH but these have yet to make a dent on specialist vacancies.
- Training programmes are stagnant
- In all high focus states, EmONC or fixed day FP services and even MTPs below DH level remains a challenge

Summary of Key Findings

- Improvements in immunisation, with adequate cold chain.
- Publicly financed emergency response and patient transport systems in place, with high degree of functionality
- Horizontal integration of disease control programmes continues to improve.
- Reports for ASHA programme are uniformly positive
- Financial flows have increased and so has absorption of funds with improved accounting system and newly created force of accounting staff.
- Increase in public share of total expenditure on health from 19.1% in 2005 to 30.3% in 2009