REPORT

OF

SIXTH COMMON REVIEW MISSION ODISHA

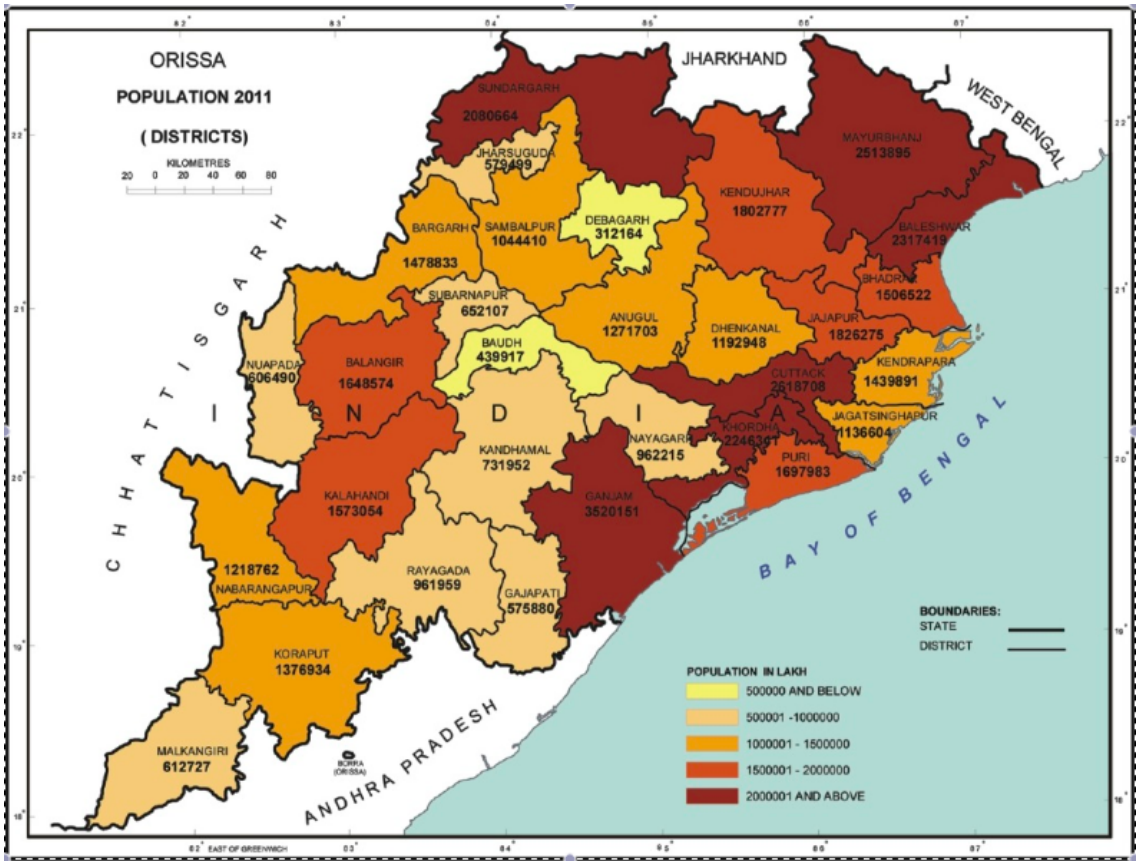

Table of Contents

SECTION-I

BACKGROUND OF THE STATE

Orissa has an area of 155,707 sq. km. and a population of 4.19 Crores. There are 30 districts, 314 blocks and 51349 villages. The State has population density of 269 per sq. km. The decadal growth rate of the state is 13.9 % and the population of the state is growing at a slower rate than the national rate.

1. **State Profile:**

Rural Population (In lakhs) (Census 2011)	349.51
Number of Districts (RHS 2011)	30
Number of Sub Division/ Talukas	58
Number of Blocks	314
Number of Villages (RHS 2011)	51313
Number of District Hospitals	32
Number of Community Health Centres (RHS 2011)	377
Number of Primary Health Centres (RHS 2011)	1228
Number of Sub Centres (RHS 2011)	6688

2. **Status of Health Indicators**

Sl. No	Indicators	Odisha	India
1	Infant Mortality Rate (SRS 2010)	61	47
2	Maternal Mortality Ratio (SRS 2007-09)	258	212
	Maternal Mortality Ratio (AHS 2010-11)	277	
	MMR in Northern Division(Bargarh, Jharsuguda, Sambalpur,Debagarh, Sundargarh, Kendujhar,Dhenkanal, Anugul, Sonapur, Bolangir)	253	
	CENTRAL DIVISION(Mayurbhanj, Baleshwar, Bhadrak,Kendrapara, Jagatsinghapur, Cuttack,Jajapur, Nayagarh, Khordha, Puri)	276	

	MMR in southern division (Ganjam, Gajapati, Kandhamal, Baudh, Nuapada, Kalahandi, Rayagada, Nabarangapur, Koraput, Malkangiri)	311	
3	Total Fertility Rate (SRS 2010)	2.3	2.5
4	Under-five Mortality Rate (SRS 2010)	78	59
	Under-five Mortality Rate (AHS 2010-11)	82	
5	Institutional Deliveries 2012-13(Upto June) (HMIS)	156309	3382229
6	Deliveries at Public Facilities (to reported institutional deliveries) % 2012-13(Upto June)	97%	5884583 against 30015000
7	Full immunization (In thousands) 2012-13(Upto June) (HMIS)	166	4865

3. Demographic Profile

Indicator	Odisha	India
Total Population (Census 2011) (In Crore)	4.19	121.01
Decadal Growth (%) (Census 2011)	13.97	17.64
Crude Birth Rate (SRS 2010)	20.5	22.1
Crude Death Rate (SRS 2010)	8.6	7.2
Natural Growth Rate (SRS 2010)	11.9	14.9
Sex Ratio (Census 2011)	978	940
Child Sex Ratio (Census 2011)	934	914
Schedule Caste population (in crore) (Census 2001)	0.61	16.67
Schedule Tribe population (in crore) (Census 2001)	0.81	8.43
Total Literacy Rate (%) (Census 2011)	73.45	74.04
Male Literacy Rate (%) (Census 2011)	82.40	82.14

Female Literacy Rate (%) (Census 2011)	64.36	65.46

4. Progress of NRHM

<table>
<tr><th>Sl. No</th><th>Activity</th><th>Status</th></tr>
<tr><td>1</td><td>24x7 PHCs</td><td>Out of 1228 only 48 PHCs are functioning on 24x7 basis</td></tr>
<tr><td>2</td><td>Functioning as FRUs</td><td>93 facilities (32 DHs, 25 SDHs and 36 CHCs) are working as FRUs</td></tr>
<tr><td>3</td><td>ASHAs Selected</td><td>43530 ASHAs selected, 43372 have been trained upto 1st Module, 41560 trained up to 5th Module and 22824 ASHAs trained in Round-1 of the 6th& 7th Module</td></tr>
<tr><td>4</td><td>ANMs at SCs</td><td>Out of 6688 SCs, 1183 SCs are functional with 2nd ANMs.</td></tr>
<tr><td>5</td><td>Contractual appointments</td><td>112 Paramedics, 881 Staff Nurses, 1186 ANMs & 1250 AYUSH Doctors are positioned under NRHM</td></tr>
<tr><td>6</td><td>Rogi Kalyan Samiti</td><td>1663 facilities (32 DH, 377 CHCs, 26 Other than CHCs & 1228 Other Health facilities above SC) have been registered with RKS.</td></tr>
<tr><td>7</td><td>Village Health Sanitation & Nutrition Committees (VHSNCs)</td><td>Out of 51313 villages, 45473 villages Constituted VHSNCs.</td></tr>
<tr><td>8</td><td>VHNDs(upto September 2012-13)</td><td>214496 VHNDs were held during 2012-13 against target of 229799 (93%)</td></tr>
<tr><td>9</td><td>Infrastructure Strengthening</td><td>
<table>
<tr><th rowspan="2">Facility</th><th colspan="2">New Construction</th><th colspan="2">Renovation/Upgradation</th></tr>
<tr><th>Sanctioned</th><th>Completed</th><th>Sanctioned</th><th>Completed</th></tr>
<tr><td>DH</td><td>3</td><td>0</td><td>32</td><td>32</td></tr>
<tr><td>SDH</td><td>0</td><td>0</td><td>25</td><td>22</td></tr>
<tr><td>CHC</td><td>10</td><td>5</td><td>243</td><td>206</td></tr>
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		PHC	2	0	118	53	
		SC	556	205	1668	1000	
10	MMU	354 MMUs are operational in 28 Districts					
12	New Born Care Units established	Sick New Born Care unit (SNCU)				19	
		New Born Stabilization Unit (NBSU)				25	
		New Born Care Corner (NBCC)				450	

5. Physical Progress of Institutional Deliveries and JSY

Year	Institutional Deliveries	JSY Beneficiaries(In Lakhs)
2005-06	255000	26407
2006-07	358000	227204
2007-08	440000	490000
2008-09	280000	506000
2009-10	514000	587000
2010-11	506892	533372
2011-12	619510	634468
2012-13(Up to June)	156309	137414

6. Services

Services	06-07	07-08	08-09	09-10	10-11	11-12	12-13
Male Sterilisation	790	1397	2274	2158	3419	3231	122
Female Sterilisation	92949	119576	21071	120013	109517	158190	4652
Full immunisation (In thousands)		772	633	785	736	685	166

7. Reproductive and Child Health Programme (RCH)

a) Immunization Coverage

ImmunizationSurvey Data

Source	NFHS 3	CES	CES	DLHS 3	CES	AHS
Time Period	2005-06	2005	2006	2007-08	2009	2010-11
Fully Immunized	51.8	53.2	74.8	63.1	59.5	55
BCG	83.6	94.6	96.2	94.4	87.3	97.5
OPV3	65.1	60.5	80.0	78.8	74.0	74.7
DPT3	67.9	80.3	80.0	74.5	70.5	72.9
Measles	66.5	81.9	85.8	81.1	71.9	86.7
No Immunization	-	-	-	3.9	5.8	0.9

- According to Coverage Evaluated Survey Data (2009), Orissa is on 19th position amongst the states in the country in terms of percentage of Fully Immunized Children (59.5).
- Hepatitis B vaccine and Measles 2nd dose has been introduced under routine immunization in the state of Orissa.

b) Information on selected MCH indicators

Indicators	DLHS-3 (2007-08)	AHS(2010-11)
Child feeding practices (%)		
Children under 3 years breastfed within one hour of birth	63.7	71.5
Children age 0-5 months exclusively breastfed	54.5	NA
Children age 6-35 months exclusively breastfed for at least 6 months	42.6	24.8
Children age 6-9 months receiving solid/semi-solid food and breast milk	59.8	NA
Awareness about Diarrhoea and ARI		
Women aware about danger signs of ARI (%)	22.0	42.7
Treatment of childhood diseases		
Children with diarrhoea in the last 2 weeks who received ORS (%)	49.0	89.1

Children with diarrhoea in the last 2 weeks who were given treatment (%)	60.5	
Children with acute respiratory infection of fever in last 2 weeks who were given advise or treatment (%)	63.4	92.4

EXISTING HEALTH INFRASTRUCTURE IN ODISHA:

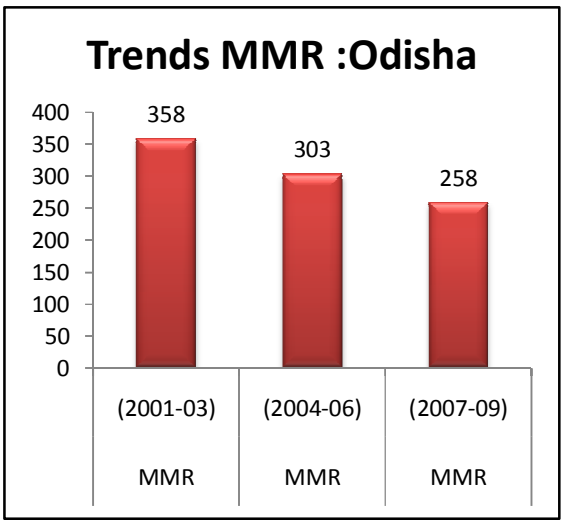
Type of Health Facility	Status
No. of Medical College and Hospitals (Government)	3
No. of District Hospitals (Capital Hospital, BBSR & R.G.H RKL)	32
No. of Sub-Divisional Hospitals	26
No. of Community Health Centres	377
No. of Other Hospitals	79
No. of Primary Health Centres (N)	1228
No. of Rural Family Welfare Centres	314
No. of Urban Family Welfare Centres	10
No. of Postpartum Centres	79
No. of Sub-Centres	6688
No. of Health Posts (Revamping) (Bhubaneswar, Cuttack & Rourkela)	3

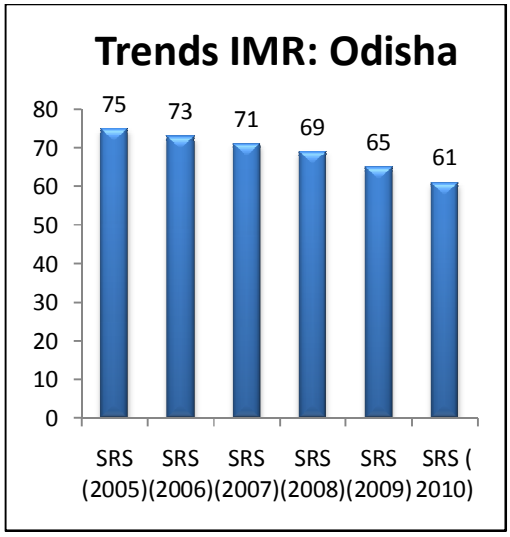
MAJOR ACHIEVEMENTS UNDER NRHM:

Crucial Health Indicators:

Orissa's MMR at 258 (SRS 2007-09) has improved from 358 in SRS 2001-03, but is still way above the national average of 212. The IMR (SRS 2010) at 61 is the second highest, following MP (62). TFR at 2.3 (SRS 2010) is the lowest among the EAG States and lower than the national average (2.5).

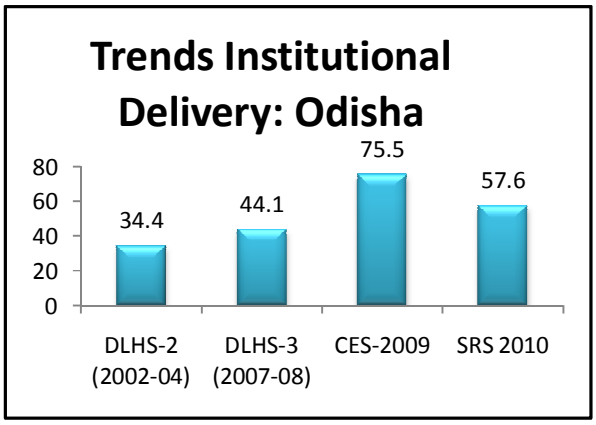
INDICATOR	ORISSA		INDIA		
	Trend (year & source)		Current status	RCH II/ NRHM (2012) goal	Remarks
Maternal Mortality Ratio (MMR)	358 (SRS 01-03)	258 (SRS 07-09)	212 (SRS 07-09)	<100	% decline per year from 2001-03 to 2007-09 is 3.9 %
Infant Mortality Rate (IMR)	83 (SRS 2003)	61 (SRS 2010)	47 (SRS 2010)	<30	% decline per year from 2003 to 2010 is 3.7 %
Total Fertility Rate (TFR)	2.6 (SRS 2003)	2.3 (SRS 2010)	2.5 (SRS 2010)	2.1	TFR has increased by 0.3 points since SRS 2003





Maternal Health

- **Institutional deliveries:** Gone up from 34.4% (2002-04) to 57.6 % (2010).
- **Safe deliveries**: Increased from 48% in 2005 to 69.7% in 2010.
- **Unsafe deliveries**: Deliveries by untrained functionaries have decreased from 52% in 2005 to 20.3% in 2010. (Source: SRS).
- **3 + ANC Coverage:** Increased from 54.6% (DLHS-III, 2007-08) to 77% (CES, 2009).



Delivery Points

- Out of 6688 sub-centres, 153 SCs conduct >3 deliveries per month
- Out of 1147PHC(N),71 PHC(N) are conducting more than 10 deliveries
- Out of 160 24x7 PHCs, 91 24x7 PHCs are conducting>10 deliveries per month
- Out of 289 Non FRU CHC, 240 are conducting >10 deliveries per month.
- Out of 88 FRUs (CHCs and other FRUs excluding DHs) 88 are conducting >20 deliveries per month. Only 49 FRUs are conducting C-section.
- Out of 26 SDH, 25 are conducting > 20 deliveries per month.
- All DHH (32) are conducting>50 deliveries per month.
- All 17 Accreditated Private Healthy Facilities are conducting>10 deliveries and conducting C-sections.

So in the State of Orissa out of 8430 health facilities, 700 delivery points are functional in the govt sector and 17 Private Health Facilities

JSSK

- State has launched JSSK from 1st Nov, 2011 in 382 facilities in the first phase
- Relevant Governments have been issued.
- Implemented all the Entitlements under JSSK at the 382 delivery points (382 facilities, from DH to all SDH and 1 CHC in each of the blocks)
- Comprehensive operational guidelines have been prepared by the experts based on the national guidelines to implement the free entitlements in the health facilities
- The standard treatment protocols for O&G cases and newborn prepared.
- Essential drug list for delivery & new born cases prepared.
- Guidelines developed for decentralized Procurement & strengthening supply chain management system
- Free blood provision will be made available in 107 designated L3 institutions (49 Blood Storage Units + 58 Blood Banks) by November, 2011. It will be scaled up to 145 institutions in phased manner by March, 2012.
- Identification of vehicle points in motorable areas for uniform coverage identified.

Community level Initiatives

- Village Contact Drive in media dark areas (integrating with MHUs)
- Swasthya Kantha Update and wall writing on JSSK on regular interval
- In Rayagada district, lab facilities closes at 5 PM. JSSK operationalized in 11 identified facilities

Training:

LSAS Training

- 3 Medical Colleges and 22 DHs conducting LSAS Training.
- 81 doctors trained and 69 posted to designated FRUs

EmOC Training

- 1 Medical College and 6 DHs conducting EmOC Training
- 38 doctors trained and 21 posted to functional FRUs

SBA Training

- 30 DHs are the training site for SBA Training
- 7316 SN/ANMs/ LHVs trained as SBA

JSY

States/UTs	2011-12					
	Physical Progress			Financial Progress (in Lakhs)		
	Estimated JSY beneficiaries	Ach.	% Ach.	Amount approved	Expend	% Ach.
Orissa	691667	634468	91.73%	10831	10151.49	93.73%

- **Performance in 2011-12:** Orissa has reported 92% achievement under JSY.

Child Health

- The state has made operational 16 SNCUs, 25 NBSUs and 452 NBCCs, as against the cumulative target of 24, 50 and 997 respectively as on November 2011.

Family Planning

- SRS Estimates:
  - TFR of the state has shown a decline from 2.4 (2009) to 2.3 (2010).

- Current CBR is 20.5 (2010).

- District Level Household Survey 3 (2007-08):
  - CPR for any modern methods has declined in DLHS-3 from DLHS-2 (from 40.3% to 39.6%)
  - Unmet need of the state remains very high (23.1%)

- Provisional data of Census-2011:
  - Every 10 years Orissa adds around 51 lakhs persons.

- Achievement under Family Planning Programme:
  - Sterilisation performance has improved marginally (from 117955 in 2009-10 to 137366 in 2010-11); for 2011-12 it is anticipated to be 135000.
  - State has shown minor decline in IUD insertion (from 137230 in 2009-10 to 135206 in 2010-11); for 2011-12 it is anticipated to be 132352.

- Seasonal variation in service delivery:
  - Data reported in HMIS (2010-11) does show seasonal variation (70.4% sterilisation reported in last 2 quarters).

- Method wise performance (2010-11):
  - Use of minilap method (59.17%) for female sterilisation is good
  - Provision PPS is only 3.54% which is a weak area.

- Delivery of contraceptives by ASHA:
  - Scheme is being piloted in 18 out of the 30 districts in the State.
  - Scheme has been started in all 18 districts and utilisation reports of all of them have been received.

PCPNDT

- Child sex ratio has declined by 19 points from 953 in 2001 to 934 in 2011
- Rural child sex ratio has declined by 16 points from 955 in 2001 to 939 in 2011 whereas Urban Child Sex Ratio declined by 24 points to 909
- 606 clinics have been registered in the state under the Act
- 20 prosecutions launched against violations of the PC & PNDT Act
- No convictions have been secured so far against violations under the Act
- State inspection and monitoring committee is not activated

Menstrual Hygiene Scheme

- In Odisha 4 districts- Dhenkanal, Bhadrak, Kendrapara and Jagatsinghapur are being provided sanitary napkins from HLL. Sanitary napkins have reached all the above districts under HLL supply and response has been satisfactory. In Ganjam, it is being procured from Self Help Groups.

ASHA

- ASHAs are selected in co-terminus with Anganwadi Centres of the district having minimum 1000 population. Total target no. of ASHAs of the state is 43530 (Rural Area -41102, Urban Slum – 458, V3 & V4 sub-Centre Area - 1970)
- No of ASHAs dropped out during the year 2011-12 : 209.Reselection of dropped out ASHAs is going on. By the end of March 2012, 132 no. of ASHAs against the vacancy aroused out of dropped out reason have been reselected.

Village Health Sanitation & Nutrition Committees (VHSNCs):

- 45490 GKS are functional at the revenue village level of the state and annual untied fund of Rs.10000/- is placed to the GKS bank account.
- State's initiative of strengthening functioning of the GKS through partnership with Organizations like CARE India could be replicated in other districts for better community involvement.

Rogi Kalyan Samiti

- 1742 facilities (including DHH-32,SDH-26, CHC- 377, PHC-1228 and Other Hospitals-79)have been registered with RKS.

Referral Transport

- The state has 167 ambulances which are supported under NRHM and have been procured recently; these 167 ambulances are yet to be operationalized.
- There are 399 functional Janani Express in the state.
- There are 422 Government ambulances functional in the state and 62 Empanelled private vehicles for hard to reach areas.
- State has a call centre for the ambulances which is yet to be operationalized.
- Universal toll free number for the ambulances has yet to be started.

Mobile Health Units (MMUs)

- 354 MHUs are covering operationalized and catering to the need of beneficiaries in inaccessible areas.
- 240 MHUs are supported by NRHM and the rest 114 by the state government.

Financial Progress against the approved PIP

State share Contribution status :(Rs. in Crore)

Year	Amounts required on basis of releases	Amount Credited through SHS	Routed under Treasury for Family Welfare	Short/ (Excess)
2007-08	68.32	37.84	0.00	30.48
2008-09	68.48	50.44		18.04
2009-10	82.97	61.00		21.97
2010-11	96.96	90.00		6.96
2011-12	122.45	190.00		-67.55
Total (2007-08 to 2011-12)	**439.18**	**429.28**	**0.00**	**9.90**
2012-13	133.39	0.00		133.39
TOTAL (2007-08 to 2012-13)	**572.57**	**429.28**	**0.00**	**143.29**

The State has not furnished any information of utilisation of funds under the Family Welfare account during the year 2007-08.

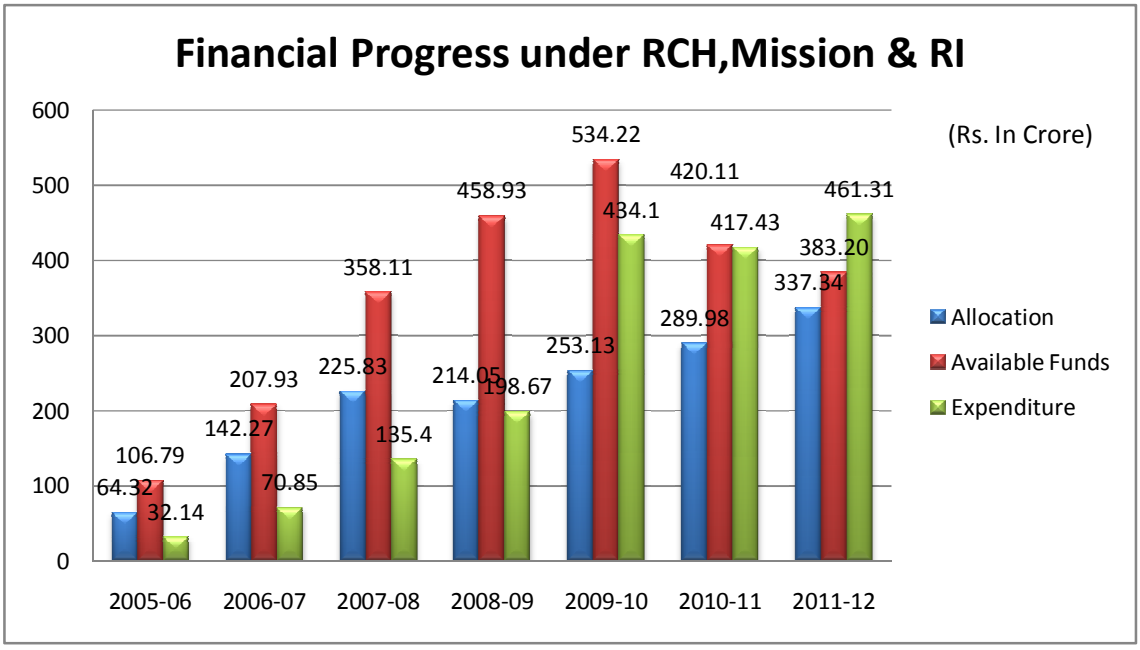
Financial Progress under RCH Flexi-pool, Mission Flexi Pool & Routine Immunisation:-

ODISHA

(Amount Rs. in Crore)

Particulars	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	Total
RCH FLEXIBLE POOL								
Allocation	58.68	71.36	106.25	111.24	117.97	133.94	147.83	747.27
Opening Balance	0.00	19.39	42.17	55.84	39.00	-2.76	-41.90	0.00
Release	40.50	60.01	108.85	111.24	117.97	153.94	177.83	770.34
Funds Available	40.50	79.40	151.02	167.08	156.97	151.18	135.93	770.34
Expenditure	21.11	37.23	95.18	128.08	159.73	193.08	215.87	850.28
% of Exps to Funds Available	0.52	0.47	0.63	0.77	1.02	1.26	0.88	0.99
Unspent Balance	19.39	42.17	55.84	39.00	-2.76	-41.90	-79.94	-79.94
MISSION FLEXIBLE POOL								
Allocation	0.00	64.97	113.58	95.81	126.20	148.54	182.01	731.11
Opening Balance	0.00	52.34	90.79	161.72	219.46	107.07	49.72	0.00
Release	59.32	66.91	107.43	123.44	151.20	158.54	191.01	857.85
Funds Available	59.32	119.25	198.22	285.16	370.66	265.61	240.73	857.85
Expenditure	6.98	28.46	36.50	65.70	263.59	215.89	237.88	855.00
% of Exps to Funds Available	0.12	0.24	0.18	0.23	0.71	0.81	0.99	1.00
Unspent Balance	52.34	90.79	161.72	219.46	107.07	49.72	2.85	2.85
ROUTINE IMMUNIZATION								
Allocation	5.64	5.94	6.00	7.00	8.96	7.50	7.50	48.54
Opening Balance	0.00	2.92	4.12	5.15	1.80	-4.19	-5.14	0.00
Release	6.97	6.36	4.75	1.54	4.79	7.51	11.68	43.60
Funds Available	6.97	9.28	8.87	6.69	6.59	3.32	6.54	43.60
Expenditure	4.05	5.16	3.72	4.89	10.78	8.46	7.56	44.62

Particulars	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	Total
% of Exps to Funds Available	0.58	0.56	0.42	0.73	1.64	2.55	1.16	1.02
Unspent Balance	2.92	4.12	5.15	1.80	-4.19	-5.14	-1.02	-1.02
GRAND TOTAL								
Allocation	64.32	142.27	225.83	214.05	253.13	289.98	337.34	1526.92
Opening Balance	0.00	74.65	137.08	222.71	260.26	100.12	2.68	0.00
Release	106.79	133.28	221.03	236.22	273.96	319.99	380.52	1671.79
Funds Available	106.79	207.93	358.11	458.93	534.22	420.11	383.20	1671.79
Expenditure	32.14	70.85	135.40	198.67	434.10	417.43	461.31	1749.90
% of Exps to Funds Available	0.30	0.34	0.38	0.43	0.81	0.99	0.32	0.88
Unspent Balance	74.65	137.08	222.71	260.26	100.12	2.68	-78.11	-78.11

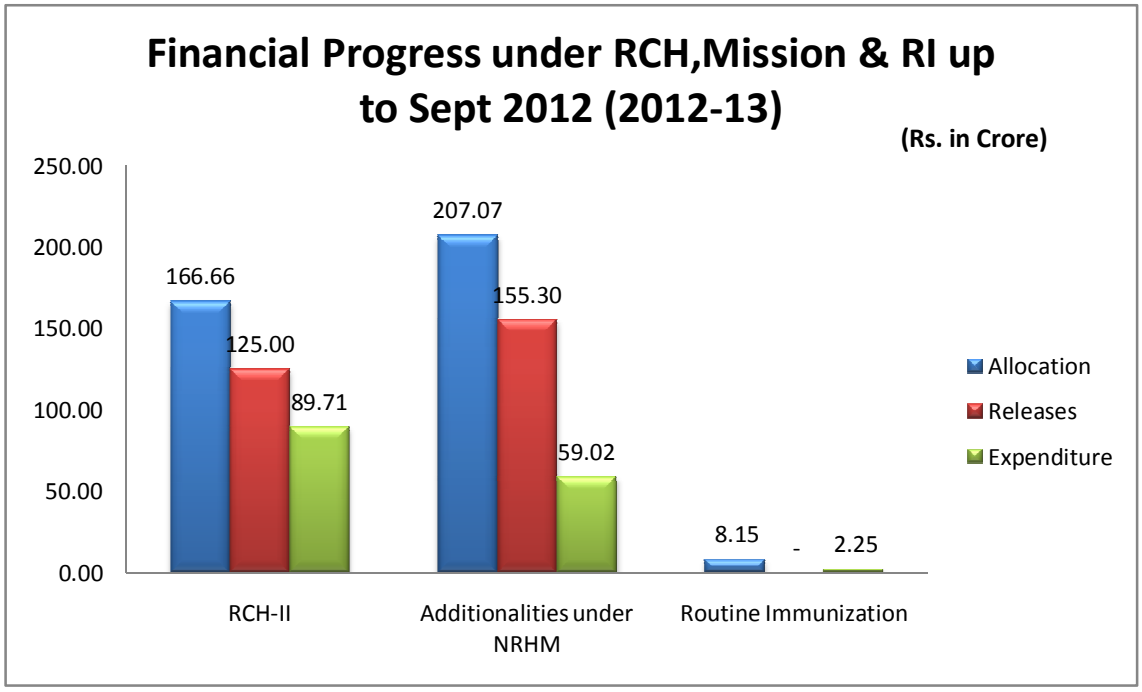


- **Allocation: -** Allocation showing increasing trend from 2005-06 to 2011-12 except 2008-09.
- **Expenditure: -** Expenditure is also showing increasing trend from 2005-06 to 2011-12 except 2010-11.

- **Available Funds: -** Expenditure during the financial 2011-12 is more than the available funds .

Allocation, Release & Expenditure up to Sept,2012 for the financial 2012-13 :-

	RCH-II	Additionalities under NRHM	Routine Immunization
Allocation	166.66	207.07	8.15
Releases	125.00	155.30	-
Expenditure	89.71	59.02	2.25



The expenditure in RCH, Additionalities and RI is low.

Major Initiatives taken on the recommendation of 5th CRM Team

- Substantial improvement has been made in reduction of IMR from 61 to 57 and increased institutional delivery from 60% in 2010-2011 to 71.7% against estimated delivery in 2011-2012.
- 43% in OPD and 49.3% in IPD has been increased during 2010-11to 2011-2012.Likewise, API (malaria) has been reduced from 9.29% during the year 2010-2011 to 2011-2012.
- Designated CDMO as District Mission Director with enhancement of financial power from 5 lakhs to 20 lakhs.
- Strengthening of District Health Society , District Health Mission & District Level Vigilance Monitoring Committee in all 30 districts
- Strengthening of field monitoring and supportive supervision system through designating officer above rank of Deputy Director as State Nodal Officer for the district, those are visiting the districts at least twice in every month.
- A composite team from SPMU is also visiting one district in each week.
- Strengthen monitoring and reporting system through e-swasthya initiatives like e- Swasthya Nirman for monitoring of civil infrastructure, e-Blood bank for ensuring availability of blood, Drug Testing & Data Management system, GPS tracking of MHU, e- attendance, HRMIS, Contraceptives Logistic & Management Information System, Integrated Training and Evaluation Management System, Telemedicine, FRU Automation etc. have been developed.
- In order to address malnutrition, steps have been taken to establish 7 NRCs in 2011 to 44 NRCs in the State during the year 2012-2013.
- JSSK has been rolled out across the State from 382 institutions to in all health institutions with major focus on 700 DPs.
- State mandate defined for RMNCHA+ services to be ensured in different categories of institutions.
- State drug budget has been increased from 47 Crores in 2011 to 100 Crores, during the year 2012.
- Community monitoring process named as Gaon Swasthya Samikhya has been implemented in 5 districts of the State on pilot basis during current year.
- Strengthened intersectoral convergence with W & CD through joint implementation of different activities like VHND, VHSNC, immunization session, implementation of MCP cards, conditional cash transfer scheme for pregnant women like IGMSY, ARSH, WIFS etc.
- Extensive of IEC / BCC campaign through multimedia approach like 52 weeks Swasthya Kantha campaign.

SECTION-II

OBJECTIVES OF SIXTH CRM

1. Review progress of National Rural Health Mission with reference to the functioning of NRHM vis-à-vis its goals and objectives-Identify the changes that have occurred in last seven years and reasons for the current states and trend.
2. Review programme implementation in terms of accessibility, equity, affordability and quality of health care services delivered by public health systems including public private partnership (PPP).
3. Review of progress against conditionalities and the State's response to conditionalities.
4. Review follow up action on recommendations of last Common Review Mission.
5. Note additional outcomes other than those envisaged under approved plans.
6. Identify constraints faced and issues related to each of the components outlined and possible solutions.
7. Document best practices, success stories and institutional innovations in the states.
8. To identify strategies and outcomes in the State in addition to the ones envisaged by the Mission, both positive and negative.
9. Make recommendations to improve programme implementation and design.

Thematic Areas

Progress of NRHM will be reviewed on the following ten parameters each of which has ten components,

1. Facility based curative services-accessibility, affordability & quality.
2. Outreach & Patient transport services-Sub-centers, Mobile Medical Unit/EMRI,ALS/BLS etc
3. Human Resource for Health-Adequacy in Numbers, Skills and Performance
4. Reproductive and Child Health Programme.
5. Disease Control Programs-Communicable and Non Communicable
6. Community Processes including ASHA,PRI,VHSNC, Community Based Monitoring and NGO involvement
7. Promotive Health Care, Action on Social Determinants and Equity concerns.
8. Program Management including monitoring, logistics and issues of integration and institutional capacity.
9. Knowledge Management including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology.
10. Financial Management-especially fund flows, accounting and absorption

Composition of the CRM Team to Odisha and Facilities visited

Table 2.1: Composition of 6th CRM Team to Odisha State

SN	Name of Team Members	Designation	Organization& Location
1	Dr. Himanshu Bhushan	Deputy Commissioner (CRM Team Leader)	Ministry of Health & Family Welfare, GoI, New Delhi
2	Dr Suryamani Mishra	Deputy Director	WCD Department, Ministry of Women & Child Development GoI, New Delhi
3	Sh. Tarun Arora	Research Officer	Planning Commission
4	Ms Jhimly Baruah	Consultant	NHSRC
5	Ms Manjula Singh		DFID
6	Sh. Saswat Rath	Sr. Consultant	TMSA
7	Mr. Anders Thomsen	Deputy Representative India / Bhutan,UNFPA	UNFPA
8	Dr Umesh Chandra Sahoo	Medical Consultant, RCH-II/ NRHM,	NIHFW
9	Dr. Vijay Aruldas	Independent Consultant	AGCA
10	Dr. Shobha Govindan	State Programme Coordinator	Micronutrient Initiative Gandhinagar,Gujarat
11	Dr. Munish Joshi	National Consultant Training, (Tech Assistance under the Global Fund)	Directorate of NVBDCP, MOH & FW, Govt of India
12	Dr. Ravinder Kaur	Sr. Consultant Maternal Health	Ministry of Health & Family Welfare, GoI, New Delhi
13	Lt Aseema Mahunta	Consultant NRHM Planning and Policy	Ministry of Health & Family Welfare, GoI, New Delhi
14	Sh. Sumantha Kar	Consultant FMG	Ministry of Health & Family Welfare, GoI, New Delhi

Table2.2:Central Team to District Bolangir

S No	**Name of Team Members**	**Designation**
1	Dr. Himanshu Bhushan	Deputy Commissioner (CRM Team Leader),, Ministry of Health & Family Welfare, GoI, New

		Delhi
2	Dr Suryamani Mishra	Deputy Director, WCD Department, Ministry of Women & Child Development GoI, New Delhi
3	Dr. Vijay Aruldas	AGCA
4	Mr Anders Thomsen	Deputy Representative India / Bhutan,UNFPA
5	Dr. Munish Joshi	National Consultant Training, (Tech Assistance under the Global Fund), Directorate of NVBDCP, MOH & FW, Govt of India
6	Dr. Ravinder Kaur	Sr. Consultant, MaternalHealth, Ministry of Health & Family Welfare, GoI, New Delhi
7	Lt. Aseema Mahunta	Consultant ,NRHM Planning and Policy, Ministry of Health & Family Welfare, GoI, New Delhi
8	Sh. Sumanta Kar	Consultant ,FMG,Ministry of Health & Family Welfare, GoI, New Delhi

Table 2.3: State Team to District Bolangir

S No	Name of Team Members	Designation
1	Dr. P. K. Senapati	Sr Maternal Health Manager, NRHM Odisha
2	Dr B.K.Panda	Director Public Health, Government Of Odisha
3	Dr Pramila Baral	Deputy Director IDSP, Government Of Odisha
4	Sh.Pranay Mohapatra	Sr .Consultant, Public Health Planning,SHSRC
5	Sh. Deepak K.Biswal	Consultant M & E,NRHM Odisha

Table 2.4: Central Team to District Kendrapara

S No	Name of Team Members	Designation
1	Dr. Himanshu Bhushan	Deputy Commissioner (CRM Team Leader),, Ministry of Health & Family Welfare, GoI, New Delhi
2	Dr Shobha Govindan	State Programme Coordinator,Micronurient Initiative ,Gandhi Nagar,Gujrat
3	Ms. Jhimly Baruah	Consultant,NHSRC
4	Sh. Sumanta Kar	Consultant,FMG,
5	Dr. Umesh Chandra Sahoo	Medical Consultant, RCH-II/ NRHM, NIHFW
6	Sh. Saswat Rath	Sr. Consultant,TMSA
7	Sh. Tarun Arora	Research Officer, Planning Commission
8	Ms Manjula Singh	DFID

Table 2.5: State Team to District Kendrapara

S No	Name of Team Members	Designation
1	Dr B .Das Mohapatra	Joint Director, Rural Health, Government Of Odisha
2	Dr B.K.Swain	Joint Director, SHRMU,Government Of Odisha
3	Dr A.K. Pradhan	State Programme Manager,NRHM Odisha
4	Dr.Biswajeet Modak	Sr Consultant ,Training,NRHM Odisha

Table 2.6: Officials met by the CRM Team

DR P. K Mohapatra	Secretary & Commissioner Health, Odisha
Dr. P K Meharda	Mission Director, Government Of Odisha
Shri Debaraj Mishra	District Collector Bolangir,Odisha
Shri D P Behera	District Collector Kendrapara,Odisha
Dr B Kindo	CDMO, Bolangir,Odisha
Dr Kanti Sharma	CDMO, Kendrapara,Odisha
Other State Government Officers & District Health Functionaries	
GKS members, PRI Members, Village Health Functionaries, ASHAs,AWWs Beneficiaries etc.	

Debriefing meeting of CRM team members with DM, Bolangir

DISTRICTS VISITED BY THE CRM – 6th TEAM

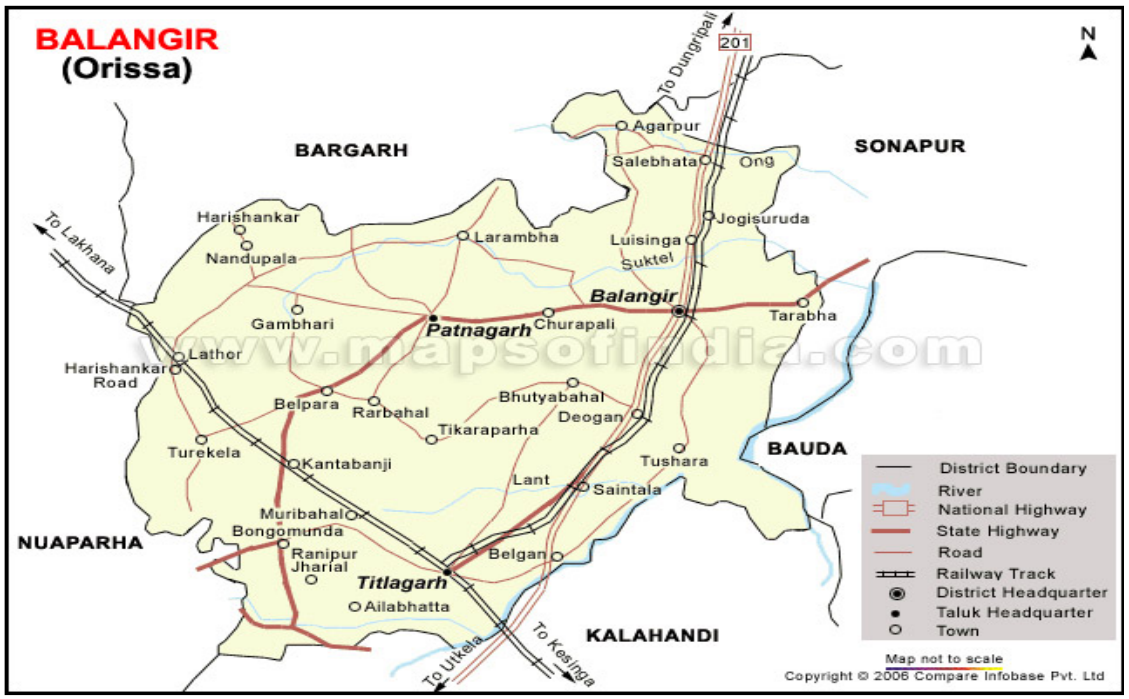


Table 2.7: FACILITIES VISITED BY CRM TEAM:

Type of Facility	Availability status in Bolangir	No. of Facilities visited by CRM team at Bolangir	Availability status in Kendrapara	No. of Facilities visited by CRM team Kendrapara
District Head Quarter Hospital	1	1	1	1
Sub Divisional Hospital	2	2	0	0
No. of CHC	15	02	09	03
PHC (New)	42	01	45	03
Area/Other Hospitals	02	0	01	0
Sub-centre	226	04	227	04
Others(MHU, Maternity Waiting Hall & GKS, AWC,VHND,VHSNC)	MHU-28	06		05

Table 2.8*:* Facilities Visited by CRM team in Bolangir district

S No	Name	Address / Location
1	District Headquarter Hospital	Bolangir
2	Sub Divisional Hospital	Patnagarh
3	SDH	Titilagarh
4	CHC-Ghasian	Ghasian
5	CHC-Saintala	Saintala
6	PHC(N)-Belgaon	Belgaon
7	SC-Jogimunda	Jogimunda
8	SC-Jogisuguda	Jogisuguda
9	SC-Desil	Desil
10	SC-Bhadra	Bhadra
11	GKS-Badamunda	Badamunda
12	VHND-Dharapgarh	Dharapgarh
13	FGD with GKS members at Convention at Ghasian CHC	Ghasian
14	FGD with ASHA at Module 6& 7 training	Ghasian
15	School : Jogimunda	Jogimunda
16	AWC: Madiapali in Puintala block	Madiapali in Puintala block

17	Regional Vaccine Store	Bolangir

Table 2.9: Facilities Visited by CRM team in Kendrapra district

S No	Name	Address / Location
1	District Headquarter Hospital	Kendrapada
2	Community Health Centre	Marsaghai
3	CHC	Pattamundai
4	CHC	Rajnagar
5	PHC(N)	Kurtunga
6	PHC	Ram nagar
7	PHC	Korowa
8	SC	Mahakalapada
9	SC	Pareshwarpur
10	SC	Damarpur
11	SC	Manikapur
12	GKS	Mulabasanta
13	School	Napangaurnita
14	VHND	Baharsobala
15	VHND	Tankidelari
16	VHND	Medinipur

SECTION-III

CRM 6TH ODISHA OBSERVATIONS AS PER TOR

I. HEATH CARE SERVICES FACILITIES:ACCESS,AFFORDABILITY, QUALITY

1.Adequacy of facilities

- Health services in Odisha are delivered predominantly by the public sector, currently served by a network of 9516 primary and secondary facilities. The status of facilities currently in place vis-a-vis required (as per population norms is presented in Table 1 :

Table 3.1: Status of health facilities in the state

Health Facility	**Required	**Existing	**Under construction
District Hospital	30	32 (additional in Khorda and Sundargarh district)	
Community Health Centres	420	377	9
Primary Health Centres	1678	1228	
Sub centres	10616	6688	82

**Source: State PIP, 2012-13

There has been considerable addition to the health infrastructure, in the state under NRHM : 146 CHCs and 762 Sub centres being added . The number of facilities sanctioned during the same period also shows incremental growth: 245 CHCs, 315 APHC/PHC equivalent, 1345 SCs, 113 SDHs.There is a shortfall of 3928 SCs despite state sanction of 1345 SCs during the period 2007-12.

Sub centre Jogisugda, Bolangir

There is differential planning with special emphasis on the 18 high focus districts, which have been accorded with maximum sanctioned health facilities.

Table 3.2.: Progress in infrastructure during the Plan period

Health Facility	*Tenth Plan (2002-2007)	Eleventh Plan (2007-12)*
District Hospital	30	32
Community Health Centres	231	377
Primary Health Centres	1279	1228

Sub centres	5927	6688

*Source: RHS Bulletin, March 2007 and March 2011

In 2012-13, eleven 100 bedded MCH wings have been additionally approved in 10 districts (2 wings in Sundargarh), including one in Bolangir DH.

Table 3.3: Facilities according to level and functionality

Level of Facilities	Total number of Facilities	Functional as delivery point
L1	6688 SC	153 SC
L2	1147 PHC(N) + 160 (24*7 PHC)+ 289 (Non FRU CHC)=1596	71 PHC(N) + 91(24*7 PHC)+240(Non FRU CHC)=402
L3	88(CHC FRU)+26 SDH+32(DHH) = 146	88(CHC FRU)+25 SDH+32(DHH) = 145
Total	8430	700

According to the UN indicators, at the population of 5 lakhs there should be 1 CEmOC and 4 BEmOC facilities. In the State of Odisha on calculationsbased on the total population (4.19 Crores) the required health facilities providing CEmOC and BEmOC services should be 84 & 336 respectively. However as per the State data there are 146 CEmOC and 1596 BEmOC. These health facilities are adequate both in CEmOC and BEmOC services. The need of the hour is to improve the functionality of the health facilities instead of building on more infrastructures, as only 8 % of the total health facilities are functional as Delivery Points.

This is also true of the PHCs where no new facilities have been sanctioned, except in the 'Other facility' category –where 315 facilities have been sanctioned during the same period. A substantial number of new constructions will be required to close the shortfall at the PHC and SC level. Currently, 82 SCs are under constructions; however this would not be adequate to close the gap of 3846 SCs required.Currently no construction is planned at the PHC level. Further , the pace of new construction is One area where the state has moved ahead in the NRHM period is residential quarters for ANMs at the SC which has improved from 43% SCs with quarters in 2007 (RHS Bulletin, March 2007) to 50.3% in 2011 (RHS Bulletin, March 2011).

Planning of facilities and their operationalization in terms of geographical locations was found adequate in both districts. In district Kendrapara (KP) which has a good network of roads , the nearest FRU is located within 30 minutes from the next facility e.g. Mahakalpada CHC, a designated Level 3 facility is 20 kms (20 mins) from the L2 facility (Ramnagar PHC) and is accessible in approximately 20 mins.

2. Infrastructure Plan

There is a clear infrastructure plan in the state with prioritisation of facility up gradation in the high focus districts. Construction of infrastructure is consistent with the plan. An exclusivecivil construction wing established especially under NRHM is responsible for all construction activities. Construction Units comprising engineers are in place at the State, District and Block level. A web

enabled system e –Swathya Nirman tracks and monitors progress on all civil constructions. The state has multiple funding sources for infrastructure:major share being from NRHM, Finance Commission Grants followed by Donor funds under the Odisha Health Sector Funds supported by DFID and NIPI.All infrastructure up-gradation and construction is concentrated in the delivery points – 74% of infrastructure funds have been allocated to these designated facilities.

Progress on PHC constructions is somewhat slow. In 2012, 171 PHCs were under construction and in 2012-13, 96 are under construction.

3. Utilization of services

OPD and IPD services in the state and the two districts visited show a positive trend as demonstrated by the data below. There has been consistent increase in OPD and IPD figures in the last three years. This was evident during the facility visits – PHCs had a range of 30-100 OPD per day and CHCs 200-300 per day. Increased case loads are reported particularly from the delivery points, which have been strengthened with infrastructure and manpower and hence attracting high caseloads for deliveries. IPD figures shown below is primarily from the CHCs and District Hospitals which were found crowded during the visits, but very low in the PHC level in the two districts. This arises from the fact that PHCs (N) are not sanctioned any beds - in the PHCs of the two districts, 2-4 beds were available and empty in most facilities. AYUSH OPDs have average of 263 patients per month and OPD services in all collocate facilities are in demand.AYUSH collocation has been done in all 314 Block HQ CHC. In 1226 PHCs (New), there are AYUSH Units comprising an MO and a pharmacist.

Table 3.4 : Utilization of services

	2009-10			2010-11			2011-12		
	State	**BLG**	**KP**	**State**	**BLG**	**KP**	**State**	**BLG**	**KP**
Bed	**14744**	**872**	**629**	**14744**	**872**	**629**	**14744**	**872**	**629**
OPD	25223935	731745	816965	2,62,46,210	8,38,477	10,16,735	2,66,23,864	10,37,490	11,39,649
IPD	965348	96676	53482	1095131	80,658	58,623	16,35,538	88,654	60,705
Bed Occupancy Rate	17.94	30.37	23.30	20.35	25	25.53	30.39	27.85	26.44

BLG : Bolangir KP : Kendrapara

4. Ancillary services

Diagnostic services: Routine investigations such Hb, blood sugar, urine are being conducted in most facilities designated as delivery points , better availability at the level 2 and 3 facilities . An additional Labtechnician is available beyond routine hrs for emergency labs at L3 facilities. Laboratory technicians from different programmes have been oriented andmultiskilled for conducting all types of Lab tests.LT at CHC Raj Nagar Kendrapara was conducting >40/day: Investigations for all programmes without any additional support.

Laboratory ,CHC Marshaghai,Kendrapara

Drugs:EDL prepared is not rational and there is a tendency to push high end, expensive antibiotics from the state to the periphery. These were available even in the Sub centres whereas the common antibiotics were available in few quantities or not available. This is due to the lack of a systematic inventory management. EDL was displayed in very few facilities,however only 50% of the listed drugs were available. Non availability of anti-rabies and anti-venomwhich is a concern since snake bites are quite common and stray dogs were ever present in and around the facilities .Record of drugs distributed and expiry registers need to be maintained.

Equipment:The PHCs and CHCs were well stockedwith equipment for care of new born e.g. ambu bag, mask and radiant warmer. However there was considerable mismatch in the availability of delivery kits, Sterilization sets as per the number of cases /day (this was an issue especially in the large number of acceptors for sterilization in the camps seen during the visit to Kendrapara). In Bolangir district, in CHC Ghasian, a heater was used as sterilizer. SDH Patnagarh had boiler for LR equipment's. This can be attributed to the fact that all equipmentare purchased and sent from the state or district arbitrarily without proper gap analysis. Availability of consumables in the lab such as gloves,masks, aprons and disposables is an issue. Sub centres had shortfall of BP apparatus, measuring tape and stethoscope. One positive aspect is the system of maintenance of equipment, whereby the equipment gets repaired easily and timely through untied fund. During the visit to Kendrapara, 60 sterilization cases were lined up, but only about 8-10 sets of equipment were available putting beneficiaries at risk.

Blood bank and storage: The state has 80 blood banks of which 58 are in the government sector; 51 blood banks and 19 Blood storage units are functional in the state. 71 L 3 facilities are conducting C-sections indicating rational distribution of blood banks and blood storage units. InDistrict Bolangir,4 Blood banks are available in the DH, SDH Patnagarh, SDH Titlagarh and CHC Kantabanji and 1 blood storage unit in CHC Saintala. The blood is collected through Voluntary Blood donation camps (50-60%), remaining by replacement. The frequency of Blood donation camps is 4 camps per blood bank. Kendrapara DH has a blood bank with 150 blood bags being issued per month. Collection has been done through 24 blood donation camps. In order to track the availability of blood, the e blood bank

system has been set up for up to date information on availability of blood in all Blood Banks across the state. This is being done through a web based system whereby consumers can access information on the availability of blood through a simple SMS.

5. Supportive services

Running water, electricity, sitting arrangements,security was available at almost delivery points , however availability of generators and inverters was low; however the wards were overcrowded, cleanliness was compromised, toilets not maintained, this in spite of the appointment of Programme managers, MCH coordinators and hospital mangers. High turnover of Hospital Managers is an issue and needs to be addressed.This indicates that monitoring of quality supportive service is weak. Facility level cleanliness services have been outsourced along with security, but this has not been effective since the service providers do not seem to be responsive to the needs of the facilities. General cleanliness of surroundings in the facilities could be better. Hygiene in the toilets need urgent attention. Since gyn wards in most facilities was crowded and space constraint, privacy compromised due to lack of curtains in the wards. Most of the labour room and wards visited were not cleaned regularly and quality of cleaning waspoor.

Waste management and laundry at the DH, Kendrapara is managed by an NGO. Laundry services in the facilities areoutsourced through the RKS. All facilities had good display of IEC material (CHC Patakura of KP) especiallyon maternal health services. Wall paintings include citizen's charter; Doctors duty, ASHA incentives, and other IEC information were displayed.JSSK signage's were yet to be displayed in the appropriate areas.

6. Infection Control measures and bio waste management

Infection control protocols were not in place and even though colour coded bins were available in all facilities segregation of wastes was not being done. Availability and use of gloves, gowns and masks is a problem. In the NewBorn Stabilization Unit in the CHC Pattamundai, the staff within the Unit were not using gloves, masks or gowns, neither were entry of visitors restricted – this makes the admitted sick infants highly susceptible to infections. Autoclaves are available in CHCs and being used; training of staff on autoclaving would be useful. Disinfection of OTs and labour room is weak and not done regularly, fumigation and carbolisation is not being done for Operation Theatres, only wet mopping being done. Bio medical wastes are currently being disposed in burial pits. Although deep burial pits have been constructed at containment area in the SDH Patnagarh in Bolangir and PHC Kutunga in Kendrapara,yet all wastes are being mixed and dumped into the pits. General wastes were strewn behind the labour rooms. Empty vials and used syringes were lying outside the deep pits. Uncovered sewer drains near DH Bolangir were a breeding ground for mosquitoes. Waste disposal pits were available through outsourcing in Bolangir. The outsourcing is done through local persons and adequacy of disposal is a questionable.

Open Drains in DHH Bolangir

Open Deep burial Pit at SDH Patnagarh, Bolangir

Bio medical waste management at DHH Bolangir

7. Cost of care for services

User fee is charged for OPD and IPD and lab services in the facilities , exemptions in place for pregnant women and sick new born , and this was evident during the facility visits , more so following the introduction of Janani Sishu Suraksha Karyakram (JSSK) and for BPL . However, out of pocket expenditure is still being incurred indrugs, (outside prescriptions), diagnostics and referral transport by patients in most facilities. In transport, spending was on hiring of transport to the facility (averagespending Rs. 400-500). In diagnostics this is more so in the level of the larger facility, the District hospital, i.e. Bolangir, where USG machine is out of order and hence spending on USG outside. Another area of OOP is informal fees which was rampant in most facilities including PHCs. Dissemination of information related to the free entitlements (under JSSK) for mother and sick new born was weak and interviews with patients in the facilities show that they were mostly unaware of the entitlement of free drugs , diagnostics and drop back facility.

RECOMMENDATION

- Orientation of Assistant Engineers and Junior Engineers, especially those posted at the district level needs to be undertaken, in consultation with the Programme Officers the programme requirement for new construction, up gradation and maintenance of infrastructure.
- Training of all service providers including lab technicians, pharmacists, Grade IV needs to be done on Infection prevention and bio medical waste handling and management. Display of these standard protocols in the facility needs to be undertaken in all facilities.
- Health Managers in the district, sub district and facility level need to be responsible for quality of care particularly hygiene, cleanliness and sanitation and practising of IMEP and other managerial issues. Supportive supervision and monitoring visits by districts health managers would need to be strengthened.
- Essential Drug Lists need to be prepared specifically for delivery point and non-deliverypoints forenduring rational supply of drugs and displayed in the facilities. Drug

inventory management needs to be strengthened to ensure that drugs are dispensed asper facility wise gap assessment and requirement and not irrationally as is the practise currently. The same principle holds good for equipment.

- Considering the high Out of pocket expenditure on drugs, diagnostics and referral transport , the state should ensure that drugs and diagnostics are available in house and if required certain diagnostic facilities could be outsourced (wherever USG and other such facilities are not available) .
- In order to empower patients to demand their entitlements, wider dissemination of information on the 'free' entitlements for pregnant women and sick new bornshould be done through various fora.
- The practise of payment of informal fees on delivery related services needs to be discouraged and patients need to be encouraged to utilise the grievance redressal mechanism (complaint boxes, help lines) to check such practices.

II. OUTREACH SERVICES

1. Adequacy

The state has 6688 sub centres against a requirement of 10616 SCs.Out of these , 153 SC s have been identified as delivery points ; of these 76 SCs are functioning as Level 1 Delivery points (conducting over 3 deliveries per month). There are 7082 ANMs against a sanctioned strength of 7607 positions, and 1043 second ANMs against sanction positions of 1696, altogether being 8125ANMs. The criteria for deploying the second ANM being a population of over 3000 in tribal areas and over 5000 in non-tribal and coastal areas and also in all delivery points. Area / population demarcation is done for both the ANMs in non DP. In DP, second ANMs are responsible for outreach services, while the first ANM is to be based in the facility. ANMs in all delivery points visited were SBA trained.

- The services provided under the sub-centres are village health and nutrition day services and routine immunization services on separate days.
- No of SC visited four in Kendrapada and five in Bolangir of which two were delivery points
- Out of three SCs identified as delivery point in Bolangir only one SC was fulfilling the norms of delivery points. In Kendrapada similarly one SC was not performing as delivery point.
- Even the SC with 2 ANMs was not opening the sub centre and there is no defined OPD timing displayed.

1.1. Infrastructure, equipment, drugs at Sub Centre's

The required Infrastructure for delivery points was not available. Jogimunda SC at Bolangir conducted about 40 deliveries per month was functioning in one room. The villagers had given more than one acre of land and the district CMO was advised to prepare and submit a plan for SC and staff quarter in this financial year. Similarly, SC Damarpur in Kendrapada district was also a delivery point

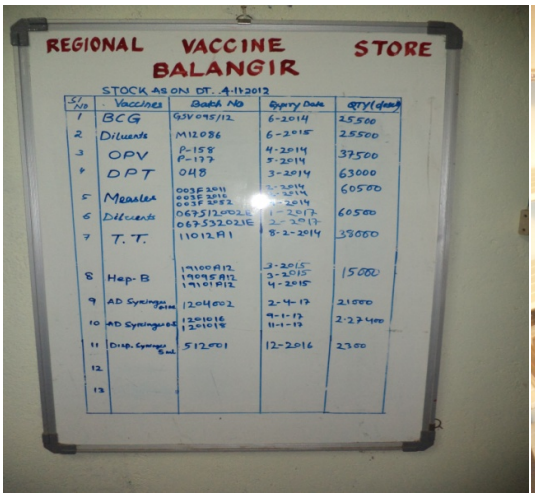
functioning in one room without the toilet. Infrastructure of non-delivery point SCs were by and large adequate and all visited SCs were functioning in government building except Manikapur (functioning in AWC) and Pareshwarpur SCs having only one room in Kendrapada.Due lists and untied funds were available along with annual maintenance grant-AMG at delivery points.Records and registers were maintained very well in both districts except the SC Pareshwarpur (BLG).

- Almost all SC were having only one ANM except Desil SC – Non delivery point (Bolangir) which had two ANM. It was difficult to manage the SC with one ANM.
- Medicines including IFA, ORS, and Vitamin A were available; at some SC like Jogimunda (Bolangir) and Manikapur (Kendrapada) high end antibiotics like Cephaxime besides other antibiotics were available probably pushed from the higher centres.Zincis not available in any centre.
- Availability of Oral pills, condoms were seen in almost all SCs although the supplies were not done as per the demand e.g. Desil SC. However IUDs were neither available nor inserted since ANMs were not trained.
- IUD availability and facilities were not there at any delivery points since ANMs were not trained. However at the Jogisurada, Bhadra and Desil SC under Bolangir are trained in IUD and SBA. IUD was not availability at all SCs however the Bhadra could get it through mobile messages Contraceptive Logistics Management Information System-CLMIS established with the support of UNFPA.
- Equipment like BP instruments, Haemoglobinometer, Uristix, and Accucheck were available in most of the centre. Blood pressure was measured. However, their confidence for conducting test like blood glucose, Hb testing, urine testing was not adequate, except SC Jogimunda, Bhadra in Bolangir conducting accurately and with confidence.
- ANC, PNC at SC were mostly not done and was conducted mainly during the VHND.
- Even though state introduced the system of incentivising ANMs @Rs. 250 per delivery along with a hardship allowance of Rs. 200 per month for conducting home deliveries in 182 Sc areas located in most difficult areas (V4), yet home largely not done except in Bhadra SC in Bolangir (30% home deliveries in Bolangir, AHS, 2010-11).
- ASHAs trained in Home based new born care are undertaking home visits in Bolangir(where training in home based new born care has been rolled out on priority as a high focus district) but this is yet to take off in Kendrapada since it is a non-high focus district.
- Separate line-listing and follow-up of severely anaemic women not being maintained.
- Although ANMs register for MCH was maintained at most of the places but registration through MCTS and service delivery linked to MCTS were not being undertaken. Generally the registration was late by one- two months and the ANMs and ASHAs were not motivating the women for registration within 12 weeks.

2. Immunization

- Routine Immunization sessions are held on Wednesday as per the micro-plan and due list is available .Cold chain is maintained well in all ILR points visited. Registers and records were maintained well at all centers visited. The preventive maintenance is not done quarterly as expected at all the facilities. The vaccines were adequately available at all centers visited. Vaccines were transported through alternate vaccine delivery.

- Supervisory visits are undertaken by AYUSH medical officers.
- Analysis of drop outs is available at the district level though SC wise drop out lists would be useful to track left out and drop out children



Regional Vaccine Store at Bolangir

Walk in Cooler at Regional Vaccine Centre Bolangir

3. Village Health and Nutrition Day- VHND

- VHND is being organized on Tuesdays and Fridays of every week held regularly as per the plan and due list with the help of ANM, ASHA, and AWW. The VHND were providing , health check-up and referral services, health and nutrition education is also provided for all women in the age group (15 to 45 years), family planning counselling and distribution of contraceptives, symptomatic care and management of persons with minor illness are being treated at VHNDs in Kendrapda.In addition to the above VHNDs also register the births and deaths.
- The MPW (M) worker chlorinates water sources and wells in Kendrapada however the same is compromised in Bolangir.
- Almost all VHND visited were being conducted in AWC. But due to lack of adequate infrastructure in the AWC, examining thepregnant women with privacy was an issue.
- Lack of Mother and Child protection card was affecting the record keeping and tracking of pregnant women for ANC. Photostat copies of MCP cards were available with a few women in the VHND in Kendrapara. Safe Motherhood booklets were not seen in the facilities.
- IPC and counselling on the benefits of JSSK and JSY could not be seen at the VHND organized.

4. Menstrual hygiene

- ASHAs effectively under taking social marketing of the sanitary napkins provided for the menstrual hygiene and sanitation program for adolescents girls in Kendrapada. Interactions with the adolescents indicated napkins being used and are high in demand. Generally quality

of napkins were satisfactory, however some of them wanted more number of pads in one pack.

- Weekly IFA supplementations are being done in both districts .The IFA and Albendazole stock available at AWCs. The WIFS training was completed for all FLWs .The WIFS tracking registers well maintained in all centres visited
- Supervisory visits were done regularly along with the check lists mostly by AYUSH doctors

5. Referral services and Ambulance/ Mobile medical Units

- State has Janani Express- JE vehicles, ambulances and empanelled vehicles and providing home to health facility and drop back services to beneficiaries. The JE and Govt. ambulances are placed at the ratio of 1:50,000 population in the state whereas in Bolangir the same is 1:40,000 and in Kendrapada it is 1:70,000. The JE vehicles were mostly placed at L2 and L3 with geographical mapping
- The outreach coverage by JE is at varying degree largely because lack of adequate IEC and awareness by the beneficiaries and PRI members.
- The response time for reaching is also not satisfactory as conveyed by the clients and in some cases more than one hour is taken.
- Call centre functioning in the district is not professionally managed resulting in delayed response. Records for drop back are not maintained.
- ASHAs have the information on the contact numbers of the vehicles, but not the beneficiaries and hence this affects the access to services. There is a need to introduce 102 toll-free numbers through centralized call centre.
- Mismatch in coverage and services :At Patkura CHC (Kendrapada) in the month of April 70 deliveries were conducted and total kilometers covered in a month was 3500, which needs to be further examined.Monitoring and supervision particularly on the response time, optimal utilization, and other quality parameters is required urgently.

6. Mobile Health units-MHU

- State has 354 mobile health units(240 under NRHM and 114 from State budget)functioning 2 MHUs allocated to each tribal/ LWE/KBK blocks . One MHU in hard to reach areas of Bolangir District providing outreach services. This is being managed by Govt. staff: 1 AYUSH MO, 1 pharmacist, 1 ANM and 1 attendant and moves in the villages for 22 days as per the fix-day schedule and currently providing routine screening however linkages with PHCs, CHCs on referrals and follow-up is not adequate
- It is envisaged that MHU will cater to only those villages which are situated more than 2 Km away from the functional facility
- The distant hamlets from where the PW are not able to come during VHND are also being served
- However there is a need to undertake quick analysis for linkages with VHND and SCs on provision of services particularly to pregnant women, adolescents with clarity of roles for each other including MHU is not clear .

7. IEC/ BCC

- Weak and the beneficiaries did not know their entitlement and benefits under JSSK, including free transport and mechanisms for grievance redressal.

Positive features

- Improved availability of contraceptives in the SCs due to procurement enabled through Contraceptive Logistics Management Information System-CLMIS established with the support of UNFPA.
- System of supervisory visits of VHNDs through AYUSH MOs.
- Effective utilization of VHNDs for registering vital events
- Good response and demand for sanitary napkins under the menstrual hygiene scheme due to the active promotion by ASHAs

RECOMMENDATION

- For outreach coverage, Geographical division should be for both the ANMs and SCs should be opened both in forenoon and afternoon.
- Purpose of VNHD is defeated by holding immunization on separate days and hence it needs to be held on the same day.
- Infrastructure up gradation required in SCs - toilet facilities for delivery point SC.
- Line-listing and follow-up of severely anaemic women to be done; early registration of ANC and full ANC checks to be ensured through VHNDs and SCs.
- Mother and Child Tracking system (MCTS) needs to be utilised for tracking of cases and improving coverage to pregnant women and Infants.
- Bottlenecks in the supply of MCP card needs to be resolved and all women to be issued the same forregistration of ANC at any facility including PHC without referring them to the nearest VHND. Safe motherhood booklet also needs to be issued.
- IPC and counseling on the benefits of JSSK needs to be done during VHND.
- Benefits of JSY including microplan with focus on registration within 12 weeks, completing all ANCs and identification of transport should be ensured
- A quick analysis on quality of napkins and any problems related to it could be undertaken and feedback given to GOI.
- Convergence between health and WCD to be further strengthened for ensuring privacy and examining facilities for PW at AWC.AWC to be strengthened for privacy and ANC check up in terms of space, examining facility etc.
- The preventive maintenance need to be done quarterly as expected at all the facilities
- SC wise drop out lists would be useful to track left out and drop out children.
- A professionally managed call center with 102 toll free number needs to be established for better availability of referral transport. There is a need to rationalize the number and location of the vehicles. A nodal person / or team needs to be set up for monitoring the system and for analyzing the percentage of calls attended for facility and drop back for both district and state; analysis of the time of call and time of reaching a facility can help study

the delays in seeking health care in the state.Focused IEC for informing public on availability of different transport under JSSK.

III.HUMAN RESOURCES FOR HEALTH - NUMBERS, SKILLS, PERFORMANCE

1. GOOD PRACTICES

Manpower status

The state has 67% gynaecologists in position, 48% paediatricians, 98% surgeons and 74% Medicine specialists. However, only 31% anaesthetists are available. Additionally 38 MOs have been trained in EmOC and 115 in LSAS. In Bolangir in the 5 Level 3 facilities, anesthetist was available in the DH, in SDH Titlagrah , an LSAS trained MO was in place but not performing. In all of the 4 L3 facilities anesthetists are on call.

Table 3.2.: Manpower details

Sl. No	Category of Specialists	Sanction	Position	
1	O & G	514	344	
2	Pediatrics	377	182	
3	Anesthesia	87	27	
4	Surgery	243	237	
5	Medicine	245	181	
Sl. No	**Category of Posts**	**Sanction**	**Position**	**Vacancy %**
Regular				
1	Staff Nurse	2124	1672	21.28
2	Lab. Technician	875	607	30.63
3	Radiographer	235	117	50.21
4	Pharmacist	1945	1814	6.74
5	MPHW (M)	4729	2948	37.66
6	MPHW (F)	7607	7082	6.90
Staff under NRHM (Clinical Staff)				
1	Addl . ANM & Staff Nurse	2675	2022	24.4
2	Laboratory Tech.	112	112	0

1.1. Creation of Special Secretary (Technical) position: Odisha has created a position of Special Secretary (Technical) to oversee the technical aspects and capacity of the health staff in the state. This new position needs to be in sync with the Human Resource unit for better distribution of the technical manpower in the state.

1.2. Leveraging on technology: The state is one of the pioneers in the country to leverage technology to manage the human resource. Odisha has an online Human Resource Management Information System (HRMIS) with database of all the health staff (contractual and regular) and health institutions in the state. Odisha also initiated a procedure to develop online software called ITEMS to assess service delivery of trained manpower.

2. Strategies for retention of manpower: The state has introduced various strategies for retention of staff which includes up-gradation of post, Financial and other incentives, professional growth, exposure visit etc. As part of retention policy the state has upgraded the entry level Class II rank of Asst. Surgeon to Junior Class-I (Rs.15,600/- to Rs.39,100/- with GP Rs.5,400/-). The retirement age of regular doctors has been enhanced from 58 years to 60 years. Additionally KBK & KBK+ allowance introduced for doctors for Rs.8000/- at periphery and Rs.4000/ at district & sub district Hqrs. The state has also introduced/ enhanced various allowance for doctors including increase of specialist allowances from Rs. 150/- to Rs.3000/- and introduction of postmortem allowance to all doctors of Rs.500/ per case. Visit to facilities in Bolangir , a KBK district shows that these strategies seem to working ; even in non delivery points in Bolangir,2 MOS (1 AYUSH) were posted and 2-3 SNs were seen in most facilities in Kendrapara and Bolangir.(details on various forms of retention strategies adopted by state is provided in Annexure 2)

- Under AYUSH , 672 Ayurvedic MOs,580 Homeopathic MOs and 5 Unani MOs are in place . AYUSH MOs collocated in PHCs have been trained in SBA and 74% of the trained MOs are conducting deliveries . They have been trained in IMNCI , Immunization, NVBDCP and RNTCP .
- The state has adequate support staff like ward boys/ ayas, administrative staff and cleaning staff recruited through the RKS. The FRUs in the state are being provided an additional recurring grant (apart from AMG, RKS and UF) for non clinical service. However the cleaning staff is not being utilized for maintenance of hospital hygiene and sanitation activities.

3. Strategies for performance review system: The state has a structural procedure of annual performance assessment of all staff engaged under NRHM. Odisha has also developed procedures to assess the performance of LSAS and EmOC trained doctors. Based on the result of performance assessment one of the LSAS trained MO from the state has been awarded at national level for outstanding performance. However implementation of the performance review system may be better. The planned performance review is done as follows:

- **Composite indexing-for the district:** In order to encourage team work and better performance against PIP target, Performance incentive as per composite index gradation was done during 2011-12 at district level. The Composite index format consisted of major performance indicators from programme, finance, M&E and civil. Under this

scheme the amount of PI was decided as per district performance based on the achievement against the target.

- **Review meetings:** Review of DPM, DAM, DHIO, DMCH, Asst.Eng. on monthly basis by State and the same mechanism is also followed at district level for review of block level personnel viz.,BADA, BPO, MIS coordinators. CDMO conference is being conducted on quarterly basis by commissioner cum secy, health for review of all districts.
- **Performance Appraisal System:** Based on performance of each individual against the task assigned performance appraisal is being done at block, district and state level contractual employees. It is done both Quarterly & Annually leading to payment of performance incentive and renewal of contract at all levels. The format is enclosed herewith as annexure.

4. Availability of staff for L3 delivery points: In the state out of total 8429 health facilities, 700 facilities as identified delivery point of which 145 are identified L3,**however 75 of these facilities do not conduct c-section.** By definition, 70 facilities could be termed as L3, as per standard the minimum HR requirement for these facilities would be 70 O&G, 70 Pediatrician, 70 Anesthetist, 70 Lab technicians, 280 MOs and 630 SNs. The state has enough manpower to saturate all of these 70 facilities, with 344 O&G, 100 Anesthetist or LSAS trained MO, 182 pediatrician, 3694 staff nurse and 607 lab technicians. However the appropriation of staff in the state is an issue and discussed in the weakness section.

The state is in process of establishing a Public Health Directorate to provide optimal primary health care to the community. An exclusive public health cadre will ensure a dedicated team of doctors, paramedics and public health managers with scientific public health knowledge and commitment for preventive occurrence of diseases, protecting health through specific interventions, promoting healthy life styles, and better epidemic and outbreak management.

The state has approved the establishment a Nursing Directorate (in-principle) for service and public health nurses. This will ensure better career opportunity for the Nurses and Nursing Administration in the State. To strengthen the capacity of the nursing cadre, the state has planned for 1 GNM and 2 ANM training centers. Further to improve the quality of clinical learning in nursing/ midwifery education the state has collaborated with the Nottingham School of Nursing, Midwifery and Physiotherapy for faculty development.

As per the conditionalities led out in the ROP 12-13, the state had to create a separate public health cadre. The state has a created a separate Directorate of Public Health. Policy decision has been taken for creation of separate public health and nursing education cadre.

- In Kendrapara in-campus residential quarters for doctors and staff nurse were available at CHC Pattamundai and Raj Nagar .

- Active involvement of AYUSH MOs in conducting institutional deliveries, participating in school health check ups and monitoring of VHNDs and immunization.

OBSERVATIONS

1. Healthcare post vacancy: The state has 33% of vacancy for OBG 69% for anesthesia 52% for Pediatrician, 30% Lab Technician and 21% Staff Nurse. Similarly Bolangir has 27% vacancies for doctors and Kendrapara has 45% vacancy for doctors. The state has a plan to create 16,342 new positions for staff nurse, HW(F), Radiographer, LTs and HW(M), but do not have enough training institutions to meet the current manpower demand and the envisaged HR plan.

2. Rational deployment of manpower: Odisha has 700 identified delivery points facilities, out of which 145 are identified L3, however only 70 of these facilities conduct c-section. The state has enough manpower to saturate all of these 70 facilities, with specialists, MOs, staff nurse and Lab Technicians. However 4 of such facilities do not have any O&G or EmOC trained, 15 do not have any pediatrician, 20 do not have anesthetist or LSAS trained and 35 facilities have less than 9 staff nurses.

Although the state does not have a transfer policy , they have planned for appropriation of staff. In Odisha 63% of the deliveries are held in L3 facilities, 34% in L2 and 2% L1 facilities. The distribution of specialist (including O&G, Ped, Anth and EmOC & LSAS trained) in position across the delivery points is 69% specialist in L3, 29% L2 and 1% L1. In Kendrapara, the distribution of specialists is skewed with a large number still being retained in L 2 facilities :e.g. 40% of the specialists are placed in L2 with 28% delivery load whereas 60% specialists are placed in L3 for 72% delivery. More specialists from L2 could be apportioned to L3 facilities:

Table 3.3: Sanction of manpower based on functionality of health facility

Identified delivery point	ORISSA		KENDRAPARA		BOLANGIR	
	% of delivery	%of specialist in position	% of delivery	%of specialist in position	% of delivery	%of specialist in position
L3	63	69	72	60	78	81
L2	34	29	28	40	20	19
L1	2	2	0.4	0	2	0

L : Level 1,2,3 Delivery points

In Bolangir district, the District Hospital conducts more C-section than the whole of the other district health facilities since rationalization of the staff in the district has not been done, neither there is any comprehensive plan for such rationalization. Same is the situation of personnel trained in other trainings like SBAs, IUD, NSSK, etc. For Eg AYUSH MO trained in SBA, in Belagaon PHC, does not conduct deliveries despite having facilities for the same.

3. Functioning of HR Unit: The state has a dedicated HR unit (State Health Resource Management Unit) headed by officer in the rank of Joint Director. However, the unit does not know the posting

place of HR and neither do they have record on performance monitoring.This unit should contribute more towards state HR planning and rationalization of resources.

4. HR strategies vis-à-vis implementation: The state has various strategies for HR development, including performance appraisal, retention and promotion. The HR hired against different posts are not being optimally utilized as per the requirement of the programme. They feel their responsibilities areconfined to submission of information required or routine dispatch. For e.g. none of the data managers are analyzing the data as per programme requirement and their job is finished on submission of data. There are such examples against each post.

5. Supportive Supervision: The supportive supervision in the state is weak, there is a checklist developed for state level supportive supervision, but no checklist was found at the district and block level. Additionally proper records of proceedings of the supportive supervision visits were not available.

6. Confidence of contractual staff under NRHM: Salary structure of the staff and their annual increment should be at par and consistent within all programmes and hike is not differential based on strict and transparent appraisal resulting in de motivation for those who are high performance.

The contractual staffs under NRHM have low confidence on job security, especially the contractual staff nurses who feel that they would not have any job once NRHM is over. Some of the NRHM staff nurses have migrated to the Odisha state contractual positions where the provision is to accommodate the nurses as permanent with seven years of contractual service. The PMU staff is equally low on confidence regarding their job security due to their job contract which is renewed every eleven months.

RECOMMENDATIONS

- Rationalization of postings :Since only 8% of the total facilities are functioning as DPs, rationalization needs to be done by Posting the HR from Non performing facilities to the performing facilities e.g. MOs trained in like LSAS and EmOC needs to be posted at L3 facilities from non functional units on priority.They should be assigned for performing the designated specialty rather than performing general duties.
- HRMIS should be used for HR planning and not just as a database of the manpower. The state HR unit needs to play an active role in the HR planning

IV . REPRODUCTIVE AND CHILD HEALTH PROGRAM

Table 3.4.: Indicators of Health

Indicator: HMIS (Apr- Sep 2012)	**Orissa**	**Bolangir**	**Kendrapara**
ANC registration against expected pregnancy	37	38	34

Institutional delivery against estimated delivery	32.5	33.8	29.5
Still births per 1000 population against reported live births	54	62	34
Fully immunized child against expected life birth	38	34	35
Fully immunized child against reported live birth	101	87	113

Good Practices:-

- In the two districts visited, the Delivery Points (DPs) were geographically well distributed.EDL prepared for the facilities. Equipmentwere adequate at DP. Almost all DPs had SBA trained persons in labour room.
- Analysis of maternal deaths is being done at the state level which is a good initiative.
- The quality of established blood banks at both Bolangir DH and SDH Patnagarh is very good.
- Almost all delivery points had functional New Born Care Corner.
- There is assured referral transport through Janani express, Empanelled vehicle and Govt ambulances.
- Facility based web enabled software initiated for tracking of discharged SNCU cases and their follow up at Bolangir.
- Cold chain maintained very well at all levels. All centres visited have adequate cold chain equipment
- The routine immunization services are provided in all centres and outreach as per the available micro-plans. Services provided every Wednesday at all levels. ANMs were trained in immunization and AEFI.
- JSY Payment through cheque and mostly it is current subject to beneficiary submitting the required document.
- Oral pill demand is high across the Bolangir district, and SCs have reported stock outs and presents an opportunity for spacing.
- Contraceptive Logistics Management Information System being used at some health facilities is a good initiative and needs up scaling
- LTs were being utilised optimally and comprehensively

Observations:-

Delivery Points: The DPs have been planned by taking into consideration the delivery load of institutions at the state level; however districts involvement in planning was lacking. Comprehensive planning for saturating DPs for SBA, NSSK, IUD, Minilap, BEmOC, IMNCI, and FIMNCI was not available in both districts. None of the DPs were providing comprehensive RMNCHA+ services.

- Rational distribution of the trained manpower and capacity building of the staff was an issue. Infrastructure in all the health facilities visited was good, however staff quarters were inadequate and not well maintained.
- Total 5 FRUs were there in the Bolangir district. The numbers of CS are more at Bolangir DH since rationalization of the staff at other places has not been done. 4 Blood banks are available. Mostly the blood is replaced by Voluntary blood donation camps (50-60%), remaining by replacement. The frequency of blood donation camps is 4 camps per blood

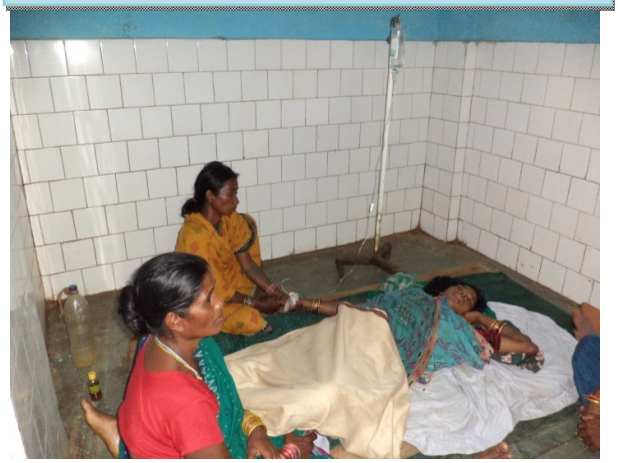
bank. The unit of blood required for C section and other maternal complications is around 30% of total C – Section.

Services under delivery Points

Maternal Health

- All the DPs were conducting deliveries in large numbers despite HR constraints.
- Caesarean Section were being conducted in 4 out of 5 in BG and 1 out of 7 in KP.
- LSAS and EmOC trained doctors were not paired and posted without any plan even at the facilities which were not FRU.
- DH Bg needs a separate electricity back up, generator.
- Irrational prescriptions were less in numbers and drugs available in the HF were being prescribed.
- Technical knowledge and skills of the staff needs to be upgraded, e.g AMTSL was initiated without giving injection Oxytocin and waiting for the signs of placental separation at Kp, Partograph plotting was incomplete.
- High risk pregnancies are being tracked, however implementation is inadequate and the technical skills of the staff as well as ownership to handle is lacking.
- Referral in and out registers were not being maintained.
- Severe Anaemia tracking is inadequate.
- VHND and Immunisation days are on different days i.e Tuesday and Wednesday respectively, is a cause of concern that the mothers have to come twice in a week.
- A pregnant woman is registered only at the AWC and not at any other health facility.
- The MCP cards were in shortage and photocopied cards were being used.
- Shortage of IFA tablets, Magnesium sulphate across the districts.
- Special care units eg: Eclampsia Room in DHH Bolangir requires provision of adequate facilities and equipments to provide quality care to patients.

Patient lying on floor in Eclampsia Room at DHH, Bolangir



Child Health

Out of total 30 districts, 21 SNCUs are functional in 16 districts. SNCU has been established at DH Bg but not at DH Kp.

- SNCU has recently been established in Bg DH, usually double occupancy. Demand is very high. It was new SNCU, well equipped. However there were some teething problems and staff training requirements. SNCU death rate is as high approx.14% and it was heartening to observe the lifesaving treatment been provided to premature babies, asphyxia management and other complications being attended.
- At Kendrapada district hospital there was a well-established pediatric ward, but no SNCU.

- Neo natal mortally is still high at SNCU in the Bolangir and one of the reasons may be inadequate training i.e only 4 days for SNs and MOs on duty. Even pead needs reorientation on latest technical protocols.
- Toilets and bathrooms of SNCUs were extremely dirty, giving chance for the spread of infection and needs priority attention. Proper hand washing facilities were not available.

Uncut Needles in theHub cutter at CHC Ghasian,Bolangir

- On the day of visit there was restlessness in the public, as there was twoneonatal death in the SNCU, on detailed review it was found that there was shortage of Pead/MO and also inadequate training/orientation of the staff posted in the SNCU.
- Similarly in Bg, NBCC established in LR but neither the paediatrician nor the MO or senior staff ever monitors the proficiency of staff on duty.
- CHC Patamundi in Kendrapada had a pediatrician and new functioning NBSU.
- A large number of neonatal deaths were due to low weight at birth. There is recording of neonatal, infant death but however there is a need for a review of deaths.
- NBSU in SDH Titlagarh was underutilised and NBCCs were grossly underutilised. Infection prevention protocols were not followed in the NBSU in Kendrapara .

Adolescent Health

- Bolangir does not have ARSH program.
- Kendrapada had a well-established ARSH program. The CHCs had space for Adolescent Friendly Health Clinic-AFHC in Kendrapada
- Menstrual Hygiene in Kendrapara:- Sanitary napkin available and good response from the community, Good register keeping for WIFS.

Immunization

- Immunization services are very good along with well-maintained cold chain .Immunization registers are updated and arrangement of logistics as per the Micro plan are done.
- Routine sessions monitoring is done through AYUSH doctors using checklist.
- Preventive maintenance is not happening in a quarterly frequency.
- At the outreach centres, though colour coded bags have been given to the FLWs the usage seems to be rare.
- The SCs have an updated MCTS register except Jogimunda and Bhadra in Bolangir most of them do not take any efforts to track dropout children.
- Bg also has good vaccine and logistics management system with well-maintained walk in cooler.
- State has high IMR although declining, but their NMR is by and large constant.
- Hub cutters utilisation and other waste management procedures needs to be strengthened

Safe Abortion Services:

- Four doctors has been trained in MTP and been placed in 4 facilities out of 18.(DHH Bolangir CHC, Kantabanji,CHC Loisingha,SDH Titlagarh). However only one institution is providing Safe abortion services and two private institutes are accredited for providing CAC services.
- The District level committee is in place for certification and regulation of Private sector providers for safe abortion services. Two private health facilities have been accredited for providing CAC services.
- Safe abortion services and RTI/STI are not being provided comprehensively as per the level of the facilities. One of the reasons being lack of linkages between utilisation of trained manpower at the facilities performing as DPs.
- In Bolangir- A lot of cases of incomplete abortion cases were recorded as the incidence of self-medication are high. There is a need to increase the availability of safe abortion services at the government health facilities.

Family Planning services:

- In Bolangir , most of the ANMs were trained in IUD insertion except in Jogimunda SC, however IUD insertions were not taking place.
- The demand and retention rate was very low in Bolangir, due to reported pain, bleeding and discomfort.
- In Bhadra SC, ANM actively uses Contraceptive Logistics Management Information System-CLMIS and her demands were met without delay.
- Sterilizations are being done in camp mode and IUD services are limited.
- Inadequate numbers of sterilised sets of equipment during camps.
- Fixed day FP, and ARSH clinics are not being held as separate clinics rather services were being given through routine OPD.
- FP counselling was weak. A counsellor has recently been appointed in the districts.
- ASHA home to home contraception scheme has picked up in the districts.

Referral transport:

- JE+ Govt ambulance coverage is 1:50000 at State, 1: 40000 in Bg, 1: 70000 in Kp. In Bolangir a separate district level call centre is available. The record maintenance is poor and needs to be maintained.
- Mostly ASHAs are aware of the number. However there is a need that the number is prominently displayed at various positions and is well advertised.
- As per the plan the vehicles are located at PHCs and CHCs for covering radius of 15 Kms and timeline of reaching within 30 mins of call.
- However on interaction with clients it was indicated that coverage of 50-70% from home to HF and <40% drop back.
- Monitoring of referral is not being done at any level for its timeliness, optimal utilization, functioning of call centre etc. For eg CHC Pattkura in Kp has 70 deliveries in a month and Km booked was 35000, i.e 100% coverage

JSY:

- 48 hrs stay is not being adhered, however at the facilities 24 hrs stay is ensured to facilitate JSY payment.
- No complaints received on wrong payments.

- Mandatory 10% checking of JSY beneficiaries not routinely followed.
- Microplan, registration within 12 wks, identification of transport etc is not being done due to late registrations.
- However outreach services like VHND are identifying high risk cases and referring to higher facilities.
- At some of the PHCs: ANCs were referred back to VHND, since MCP card was not available.

Janani Sishu Surakhsha Karykaram For Pregnant Woman:

- Has been implemented at all DPs.
- Drugs are being given to more than 90% of the PW at the facilities visited.
- Routine diagnostic services are available upto L2 facility and emergency diagnostic at DH expect CHC Saintalla where diagnostics were being charged.
- Sonography were being referred to private clinic and no mechanism for reimbursement
- Home to Health facility transportation is being availed by 50-70% of women, however drop back is up to 40-50%
- Blood is available free of cost
- No user charges
- Diet being provided at most of the facilities.

JSSK for Sick neonates

- Overall focus on JSSK entitlements on sick neonates is poor.
- Drugs and consumables being provided as per the availability.
- Diet being provided to the attendants
- Investigations not even being prescribed as per the required protocols
- Awareness of beneficiaries on free transport is poor and as such there is no demand.
- IEC is limited to few hoarding and no awareness campaigns through mass media.
- Similar is the fate of Grievance redressal, although GR box is present at the DPs.
- Drugs for sick new born were being charged in the NBSU in CHC Pattamundai , Kendrapara. Attendants were not aware of the free entitlements since the IEC materials materials were put up recently.

Out of pocket: Expenses under JSSK was limited to 10-20% ranging the expenses on drugs, transport and in some instances money given to service provider, e.g PHC Ramnagar where nurse refuse to attend to delivery till she is paid Rs 1200/-. Since Amount was not paid PW was given slip amounting to the same amount.

Maternal Death Review:

- Maternal death review has been initiated however there is a need to establish programme linkages. The MD forms are available and filled, however incomplete information is there. Both Maternal and infant death reviews need to be linked to corrective actions, which was missing.

RSBY:

- Both APL, BPL PW have free entitlements for INC under JSSK, however some of the drugs being purchased are booked under RSBY.
- There is no accreditation system for RSBY facilities resulting in compromised quality of services

Nutritional Rehabilitation Centres:-

Infrastructure:

- The state has established 16functional NRC. NRC was present both at Bolangir and Kendrapara. The NRC at Bolangir has been inaugurated recently on 2nd November 2012.A nutritionist Cum Counselor has been posted and trained on NRC.1 Doctor and 2 cook cum attendant and 1 sweeper has been posted.

Table 3.5: Status of NRC at the state level

Baseline (11-12)	Target (2012-13)	Achievement (12-13)	Under Progress	Remarks
7	33	9	28	• Cum. Target-44 • Civil works delay

- Infrastructure available for NRC in both districts. Training of staff in the final stage of completion. Guidelines and protocols for NRC developed.

Quality of Care: No information available as NRCs are yet to be fully operational in both the districts.

Utilization:

- In Kedrapada only four SAM cases were registered, with an average stay of 15 days per episode. The patients were discharged early as the staff had to undergo training and no staff was available at the center.
- The staff orientation and 3 days training were completed only a day prior to the review team visit. Due to lack of training of the newly recruited staff, none of the records and protocols were maintained.
- AWW were not aware of NRC in the Bolangir; In AWC and SC growth monitoring records were not being maintained or were incomplete

Referral and Follow-up

- At the VHND (refer Annexure 1: field notes VHND, Kendrapada and Bolangir), children are weighed (using salter scale) and severely underweight children are screened and referred to Pustikar Diwas (at the CHC level held every 15th of the month) for nutrition counseling and medications. Only those with severe complications are referred to NRCs. Frontline providers (ASHAs and AWW) play an important role in screening. In Kendrapada frontline providers have not been trained and are not maintaining records of growth charts. In Bolangir AWW is maintaining growth charts but their plotting in some cases are not accurate.
- At present there is no systematic mechanism in place for following up SAM children at the community level.

Supportive Supervision:-

- There is a state level team for Supportive supervision however the districts lack a definite supportive supervision plan for RCH Services by the district level teams.

Recommendations:-

Service Delivery:-

- Service delivery and follow up for ANC/PNC/ immunization & Infants linked to MCTS must be undertaken.
- MCP card to be issued for registration of ANC at any facility including PHC without referring them to the nearest VHND. Safe motherhood booklet also needs to be issued. Joint MCPC to be maintained properly and used as a tool for monitoring and providing services. SC wise drop out lists would be useful to track left out and drop out children. Separate line-listing and follow-up of severely anemic women to be done
- Planning of equipment should be linked with training of service providers
- Every district hospital should have efficient casualty services for handling emergencies and trauma with necessary drugs and resuscitative equipment
- The preventive maintenance of equipment need to be done quarterly as expected at all the facilities.

Referral Transport:-

- A professionally managed call center with 102 toll free number needs to be established.Need to rationalize the number and location of the vehicles. Analyze the percentage of calls attended for facility and drop back for both district and state. Analysis of the time of call and time of reaching a PHF can help study the delays in seeking health care in the state. Focused IEC for informing public on availability of different transport under JSSK.

Infection Prevention:-

- Infection prevention protocols and bio medical waste disposal should be seen as one continuous activity and not stand alone. Repeated orientation and daily facility based monitoring is needed for its implementation
- Adequate numbers of equipment for delivery, sterilizations and other operative procedures be made available as per the case load to all DPs performing surgeries. Pre sterilized equipment needs to be kept before each procedure

Supportive Supervision:-

- Although the information/data is available with the state/district, still the MCH coordinators and other programme officers at the district level needs to analyze using the available data for strengthening delivery points. District officials and program managers need to be oriented on the concept of DPs and monitoring points for respective programs on priority. e.g. the District Health Information Officer of Bolangir was not responding on the data, facts and figures during CRM briefing and had never done any analysis despite handholding by district officials.

RSBY:-

- Instead of all govt HF providing RSBY services, only those providing good quality services should be accredited.
- Need to provide free services to the Pregnant women irrespective of being RSBY beneficiary or not. Moreover the amount for Normal delivery and CS should not be booked even in case of RBSY beneficiary.

TOR V: DISEASE CONTROL PROGRAMMES

5.1.Integrated disease control programme

- Recording and reporting of data is better and nearly 60% of the reporting units are reporting on time.
- However, there is vacancy of 24 district epidemiologists, 7 districts managers and 5 data entry operators in the state. The man power requirement is essential for operational units at all levels. The quality of data needs to be improved.
- In absence of adequate manpower, quality of data availability and analysis is hampered.
- Generation of data on out breaks, alerts are available in both Bolangir and Kendrapada district surveillance units.
- OPD data collection from major hospital needs improvement.
- In Bolangir district, 3 units are persistently defaulting in reporting. (In the year 2011 & 2012 , the default reporting units are Sindhekela, Turekela, & Khaprakhol) Being an under developed district, persistently defaulting units lead to incomplete data collection and even timely outbreak reporting.
- Kendrapada district is reporting 100% completeness and timeliness of the report for the year 2012 in all the 3 forms which needs to be cross checked [The surveillance unit is functioning without the district surveillance medical officer and the rapid response teams(RRT) constituted does not have any epidemiologist and microbiologist]. The analysis of the data is very limited and there is no effective mechanism to cross check the data received. The facility for video conferencing is there but could not be utilized due to shortage of staff. Also there is a poor linkage between the State surveillance unit and National surveillance unit.

5.2.Vector borne disease control programme

- State has shown commendable progress as regards malaria control.
- Positive cases have decreased by 20% and deaths by 30% (2011 Vs 2012 by September)
- 38 lakh LLINs have been distributed in 21 clusters of 26 districts (around 85 lakh Population protected)
- State specific guidelines for LLIN distribution have been followed.
- Cluster approach and distribution through GKS has been implemented.
- Documentation of the processes & best practices are in place.
- Special BCC campaign for the LLIN distribution has been held.
- In Bolangir, District Hospital, 2 SD Hospitals and Area Hospital are not submitting the monthly reports to the DMO regularly. Moreover, the reporting is not in the proper (M4) format. This is a serious lapse as majority of serious and complicated cases of vector borne diseases are attended by these hospitals. Non- reporting of cases may lead to erroneous VBD picture of the district.
- Quality of IRS needs to be improved across the state. Monitoring of IRS activities is suboptimal which results in lower quality of IRS.

- In Bolangir, expired Anti-malarials were found in some peripheral health facilities. Judicious distribution and relocation of drugs is advised. Drugs are issued from the district stores to the periphery without technical calculation of the drug requirement. This leads to expiry of drugs at some places and stock outs at other.
- In Kendrapada district, the peripheral health workers are doing RDK testing and blood slide preparation for Malaria. However, non availability of anti-malarials may affect the Complete and Prompt Treatment component of the programme. Additionally, capacity building of the peripheral staff is needed for better EDCT (early diagnosis and complete treatment)
- JE surveillance is better, reporting and response time to out breaks has improved(five suspected JE cases reported from Malkangiri on 8-11-2012)
- RDK and drug availability is ensured in district Bolangir. National drug policy 2010 is in place and followed here. deleted
- Sentinel site Hospital have been identified and functioning. However, reporting is not regular

5.3.RNTCP

- The Programmatic Management of Drug Resistant TB Cases (PMDT) is currently being implemented in 22 districts of the state. However, very few cases were identified as of MDR TB in the state. Treatment modalities and patient
- The Central TB Division has approved the implementation of PMDT in the remaining 9 districts pending completion of MDR TB. Follow up and tracking of cases needs improvement at DR TB Centre at VSS MCH Sambalpur.
- The Solid Culture DST and LPA Labs accredited and functional at IRL Cuttack. The CB NAAT Lab functioning at Koraput. The Liquid Culture Lab at IRL under construction.
- The human resource needs to be improved as 78 out of 109 LTs posts sanctioned are vacant, 26 out of 109 posts are lying vacant and 12 out of 109 posts are vacant.
- Regular review meetings are held monthly.
- Funds are available at district level.
- In Kendrapada, ASHAs are doing a great job by taking full responsibility of completing the treatment of detected TB cases at the door steps of patients. Payments to them are made timely.
- In Designate Microscopic Centres (DMCs), the LTs are overburdened as the same person is doing the sputum microscopy, testing slides for malaria and other routine pathological tests. Filling up of the vacant posts of LTs can help in reducing the load which will not only improve timely reporting but also quality of reporting
- Consumables like gloves, masks are not available in all the facilities visited. Protocol for Infection Prevention and Bio-Medical waste Management are not available at Laboratories.

5.4.NPCB

- The regular ophthalmic surgeons are in place but all the contractual eye surgeon posts are lying vacant along with 15 posts of ophthalmic technicians. Only 10% of cataract surgeries are done at public health facilities whereas 90% are being carried out at private hospitals. Capacity building of the public health personnel is needed for better outputs.

- 5 centres of the state have been identified for eye donation.
- Better convergence is needed between school health programme and Blindness control programme.
- Timely referral is required along with needed follow-up.

5.5.NLEP

- The state has achieved Leprosy elimination at the state level.
- However individual districts need to achieve the status of leprosy elimination
- 8312 cases of leprosy were detected during 2011-12 and 5251 up to Sept.2012.
- Proportion/ number of disability cases amongst new cases still more than 3% which means cases are detected late in the community. They need to be detected early.
- Proportion of Child cases /number is still high which means transmission of disease is still active in many districts and pockets.
- Still 10-15% cases are wrongly diagnosed in the field, which necessitates continued training and validation
- NCDR has increased in the state because of better surveillance. However case follow-up and completion rate has also improved.
- More IEC activities should be undertaken to generate awareness in the community and measures to alleviate the social stigma attached to it.

5.6.Non-Communicable diseases

- The state has taken up case detection in non-communicable diseases.
- ASHAs have been provided with glucometer and BP instrument to check for diabetes and hypertension. All the sub-centres visited were having the record of the same.
- However, referral mechanism for NCDs is not in place at PHC and other higher centres.
- Recording and tracking of NCD cases needs improvement.

RECOMMENDATION

IDSP

- Data recording for the left out reporting units needs further strengthening. Filling up of vacant posts on priority basis
- Timely alert to the state officials for better reporting is to be ensured.
- System for establishing cross checking the reported data.

NVBDCP

- Regular review by state officials, district malaria officers and technical contractual manpower provided under the WB project is needed.
- Defaulting units should be followed up for timely and proper reporting every month
- Judicious distribution and relocation of drugs is advised.
- JE cases reported needs better surveillance and tracking.

RNTCP

- Recruitment of man power should be taken on priority basis. Better tracking and follow up of MDR TB cases
- Consumables should be made available at all HFs.

NPCB

- Timely filling up of the contractual posts. Capacity building of public health personnel is needed
- Convergence with school health programme
- Timely referral is required along with needed follow-up

NLEP

- Good surveillance and patient tracking at peripheral level is needed
- Early case detection and prompt treatment will reduce the disability percentage
- Adequate IEC,BCC activities are needed at community level

Involvement of AYUSH doctors in national health programme especially in NCDs is needed.

- In most of the health facilities visited, AYUSH doctors are in place.
- On an average 15-25 patients are seen by the AYUSH doctors in OPDs.
- In both Bolangir and Kendrapada districts, AYUSH doctors were not aware of their role in National Health Programmes.
- Sensitization of AYUSH doctors in national health programmes and NCDs needs improvement.

Screening programmes available for conditions as Thallassemia, sickle cell anaemia and genetic disorders

- Presently the screening is done at medical colleges.
- DHs are not doing routine screening for such conditions. Screening programmes available for conditions as Thallassemia, sickle cell anaemia and genetic disorders But their utilization should be ensured by developing a mechanism for better outcomes
- Presently the screening is done at medical colleges. Referral from periphery and sub-district hospitals to district hospitals and medical colleges needs to be strengthened.
- Referral from periphery and sub-district hospitals to district hospitals and medical colleges needs to be strengthened.

Special programme for disability screening and treatment

- School health programme is in place at all levels. However, better linkages and referral tie up with the higher centres are needed for disability reduction and rehabilitation, vocational training.

- Linkages with the other national programmes with the school health though working, yet it still needs improvement for an institutional mechanism for referral and follow-up action.

VI .COMMUNITY PROCESS

GOOD PRACTICES

1. PRI involvement in community processes

- The PRI member is the ex-officio chair of the GKS. Over the past few years, their attendance and participation has improved and is now considered good. After the recent panchayat elections, the new PRI members who have joined 6 months ago,have not yet had orientation. As a result their confidence is less, and there is a strong possibility that the earlier gains will be lost if the training is further delayed.

2. Village Health and Nutrition Committees/ Gaon Kalyan Samitis

- The establishment of GKS's has been a thrust area of the government and has been successful45262 GKS formed at Revenue village level. Majority of members are women - Ward Member (50% women) - President, AWW – Convener, ASHA – Facilitator. (Bolangir: Number of GKS 1728, number of revenue villages 1792; 96.4 %; State: Number of GKS 45202, number of revenue villages 51313; 88.1 %); bank accounts 100%
- The ANM is the secretary of the GSK. The ASHA in these GKS' is typically an ex-officio member. There is no village where there more than one ASHA (according to the ASHA coordinator). Nevertheless, in many GKSs, the ASHA plays the important role of reminding about the meeting, and is part of the follow up actions.
- GKS members functional in community health initiatives and complementing the district officials efforts – involved in distribution of LLIN, IRS campaign,c leanliness drive, waste disposal, tube well maintenance and repairing ; proactive in IEC campaigns – Sishu mela, swasthya kantha, jalachatra and folk and media drives on malaria and diarrhoea.

GKS Nasipur, Kendrapara

- There seems to be a good involvement of marginalised (caste) groups in the villages we reviewed, where the marginalized caste groups were in larger numbers. This could be a challenge in the villages where there are few of the lower castes. There is no evidence of attention to the involvement of other marginalized groups e.g disabled.

3. Inputs to VHSNCs/ GKS

GKS Convention at Ghasian Block,Bolangir

- GKSs' have had training from the government as well as by NGOs working on their own or on contract from the government. The training has largely focused on records keeping, maintaining of minutes, utilization of funds, and health awareness.
- The proceedings of the GKSs' in both the districts were good.Keeping of receipt books, recording theminutes was been undertaken; All GKSs have bank accounts; The fund flow has been streamlined; many of the GKSs had prepared activity plans for their untied funds and these are displayed in the AWCs.

- A group discussion with GKS members (ASHAs + AWWs + ward members from around 10 GKSs) expressed a consensus , on the need for:-
  - "record keeping"
  - GP-level GKS meetings, to help them learn from each other
  - Learning how to create awareness in village and influence their behaviors
- This is an encouraging sign – that the GKSs have now reached a point where they are feeling that they need help to mobilize their own community in order to function better.

- **2.1.Utilization of untied funds** : The Utilisation patterns in the GKS's has been encouraging:In the GKS we reviewed, the minuted discussions as well as the pattern of utilization showed an increased attention to locally identified health needs of the village over the years. This increasing maturity of their thinking is evidenced by:
  - The GKSs have realized the value of learning from each other, and are seeking such opportunities
  - They want to learn not just about health, but about ways to influence their village and change behavior

- While utilisation has improved, a considerable number of GKS' had unused balances, and getting UC and SOE's has been a problem. The state GKS untied funds utilisation average was 68%. Therefore, the transfer to the GKS for 12-13 has been kept at Rs 7,200. We were assured that the GKS' that had good utilization continued to receive Rs 10,000.In response to the continuing uncertainties in GKSs about what is appropriate use of untied funds, the district has prepared guidelines on do's and don'ts- including guideline budget for usual items.

While untied funds are carefully monitored from the audit perspective, the major items of expenditure are recorded at the block level, and what is transmitted to the district level is only the total amounts. The GKS-level details are not available, nor is it analysed at a district or state level. The GKS coordinator (in position for only 6 months)was not aware of the pattern of utilization.As a result there is no systematic understanding of how the money is being used, and consequently little systematic effort to help GKSs make good decisions about how best to train the GKSs and how they can better utilise their funds.

4. ASHAs – adequacy, key tasks and performance -

- The state has highly motivated and committed ASHAs who perform the key tasks of home visits, newborn care, childhood diseases, community mobilization, motivating for institutional delivery, family planning, malaria, DOTS, menstrual hygiene Programme, in addition to GKS meetings, accompaniment of pregnant women for deliveries, etc. ASHAs linked to / near a particular delivery point do rotation duty at those delivery points, so that there is an ASHA always available there 24 hours.

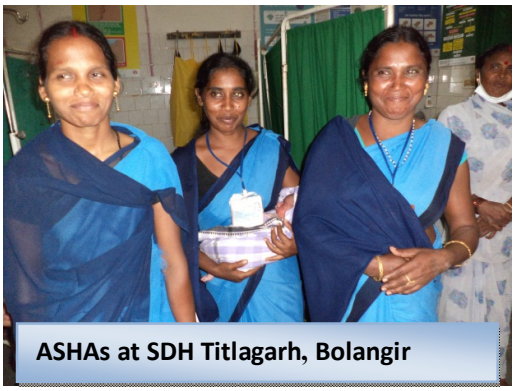
- The state of Odisha has 43068ASHAs which is much higher than the required number 34951 ASHAs as per rural population of the state . This is due to additional ASHAs deployed in the difficult areas , V3 and V4 Sub centres , where an ASHA is put in place per 100 population . The state mentions a **vacancy of 462 ASHAs since the state had a higher target of 43530 and other reasons being (** Elected as PR functionaries – 153, Death – 24, Resignation – 243, Migrated/absconded - 18, Non selection – 24)

Table 3.6: Detailed data base maintained & updated, Attrition rate tracked (0.61%)

	Target	**In position**
Rural	41102	40690
Urban Slum	458	456
Addl. ASHA (V3 & V4 SCs)	1970	1922
Total	**43530**	**43068**

- Overall, this is satisfactory. However, there are a number of Anganwadi centres that have no ASHAs, and a policy decision needs to be taken on this.

- The selection process for ASHAs seems to be quite transparent. For filling up vacancies, the ANMs in the block are given ASHA application forms in Oriya. ANM notifies the villages and GSKs, applications that are received are checked, and the list of applications received and accepted/rejected (with reason for rejection) is put up on notice board at the AWW centre. Then interviews are conducted, documents reviewed, selection made and letter issued by MO.



ASHAs at SDH Titlagarh, Bolangir

- The performance of the ASHA is reviewed informally at the GSK and formally by the ANM, the Block coordinator and lastly by the MO (mostly by the first two). There are no ASHA facilitators at present, there is a request for sector ASHA facilitators in this year's 2012-2013 PIP
- There is an annual ASHA award given at each block based on performance. Earlier, it was based on a scoring taking into account the quantum of work done.

- The review is presently done by looking at their diaries, their registers (which they purchase on their own). The 10 point criteria-based performance review has just been introduced but not yet started.

5. ASHA Training

- The quality of ASHA training seems to be adequate. However, considerable re-training of ASHAs is necessary since (e.g Kendrapada) the awareness of government programmes was found to be quite weak. This is not unexpected, given the brief training, and the constantly enlarging expectation from the ASHA.
- Round 1 training has been completed for 22824 ASHAs trained in 18 High Focus districts and Round 2 training initiated in High Focus districts. ASHAs in non-high-focus have been trained till Module 5. The process has been initiated for Round 1 training in Non High Focus districts .The resource persons have been trained as state-level trainers (who are not government staff). NGOs are used to host and provide logistics support in residential training for NGOs.
- There is a feedback form at the end of the workshop when the participants give their feedback on the workshop. There is also an end-of-workshop evaluation of the participants.
- Currently there is no mechanism in the state for systematic training of new ASHAs, the expressed problem being that a batch size should be 30 to conduct training. New ASHAS are first given the ASHA modules available with the ASHAs who were trained earlier, and given their own copies after they are collected from the state. The new ASHAs are provided on-the-job training and orientation by the ANMs, BPOs and MOs, and the ASHA coordinator. While their knowledge level is adequate (in the opinion of the ASHA coordinator), their skills levels for practical aspects of their job is limited and needs to be strengthened– eg making blood slides, use of drug kit, disposable delivery kit, ORS, treatment aspects of malaria and leprosy.

Round 2 Training of ASHAs at Ghasian Block,Bolangir

6. Incentives and Grievance Redressal

- The ASHAs receive incentives ranging from Rs 1000 to 5000 plus, with a state average of Rs 1800.Payment is through e-transfer into personal bank accounts of ASHA. In these, the JSY related incentives (which are the majority of the payments) are given regularly. The National Disease Control Programmes-related incentives are given after the treatment is completed and therefore may be received some time after the patient is mobilized. However, it was felt (and needs to be checked)that these are not disbursed as soon as they are due. Non-monetary incentives include uniform (given annually), cycle, umbrella, ID card, and the respect given by the community.
- The replenishment of supplies in the drug kits seems to be happening well, reaching them through the ANM.
- ASHA Gruha was available only at DH and SDH, and not at the other delivery points. These were next to the delivery point and had their own/staff toilet (not necessarily attached).
- The existing mechanism for ASHAs to express their grievances is at ASHA coordination meetings at subcentre level, sector meeting (where ANM, LHV, MO, ASHA are present) ASHA DIWAS at CHC level (where MO, LHV, BPO, BADA, PHO are present). ASHAs have expressed that overall;their problems have been proactively addressed.

7. Support structure

- The ASHA programme is supported by the Community Process Resource Centre led by a senior Consultant and the ASHA Asst. Manager at the district level.
- The ASHA mentoring process is rudimentary and totally inadequate. There are ASHA mentoring groups constituted at district and block levels. At the block level, these are of doubtful functionality (they were not referred to by staff until asked repeatedly, no clear idea about the regularity of the meeting, NGOs that are part of it, or of decisions that have been made there).
- At the district level,an ASHA mentoring group has been constituted. At Bolangir, of the 2 NGO members on the mentoring group, at least one has a long term contract with the government (for managing the call centre for JE)- there is potential here for conflict of interest. At the district level, the district group's meetings are to be held once in 6 months, but the date and minutes of the last meeting were not immediately available.

- Recently, a District level ASHA grievance redressal committee has been set up s per government orders, and it had its first meeting on 31 October 2012.
- It is clear, from our visits, that the "Activist" component of ASHA's role has been lost in service delivery push. In the absence of a mentoring support and a supervision that is not provided by the service providers (ANMs, etc), this is to be expected, and will be to the detriment of the ASHA concept. There needs to be a balance between the service provision, service facilitation and the activist roles of the ASHA, and the support and monitoring systems need to enable that balance to happen, and the block ASHA facilitators will be important for this.

- The monitoring of ASHAs is inadequate on many fronts: It is limited to a few areas (largely MCH) and not geared towards strengthening, building their capacity or identifying and addressing their problem.The District ASHA coordinator does not get the performance review; it is held at the bock level. Hence, there is no single point where one can get an overview of performance of all ASHAs. There is also the risk that the ASHA coordinator's impressions are those of the ANM and the Block coordinator, without verifiable information, and that he/she will be aware only of those who are highlighted by them. Good performers as well as weak performers may be "hidden".
- Although an ASHA database is maintained, it is not linked to the performance information of the ASHAs. As a result, a systematic analysis of issues – e.g work areas where the majority of ASHAs are underperforming in, which ASHAs can be tapped for 'best practices', are there areas that need emphasis in training, and do these areas improve after the training – is not possible, and if done, would greatly and strategically enhance the ASHAs work.

8. Community Based monitoring

- In spite of the strong and consistent focus that the state has had on ASHAs and GKSs, the Community monitoring process has unfortunately been much delayed in Orissa. It is good that this has now been initiated, the state level meeting of the proposed "Gram Sabha Samakhyas" (GSS) has been held recently, and it will be rolled out at the district level.
- The ground level preparations have been good – a strong ASHA base and GKS activity, the start of microplanning at the village level in many areasetc. NGOs have been involved in several areas – Mobile Health Units are managed by NGOs in LWE areas, the training of the Modules 6 and 7 is supported logistically by NGOs; much of the GKS training has been managed by NGOs, in Bolangir the Janani Express call centre managed by an NGO, etc.
- There is therefore, a great opportunity for the GSSs' to be participative, constructive and ensure a responsive local health administration. As these are being initiated, it is very important that efforts are made to equip and prepare the district health administration to build this forum in a positive manner, and that a good working relationship is developed.

RECOMMENDATIONS

- New Ward members on the GKS need to be trained urgently.Training not only on GKS issues, but also on their role in the Panchayat as a champion for health issues. Use the best Outgoing (or existing) PRI members to be part of the training so that practical, peer-to-peer tips can also be imparted and be motivational.

- Initiate the GSS/community monitoring in the planned 5 districts at the earliest.Prepare the District Health Structure to respond to it and have a District staff person assigned specifically (and initially exclusively) to follow up the GSS process and establish it well, supported by a state level person.

- To move towards strengthening of GKS to make better and locally-relevant decisions the GKS training should develop appropriate, need-based sessions on record keeping,

influencing community behaviours, how to make good decisions on use of funds, how best to maximise the impact of the funds used .The retraining on "record-keeping" should be not more of the same. It should be based on an understanding of what their uncertainties are, an analysis of existing practices, and a plan of how the proceedings can be used not just for monitoring of expenses, but also for management analysis by district and state levels

- Streamlining, analysis and tracking of GKS-wise major heads of expenditure should be done at the district-level, so that strategic inputs can be given to the GKSs that need them, innovations are picked up and disseminated. If this is done, then the district and block level monitoring will naturally evolve into one that incorporates a focus on decision-making processes in addition to the attention to "proper" utilization. This will need to be added to the strategic focus at the state level.
- The next round of GKStrainings should incorporate a component of how members of the GKS can influence the community (going beyond the theme-based training that is usually given). In this, there should be a focus on skill building as well as building their capacity to innovate with locally relevant strategies.
- The untied fund amount should allocated on the principle of differential financing - linked to population of the village (just as there is a provision for the number of ASHAs to increase for larger villages, the amount of untied funds could also have a similar provision).
- GKS-wise tracking and analysis of funds utilisation under heads of expenditure – thus build GKS capacity to make good decisions
- Performance-based tracking of individual ASHAs - identify common training needs / individual mentoring needs, follow-up progress
- The district and state level database of ASHAs needs to be linked to performance assessments, attrition with reasons, vacant positions and recruitment process, and individual performances over time to be tracked and appropriate strengthening inputs given collectively or to the individual.
- With a regular attrition of ASHAs being an ongoing challenge, there needs to be strategy to train smaller batches and individual new entrants through a combination of formal classes (held by health staff, posting alongside award-winning ASHAs and ANMs (to learn practical aspects of job from the best), etc. They should also be tested using the assessment forms at the end of each module to test their knowledge.
- The identification and removal of knowledge gaps of previously-trained ASHAs is a critical need. There seems to be an unspoken belief that the ASHAs will now as much as the ANM or AWW, who in fact have much more training and stronger support systems. This needs to be addressed urgently to prevent loss of credibility of the ASHA.
- The ASHA mentoring group at district and block levels needs to be revitalized, and strategies for ASHA mentoring need to be planned and implemented. This is a weakness at the state level, that is showing up at the district as well. In the absence of a mentoring system, the ASHAs will be functioning in a vacuum where their crucial activist role for being supportive to the community will be lost while their role in supporting health service delivery will take absolute precedence.
- The system of block facilitators, which is being initiated, should have a special and predominant focus on facilitating the activist role: this needs careful planning, proper role definition, adequate and appropriate training, and orientation of the other members of the

healthcare team so that they do not expect the facilitators to focus only on the service delivery aspects

- There is no government medical support for ASHAs who have injuries/ accidents unless they already fall under some category (BPL/RSBY/JSSK). With the greater amount of travel and the increased risk of injuries / accidents, there should be some assurance of free medical care or insurance for accidents / injuries / illness

VII : PROMOTIVE HEALTH CARE , ACTION ON SOCIAL DETERMINANTS

- Convergence between the ICDS, education department, water and sanitation is visible in the State PIP and also in the field. Good coordination among frontline providers (ANM, AWW, ASHA) for delivering services at VHND. GKS convention at the block level CHC Ghasian should coordination between AWW, ASHAs and PRI members.
- GKS composition – preference is given to SC and ST population to become member of GKS
- Training provided to main office bearers of GKS on management and activities of GKS.
- Special Efforts to reach the marginalized sections is being undertaken. Sarpanch from tribal population is the convener of GKS.
- The state has introduced an innovative *MAMTA* cash transfer scheme with the objective to improve the health and nutrition status of pregnant and lactating mothers and their infants' up to 1 year. This is a classic example of the convergence between two departments: the Department of Women and Child (DWCD) and the Department of Health and Family Welfare (DoHFW) and so far over 5 lakhs women have registered. The state has introduced transparent system of payment through e-transfers.
- A joint coordination meeting with CDPOs and MOIC (chaired by the DM) is conducted on monthly basis at the district level to review and address convergence related implementation and monitoring issues.
- Joint MCPCs are provided to women/mothers from AWCs and are in some cases not filled up properly by ANMs and AWWs.
- Good coordination among frontline providers to deliver services to women and children at the VHND.

- For hard to reach areas for example in Bolangir there are 28 more number of MHUs assigned i e 2 per block.
- RCH services are being provided through NGOS; Special RCH programmes through PPP mode for vulnerable pockets.
- Additional ASHAs have been appointed with scattered population for hard to reach areas (for population's upto 100).
- Additional incentives for paramedics (V3 institutions Rs 1000; V4 Rs 2000 per month); and ASHAs' (double incentives- Rs 700) have been introduced.
- For NRC refer TOR 4

Water, Sanitation and Hygiene

Table 3.7: Coverage of WASH programmes in Odisha 2012-2013

	Odisha	Bolangir	Kendrapada
Piped Water Supply	15.31%;	26.28%	1.47%
Sanitation (toilets constructed)	Target: 7056648 Achieved: 3918463	Target: 342234 Achieved: 141380	Target: 216192 Achieved: 149119

- In both Bolangir and Kedrapada districts, Gaon Kalyan Samitti (GKS comprising of ASHA, AWW, PRI members) are very active, meet regularly and are using untied funds (upto 10,000) for maintenance of tubewells, awareness programmes on WASH (hand washing), and cleanliness drives in the village.
- As the demand for WASH has been created, more funds will be required by the GKS to implement WASH activities in the villages. There is scope for enhancing the GKS funds based the population of the villages.
- ASHA is a key member of GKS and plays an important role in mobilizing communities for promotion of individual household latrines. In Bolangir (Badamunda Village In Saintala Block) the demand for toilets has been generated, list of households has been submitted to the Sanitation officials. However coordination with the local officials needs to be strengthened to expedite the construction of household toilets.

PC PNDT

- The state has recorded a 6 point increase in the overall Sex Ratio between 2001 and 2011. However there has been a 19 point decline in the Child Sex Ratio in the same period. The Child Sex Ratio (2011) declined in 26 districts; in Gajapati district it remained the same, and in 3 districts (Nuapada, Jagatsinghpur & Boudh) it has increased.
- **Table 3.8 : Sex Ratio**

Country/ State	Overall Sex Ratio		Child Sex Ratio	
	India	Odisha	India	Odisha
2011	940	978	914	934
2001	934	972	927	953

- With respect to Sex Ratio at Birth (SRB)- which is more relevant for PCPNDT, there has been a marginal decline from 941 (2007-09) to 938 (2008-10)with an urban SRB at 918 and rural SRB at 940. As per AHS (2010 – 11) estimates SRB of Bolangir is 940 and Kendrapda is 899. Whereas state average is 905.
- In 2009, a PCPNDT Cell was established. Over the last three years (2009-2011), the state has undertaken action and activities on the PCPNDT Act implementation, including revival of state and district advisory committee and a series of sensitization and training programmes. Complaint registering mechanisms have been established with a toll free number (1800 – 345-6746) and an online complaint registering system is available on the government's website (www.pndtorissa.gov.in). The toll-free number was used initially, but now receives hardly any calls.

- Inspection teams at state and district levels have randomly inspected clinics with ultrasound units. 627 USG Clinics registered in the state under the Act. During 2010-11, 37 ultrasound units have been inspected by the state level team and the districts report inspection of 423 ultrasound units. Four clinics have been sealed due to non-maintenance of records, 92 clinics were issued show cause notices and warnings were given to 32 clinics. During the year 2011-12, four clinics were raided and four cases have been filed against ultrasound clinics for violation of the PCPNDT Act.
- In Bolangir the overall sex ratio 983 and the per 1000 males; and child sex-ratio at birth is 940. The CRM team observed that the Form F are routinely collected and well kept for the 18 registered private clinics with ultrasound machines. Further cross checking of records in suspicious cases not performed and needs improvement. Follow-up meetings on late abortion cases should be conducted (Data can be sourced from the MCTS). The CDMO observed that the paper work was very cumbersome and suggested to introduce a more efficient on effective online system for record keeping.
- In Kedrapada district the sex ratio is 1006 per 1000 males; and the child sex-ratio at birth is 921. PCPNDT committee has been established under the chairpersonship of the Collector on January 2011. Only one meeting of Advisory Committee and District Task Force has been held so far (October 2012). 9 Ultra sound clinics have been registered. No case has been reported under PCPNDT act in the district.Form F are collected on monthly basis and verified by ADMO (FW). However cross checking of records in suspicious cases not performed and needs improvement.
- **Mass media Campaigns:** Save the Girl Child Mega Campaign has been held through mass media in Radio and Television covering an estimate of 60% population (Radio and television penetration as per census 2001); A six month action plan has been developed by the Gender, Equity and Advocacy Cell; Orientations have been carried out at state level and for district heath officials on postpartum care, equity advocacy and pre-conception and prenatal diagnostic techniques. A message board informing the PC & PNDT Act mentioning the statutory warnings on Act in District Hospital (Kendrapada) was observed, however in Bolangir District Hospital, one could not see any signage/warning messages on PCPNDT (probably as the Ultra Sound machine was in the storage/non functional).Meetings of Advisory Committee of District Task Force were not being held in Bolangir whereas in Kendrapada, one meeting was held in October, 2012.
- District Appropriate Authority have been formed and cases for prosecutions have been filed I some of the districts, however the programme is weak in Bolangir and Kendrapara .

IEC/ BCC

- There is a Center of Excellence for IEC/BCC activities, at the state level. Integrated approach towards IEC/BCC interventions in the state, and dedicated BCC Cells in all 30 districts; an Integrated 52 week multimedia calendar has been developed to address 12 key behaviors and themes.
- Swasthya Kantha branded as 'Kantha kahe Kahani' reached 42,000 GKS, and over one lakh front line workers. TV viewership (for the first 40 episodes) is more than 30 lakhs.
- The state launched an intensive campaign on malaria,dengue and diarrhoea (Mo Mashari and Nidhi Rath campaign) and the use of the LLIN bed nets in malaria and diarrhoea burden districts. The state reported decline in malaria deaths (from 247 in 2010 to 100 in 2011) and malaria case (from 395651 in 2010 to 298423 in 2011).

- Further an independent study (Mo Mashari study, September 2011) to assess the effectiveness of the distribution strategy and the malaria intervention found that 84% of eligible pregnant women were given LLINs. Of these: a) 91% of pregnant women slept under LLIN last night and were less anaemic than the control group; and b) 88% of pregnant women slept under LLIN last night with their child under 2 years.
- Good display of IEC-in the facility include citizen's charter, Doctors duty, ASHA incentives, labor protocols, user charges, RSBY, JSY scheme entitlements.
- Grievance Redressal was in place but awareness was so poor that hardly any complaints were being received.
- NRC not part of any communication plan.
- IEC materials painted on walls gave a messy look to the otherwise good looking facilities.
- District Hospital: Labour protocols were displayed in the labour room, however the protocols were in English. Entitlements of the schemes such as JSSK, JSY and RSBY were displayed but did not seem adequate. Except for IUD, IEC materials on other family planning methods including NSV were not seen. Good display of IEC- wall paintings include citizen's charter, Doctors duty, ASHA incentives, and other IEC information but insufficient display any type of grievance redressal mechanism.

Swasthya Kantha in Bolangir District

- CHC, PHC and subcenter: Mostly good display of IEC- wall paintings includes citizen's charter, Doctors duty, ASHA incentives, JSSK scheme, and other IEC information. However sufficient display any type of grievance redressal mechanism.
- AWC and the community: display of VHND (date, time, venue), activities undertaken by GKS, health messages on the walls was observed.
- Capacity Building: A total of 40897 ASHAs have been trained Module 5 that covers communication issues/ skills (Kendrapada: 1431; and Bolangir: 1352)

School Health Programme

- ST & SC Dev. Dept, NCLP Schools under Labour Dept. & Special Schools under W & CD Dept. All children from 1st to 10th standard are covered; however +2 students in Ekalabya model (tribal) residential schools are also covered under SHP. Both Residential & Non-Residential Schools are covered in two distinct (Intensive & Extensive) approaches.

Table 3.8 : Screening date plans carried out in schools.

Indicators	Screening Modalities	
	Intensive	Extensive
No of schools	5162 (2070- Residential Schools & 3092 distantly located non-residential schools)	53848 (Non-Residential)
Periodicity of screening	Min. once in a month	Campaign approach 1st round- Sept-Oct 2nd round- Jan-Feb
Screening	Residential Schools- by MHU Non-Residential Schools- by AYUSH Doctors	HW (F), HW (M) & ASHA as a team

- There are no dedicated teams for the School health Programme as per the Government of India norms/guidelines; currently the MCH coordinator is responsible for the School Health Programme. As a result the coverage of SHP in urban areas has been low.
- There has been slow start up of the first screening round in the current financial year (April- Sept 2012).

Table3.9 : Status of School Health Programme in Odisha 2011-2012

HEAD	STATE			BOLANGIR			KENDRAPARA		
	intensive	extensive	Total	intensive	extensive	Total	intensive	extensive	Total
Total Schools	1806	57972	59778	33	2883	2916	6	2003	2009
Total Schools Covered	1806	45142	46948	33	2282	2315	6	2003	2009
Total Children	211059	5496444	5707503	6352	156235	162587	1095	246112	247207
Total Children Screened	210135	4302724	4512859	6271	46369	52640	2464	86413	88877
Total Children given on spot treatment	143560	1222058	1365618	5162	28436	33598	822	32602	33424
Total Children referred	5640	141544	147184	1284	11734	13018	33	2863	2896
IFA	160330	873816	1034146	2469	13507	15976	953	13452	14405
Deworming	208550	3792217	4000767	4962	15314	20276	1044	81052	82096

Table 3.10: Status of School Health Programme in Odisha April to September 2012

HEAD	STATE			BOLANGIR			KENDRAPARA		
	intensive	extensive	Total	intensive	extensive	Total	intensive	extensive	Total
Total Schools	5162	53848	59010	270	2058	2328	6	2003	2009
Total Schools Covered	2793	2594	5387	95	480	575	6	539	545

Total Children	698224	5748562	6446786	36554	231693	268247	1742	232633	234375
Total Children Screened	155011	142670	297681	2263	11648	22354	1369	30851	32220
Total Children given on spot treatment	52582	49106	101688	692	4229	4921	363	7115	7478
Total Children referred	3861	3952	7813	263	725	988	48	1285	1333
IFA	8529	7771	16300	415	3861	4276	482	984	1466
Deworming	25006	27565	52571	394	2967	3361	288	1151	1439

- None of the children had health cards, only few children were provided dose of worm infestation tablets, one child identified as anaemic but not provided with IFA supplements at Jogimunda Govt primary School, Bolangir.
- SHP covers the following checkups: Weight , Height, worm infestation, checking of teeth, eye, ear, stomach, skin, respiratory system, limbs, disability, other problems and referrals
- Record keeping restricted to weight and height measurement
- Dedicated school health team only for residential schools whereas the otherschool children visit the health facilities.
- 78% coverage in the last financial year
- MHU covering residential school
- No dedicated teams for the SHP as per the government norms/guidelines; currently MCH coordinator responsible as a result the coverage of SHP in urban areas has been low
- Achievements against targets were not being monitored
- Low coverage in the current financial year; slow start up of the first screening round
- Health cards not available in Bolangir; Health information on health cards incomplete in Kendrapada.

Equity

- The state has Health Equity Strategy and a Gender and Equity Cell is functional under DoHFW, with funding from the NRHM. An Equity Advocacy Manager has been appointed to provide facilitate interdepartmental coordination and allied activities on equity.
- A of two-day sensitization and planning workshops on Gender and Equity for district and block level service providers from health, Integrated Child Development Services and PRI representatives in 8 KBK districts.
- Differential financial allocations have been made based on the Health Equity Strategy ; has increased by 34% in high focused districts since 2010

Financial Allocation (Amount in Lakhs)				
	2010-2011	2011-2012	2012-2013	% increase as compared to 2010
High Focus Districts	28912	30955	44091	34%
Non High Focus	22619	23782	31531	28%

districts				

- More number of paramedic staff have been allocated to the high focussed districts.

	Human Resource: Staff Nurse/ANM	
	Sanctioned Post	**In position**
High Focus Districts	1455	1126
Non-High Focus Districts	1220	984
Total	2675	2110

Recommendations

- Need for enhancing the GKS funds based on the population of the villages
- Coordination mechanisms for benefits of the schemes under different department to be strengthened at the district and state level
- Frequent meetings of Advisory Committee should be held to review the implementation of the Act.
- Online system for record keeping can be introduced
- School Health: Dedicated teams to be assigned to improve coverage and quality implementation. Health cards to be provided in Bolangir district
- Communication about JSSK scheme details and grievance redressal mechanism at the facilities to be enhanced
- NRC to be part of the communication plan
- The IEC/BCC needs to be expanded to include audio visuals, boards, charts, hoardings and should be displayed rationally after categorization of the place.
- IPC skills to be enhanced for the frontline workers
- Concurrent monitoring of service utilization needs to be undertaken to assess the whether the SC/ST hard to reach population are catching up with the mainstream population

VIII: PROGRAMME MANAGEMENT

State Initiatives/Good Practices

Strategy for Integration with Directorate:

- There is a technical sub-committee which comprises of a team of technical personnel and management consultants. The technical personnel from respective directorates, primarily provide advisory support to strategize and develop technical designs, Whereas the 'Thematic Cell' consisting of management consultants supports planning, implementation and monitoring of thematic programmes at state and district levels. They also provide support to implementation and monitoring of district programme interventions preserving district institutional memory incase of staff turnover.

Strategy for Retention of Employees:

- The state has a blended Payment Structure where in the following criteria's are included:

- Payment of remuneration is given on the basis of fixed (Consolidated remuneration) and variable (Performance Incentives).
- Composite Index System has been adopted at the district & sub district level for release of performance incentives. It includes both physical and financial performance of the districts on critical process/ outcome indicators as per PIP.
- Deliverables are defined for all categories of clinical manpower including MHU staff and AYUSH doctors for release of performance incentives.

- There is a structured field monitoring system in place at state level which includes a Composite field monitoring team of technical and management experts.
- Different types of Web-based software for system strengthening, programme monitoring and performance tracking are in place. E.g. E-blood bank,e- Swasthya Nirman etc.
- Considerable technical support is provided to state from Donor Partners.(For e.g Bolangir is supported by UNICEF and other partners at state level are UNFPA and DFID)

OBSERVATIONS:

The State Programme Management unit is sufficiently staffed with 2556 Staff(2723 is the sanctioned post). However there are 27 % of posts lying vacant at SPMU,DPMU and BPMU levels.

Table 3.11: Total Staff strength of PMU at State, Distrct and Block level

Category	Sanctioned	Position	% Vacant
SPMU	**299**	**280**	**2.98**
DPMU	**975**	**911**	**9.74**
BPMU	**1449**	**1365**	**14.48**
Total	**2723**	**2556**	**27.22**

- Programme management system is in place at State, District and Block level with adequate infrastructure and logistics available with them which include separate DPMU unit and BPMU unit with necessary facilities. The broad categories of SPMU,DPMU and BPMU consists of the following categories.
- There is adequate supervisory manpower atprogramme management unit at district level, however supervision and monitoring of activities is compromised. For eg in Bolangir there are 43 supervisory manpower in DPMU.

Table 3.12: Staff structure of PMU at State,District and Block level

Level	Category	Position		
		At State Level	At District Level	At Sub-District Level
Level- 1	Sr. Programme Manager	State Programme Manager **Category-1:** State Finance Manager Sr. Maternal Health Manager Team Leader OEMAS **Category-2.Consultant (Clinical/ Multi Professionals)***	**RNTCP** –DOT Plus Site Sr. MO **IDSP**-Entomologist, Microbiologist	
Level-2	Programme Manager	**NRHM-** Consultant M & E / Maternal Health/ Health Plan / PPP/ Training(Cat-1) / Quality Improvement & Quality Assurance / IT / Works / RSBY, State Accounts Manager, Financial Analyst etc		
Level-3	Joint Programme Manager	**NRHM**- Consultant, Tribal Health/ Adolescent/ IEC / NGO Affairs / GIS / HR / School Health /Training(Cat-2) / AYUSH, Equity & Advocacy Manager, Accounts Manager, Accounts Executive, Budget Officer, Auditor, State Data Officer, Programme Coordinator, Community process / GKS, State Facilitator (PNDT)	District Programme Manager	
Level-4	Dy. Programme Manager (Cat.1)	**Under NRHM,SDMU,Immunisation, SEMU,NVBDCP**	Asst. Engineer ,MO DTC,Epidemiologist	
Level-5	Dy. Programme	**5.1.1.NRHM-** Accounts Manager (Audit), Accounts Officer (Jr.) OEMAS,	**5.2.1.NRHM**- RCH Consultant , MCH Consultant, District	

	Manager (Cat.2)	Consultant IT (Jr.) OEMAS, Regional Coordinator (AYUSH) **5.1.2.SHRMU-** Research & Documentation Associate **5.1.3.SIHFW-** Nursing Coordinator, Research Officer, Documentation Officer **5.1.4.Sickle cell**- Accounts Officer (Jr.)	Accounts Manager, Hospital Manager at Medical College, **5.2.2.NVBDCP**- VBD Consultant	
Level-6	Asst. Programme Manager (Cat.1)	**6.1.1.NRHM**- Training Associate, Training coordinator (ASHA /GKS /IEC /Training), Coordinator Community Process, Co-ordinator Documentation, Training & Research, Financial Analyst Jr., FMIO, Programme Associate, Assistant Manager Procurement & Logistic, Message Developer, Programme Manager (DMIS), PROMIS Coordinator, MIS Coordinator,IEC Officer(RNTCP) etc	Dist. Health Information Officer, Dist. ASHA Coordinator, Dist. GKS Coordinator, Programme Associate**,** Hospital Manager at DHH, **-** Regional Vaccine & Cold Chain Manager	
Level-7	Asst. Programme Manager (Cat.2)	Sr. Steno, Administrative Associate (PA to MD), JE, Liaising Officer, MIS Coordinator, JE (Bio-medical)**,** Statistical Asst. DOT Plus, Sr. DOT Plus & TB HIV Supervisor	Work Consultant/JE, District Vaccine-cum-Logistic Manager,Data Manager	
Level-8	Sr. Prog. Asst	Programme Asst., GIS Asst., Accountant, Computer Asst. Account Asst.-cum DEO, Programme Asst.,Accountant, Pharmacist-cum Store Keeper etc	Programme Manager SDH, Eye Donation Counselor Finance & Logistic Asst	BPO, Jr. Hosp. Mgr.
Level-9	Jr. Prog. Asst	**Includes-**Office Superintendent, Steno, **Office Asst. under various programmes**	-Accountant-cum DEO, Office Asst., DEO, FP Counselor	Accountant-cum DEO (SDH/AH), BADA
Level-10	Admin	This category includes Data	This category includes	Includes

	. Asst.	Entry Operators under NRHM and other Disease control programmes. Also includes support staff.	Data Entry Operators under NRHM and other Disease control programmes. Also includes support staff.	Community Organizer and MIS Coordinator

- CDMO is now designated as District Mission Director and heading the DPMU which in turn is there for carrying out all types of activities envisaged under NRHM.DPMU have been staffed rationally as per need.

- State Health Society meetings are being held regularly to review the programmatic interventions in the state; minutes of these meetings are regularly shared with GoI. Regular governing body meeting are also held and interaction with the district PMU is also carried out through Video conferencing.

- Funds are placed under NRHM PIP for logistic and infrastructure arrangements for district and block Programme Management units.
- Job description/TOR is available for all the PMU staff, but all programme related jobs are compromised at facility visited

- The level of coordination between district administration, district health office, NRHM staff at district level is satisfactory and same with State level also.(Lack of coordination between regular and contractual staff)
- All letters from the State to districts are being marked to Collector& District Magistrates, CDMOs & DPMs.
- State has delegated necessary administrative and financial powers to districts and sub districts level Officials/ PMU staff for effective coordination and implementation of the NRHM activities.

- State SHSRC functional with a team of 6 consultants; providing technical support in several areas.

- The state has a structured system of training and orientation of program management staff through on-job training, management development programs etc. However orientation on DP, MDR , MCTS , tracking of severe anemia are inadequate.

- Supportive Supervision: There is a structured field monitoring system in place at state level. However, the same system needs to be replicated at district and sub-district level.

- At State Level: Composite field monitoring team has been formed, which comprises of 5 Teams for 5 Weeks in month- The Composite team members include(Prog. + Finance+ MIS + Civil) and are 2/3 districts each .Monthly review of visit findings is done by MD, NRHM and sharing of findings is done with districts . Regular follow up by means of action taken report from districts is undertaken.

- Although a set format for monitoring has been formed as per PIP 2012-13 at district and sub-district level, the same is yet to be replicated at both the levels.
- For above monitoring, the team uses a comprehensive checklist, which is analyzed regularly and action points are derived and communicated to all concern. On a monthly basis, Mission Director reviews the progress on the action points.
- There is no formal grievance redressal system for SPMUs and DPMUs in the state.
- A comprehensive guideline is in place to ensure availability of drugs at all levels and necessary manpower at all levels has been engaged by the State as well as under NRHM for effective supply chain management of drugs. State drug budget has also been enhanced.
- For quality check, a software on Drug Testing and Data Management System has been developed, likewise to ensure effective supply chain management of drugs and logistics Drug Inventory Management Process (DIMS) is in process
- Procurement: at the district level a full-fledged network exists to look after the logistics & supply chain issues. The state uses DMIS at district and state level, further ProMIS is also used by the state. Need to ensure that there is no duplication of effort.
- As per State policy, 80% of drugs budget are being placed at State level to procure the drugs centrally at State level by SDMU, and rest 20% budget are given to districts as a part of decentralisation process to procure drugs during the period of short supply or as per requirement of the district.
- State has developed a comprehensive EDL for this, including specific EDL for JSSK beneficiaries. However a differential EDL facility wise needs to be developed.
- There is a system of accreditation in the state. There are about has about 20 private facilities JSY benefits. The accreditation body is set up at the district level by the approval of the district collector.

Issues

- All the contractual staff has been contracted for 11 months only. Long term commitments might improve performance and reduce attrition.
- The impact of States team structured visit on improvement of programme should be analyzed every quarter with ATR
- The HMIS/ DHIS 2 data is being uploaded regularly, however the data is not analyzed regularly for management decision making.
- Even though the PMU staff are sent for training/ exposure visits, due to large no. of PMU staff the percentage of training exposure to PMU is limited, this might affect the performance of the PMU

RECOMMENDATIONS

- Performance could be used as a criterion for incentivizing the better performing management staff in the districts and blocks.
- The capacity building of PMU staff needs to be strengthened esp. in supportive supervision and data analysis. In Bolangir and Kendrapara program data are not being analyzed. In Bolangir the DHIO is underperforming even though lot of handholding and capacity building has been provided.
- Health Managers in the district and sub district level need to be responsible for implementation of comprehensive IMEP with BMW (in terms of hygiene, cleanliness and sanitation and practicing of IMEP)
- DMNCH coordinator needs to be responsible for monitoring of performance of the delivery points(planning, gap analysis, Timely implementation etc)
- Inventory management for the drugs including the list of short expiry needs to be standardized at all facilities
- EDL prepared needs to be reviewed for further rationalization as per GoI guidelines
- Planning of equipments should be linked with training of service providers

IX: KNOWLEDGE MANAGEMENT

1. SIHFW: State Initiatives

- SIHFW has a well-structured organogram with good technical team inclusive of the following members: Faculty :Which includes a Director , Additional Director, Joint Director, 2-Deputy Directors, 2 Medical Officers, and contractual staff including a Pediatrician and OBG Specialist etc.
- All the posts have been realigned with defined roles and responsibilities at each level with proper terms of reference and deliverables.
- SIHFW has been restructured into a Centre of Excellence for communication with well equipped facility and trained manpower for health communication. This includes a well-functioningProgramme Management Unit and Material and Design Management Unit to implement health communication activities

State of art infrastructure, equipped facility and trained manpower for health communication

- All 23 staffs of SIHFW (nodal centre of communication) have undergone a capsule course on communication at Mudra Institute of Communication

2. Trainings

- Training being conducted by SIHFW are - Induction, PDC, Management training and other thematic training.Clinical trainings including LSAS, EmOC, BEmOC are being coordinated by NRHM and conducted by MC.MTP, Minilap and other FP trainings –Being conducted by SIHFW And monitored by State technical supervisory team at SPMU.IMNCI- by SPM of govt and pvt MC.

- Despite having good technical team most of the core clinical trainings are outsourced and SIHFW is conducting mostly non clinical training and some FP training.

- Performance monitoring of staff particularly the specialists and doctors trained in skill based trainings is not being done despite availability of MCH Coordinator.

3. Technical assistance

- The state has substantial support from international technical agencies for long duration – DFID, UNICEF, NIPI and UNFPA being the major stakeholders in this area. Mapping of areas of technical support with periodicity is provided below :

i. **DFID** (since 1990; Current phase 2007–2015 through OHSP): A comprehensive sector wide approach for increased use of quality health, nutrition and sanitation services by the poor (Esp in KBK + districts)

  - Complementary activities under NRHM such as mobility andcommunications for health workers, prevention and control of malaria among pregnant women and scheduled tribes- LLIN procurement, distribution, improving usage, LQAS monitoring
  - Improvements in under-funded areas such as medical and nursing education, biomedical waste management, drugs supply
  - Funding for new areas such as sickle cell treatment, and critical care services
  - Systems strengthening and reform including human resource
  - reform, cadre restructuring,improved nursing and medical education, financial planning and management, drugs and equipment procurement and logistics, sstrengthening procurement systems and infrastructure; and establishment of the Centre of excellence in Communication and development of communication strategies and campaign

- **Convergence:** support to improve quality of VHND services, Community based management of acute malnutrition
  - **Evidence building**: Independent concurrent monitoring of health and nutrition services(314 blocks; using mixed method); State Equity strategy
  - **Technical support enables**: capacity building for institutionalising reforms; conducting studies and pilots for evidence-based planning; and improvements in implementation; developing guidelines for standardised, quality service provision; procurement , strengthening for drugs, equipment and services; generation of new ideas and ways of working; documentation of best practices

ii. UNFPA

(Since 2002)

- **Family Planning:** Improving planning, monitoring, quality assurance, Promoting informed choices and spacing methods, addressing youth fertility and strengthening Contraceptives Logistics Management Information System harnessing ICT. Rolling out Home delivery of contraceptives by ASHAs scheme in the state
- **Maternal Health**: knowledge management, planning and facilitation for improving quality of care at state level.
- **Addressing gender biased sex selection** through strengthening monitoring of implementation of Pre-Conception and Pre-Natal Diagnostic Techniques Act and training and capacity building of key stakeholders
- **RCH program implementation** in four districts of Odisha
- **Human Resource support**: FP consultants (5) at state level; PCPNDT-3 district level consultants and RCH/NRHM District facilitation (4)

iii. NIPI (since 2007)

Support to the Yashoda scheme including ASHA incentives, home based PNC including incentives, support to SNCU at state level and in 3 districts, Monitoring and Supportive supervision on RI, block level RCH implementation support in 3 districts, Referral transport system in hard-to-reach areas

IV . UNICEF (Since 1989)

Supports implementation of Facility based MNCH interventions: strengthened cold chain and vaccine logistics management, improved review mechanisms on immunization, maternal health and child health, sub-centre validation, rollout of maternal death review, monitoring of IMNCI and RI, strengthening micro-planning for RI and VHND, rollout of alternate vaccine delivery systems

Support s implementation of Community-based MNCH interventions: rollout of VHND with focus on quality support to MAMTA, and adolescent anaemia control programmes, universal salt iodisation, support to VHND quality services.

Supports systems strengthening: consultancy support to SMCS cell NRHM, state and district level reviews and capacity building of health program managers

Supports Operations research studies, and emergency disaster response

- There is clear division of work particularly geographical coverage (district focus) for RCH activities between donor/ development partners in Odisha. Based on discussions with the DOHFW, donor agencies have been allocated high burden districts (21 districts)- for example, DFID's support is expected in 5 districts, UNICEF's in another 5, UNFPA in 4, NIPI in 3, and UNDP in 4. However, this district level allocation is limited to RCH only, which happens to be the area in which most partners work in. This has included support for preparation of the district PIPs, placement of personnel in these districts.

- With regard to the thematic areas, one would find more than one partner working on a particular thematic are. However the state (NRHM/ Directorates) have set up coordination

mechanisms (MCH review meetings, Immunization Task force, etc) to ensure synergy between partners as well improve coordination. In addition, most programmes have a Steering Committees/ Task Forces where multiple partners are members, thus providing a platform for sharing, addressing duplication and converging resources. As an example, Immunization activities in 2009-10 and 2010-11 had support from Govt of India as per the part C guidelines; UNICEF for micro-planning, monitoring, establishing alternate vaccine delivery systems, review meetings and state level training of trainers while DFID support was used for cold chain strengthening, as well as for district level trainings of cold chain handlers. NIPI's supported monitoring, review meetings at district level and block level in the 3 designated districts that it has been mandated to work in.

- However, with agencies expanding into other areas, and with the increasing focus on continuum of care approach, the boundaries are becoming more overlapping - having institutional mechanisms led by Govt would help limit these potential overlaps. For example, UNICEF is planning to work on adolescent health, which has been UNFPA's core focus area.

- There is no district specific comprehensive ownership of any donor partner, resulting in weak managerial capacity of the districts in planning, implementation and monitoring despite large presence of donor partners.

4. State Health Systems Resource Centre

- The Odisha State Health Systems Resource Centre (SHSRC) was set up in 2010 and was envisaged to provide support to NRHM for Policy Planning, Monitoring, support in HR skill building and overall technical support to the Department of Health and Family Welfare. It is headed by the Team Leader and has Senior Consultants for Public Health Planning, Training, M & E, Procurement, SNCU and Works; for technical support to these domain areas. It is integrated into NRHM both infrastructural and technically, in the sense that Odisha SHSRC teams and NRHM teams function together, as one unit. OSHSRC has provided overarching support to NRHM and Directorates in development of PIPs, Monitoring and data analysis, systematizing trainings, and developing guidelines for programmes like JSSK. The SHSRC in the state in functional with 9 members which include 2 NIPI funded personnel.

- The SHSRC team has efficient, skilled staff who are actively involved in programme planning, training, community processes and HR having good coordination with the SPMU. However, much of their time and efforts are going towards in management of routine micro issues of the programme/office work. It will be useful to involve the SHSRC much more in policy support, technical assistance and building the capacity of the districts and blocks in implementation of the programme.

1. Use of information for planning

- HMIS :Since 2009, state initiated the collection of facility based HMIS data with the aid of NHSRC.The data is captured across 8403 institutions, ranging from Sub Centers to DHH &Medical Colleges from different parts of the State. At the state level this practice has been

initiated since 2011 and reporting on GoI portal has been taken up for districts of Dhenkanal & Gajapati.

- Provision of **Data Validation Committees** at the state, district and block level has been set upand **Fixed Days** for validation have been allocated to facilitate faster data validation.
- In the district level Fixed Day meeting, HMIS committee along with MIS-Cum-Field Coordinator & Stat. Asst. from block level meet up to run validation in DHIS-Odisha application with DHIO and with feedback from ADMO (FW) / SI. Immediate correction in consultation with concerned MPHW – Female by respective MIS Coordinator has been planned, however its implementation is not satisfactory.
- At the State level, HMIS validation committee meeting is held under the chairmanship of DFW, Odisha
- **Capacity Building:** Capacity building of Data entry personnel(All HW(F), HW (M),Supervisor, BPO,BADA,MIS Coordinator) for quality data entry (Training has been completed for 314 BPO,BADA,MIS Coordinator regarding software application)

Support Structure for MCTS

- There is one MIS Coordinator at Block level, in place for all the blocks exclusively looking after MCTS data.
- As per GoI Framework, there are E Mission Teams at State, District and Block level for guidance, periodic monitoring and to facilitate data triangulation for implementation.
- **Review Mechanism:** To strengthen MCTS implementation monthly review meetings are conducted through Video Conferencing on NIC platform. MD, NRHM & Director (FW) interact with the CDMO, ADMO(FW), Dist Program Managers and Block level MIS coordinators to take stock of the progress. In these meetings the target for data entry is fixed for the district in discussion with CDMO.

Table 3.13: **Data Capture (2012-13) till Sept-2012**

	Target		Registered in MCTS Server	% of Achievement	
Source	HMIS	Estimated		HMIS	Estimated
Mother	376036	546475	364324	97%	67%
Child	349501	496796	332111	95%	67%
Total	**725537**	**1043271**	**696435**	**96%**	**67%**

Table 3.14:Data Updation Status as on 2.11.2012

LMP Month Apr-2012	**DOB Month Apr-2012**
Update Mother Data (ANC-2)	**Update Child data (DPT-2)**

Target	Achievement	%	Target	Achievement	%
50,450	28,383	56%	68,703	41,190	60%

Observations

- Data in the state level planning is being largely utilised, however the quality and level of data at block level is compromised in some blocks (as verified in some blocks of Bolangir district).Information at all levels can be accessed in different ways through various sources such as unit wise report, Period wise progress report, Routine report, Cold chain/Rims report, GoI report , Aggregated report , Analysis report as per the requirement as well as errors & faults in reporting and lack in the level of achievement of all the health facilities of different levels can be easily found out from the report by which necessary steps can be taken to improve it. However endeavours are not being taken at the district and block level for analysis of data. Utilisation of data for tracking various programmatic progress and implementation is highly compromised especially at district and block level.
- **HMIS:** Facility wise data entry in DHIS-2 and GOI portal is in place.All the facilities of both the districts are reporting as per the format. Facility wise data entry has been completed for 12 districts on GOI portal. In spite of the DHIS -2, which is useful in generating data on all indicators , data analysis is not being carried out at district and block level.

- It is parallel to HMIS data flow. Very few information's are derived out of data. As data analysis is highly compromised at district level, not all data is utilised in keeping track of program implementation / progress as committed in ROP. Data like due list for immunisation sessions, ANC checkups for pregnant women are utilised for sending information to HW(F), ASHAs and beneficiaries by means of SMS alert. Also state level HMIS and MCTS portal forward SMS alerts to registered Health care providers as well as beneficiaries.
- The major constraints faced is sensitizing the HM (F) s to implement HMIS at their field level other constraints like no internet connectivity are major setbacks. In Bolangir District 3 blocks donot have internet connectivity. In order combat this HMIS refresher training is given from time to time to strengthen the HW(F) and HW(M). Proposal has been given to create a data centre in the district level for regular and continuous internet connectivity and regular and timely data entry and updation of the block and district level. Out of the 3 blocks without internet connectivity CHC Ghasian has been provided with broadband internet connection, in Kholan data card is being used whereas Jamgaon still does not have any access to internet connectivity. Data entry is being done at block level and it requires a computer set and internet connectivity. Downloading of data from portal by program managers at block level is easy but not at sub district level as they are not authorized for it.
- On the basis of HMIS information, information of different health indicators through other sources, planning for the future achievements and developments are emphasized. Analysis of the HMIS data within the district is done through the data validation sheet innovated by the state.
- **MCTS:** The Mother and Child Tracking System is functioning satisfactory at the block level but not implemented in full phase at the PPU level. Mothers with severe Anaemia and other

problems are easily accessed and tracked through their unique ID at any place and any time for any service. The due service period of the mother and child are easily tracked through work plan for their timely updation.By Nov-12 it would be fully functional. The other tracking system functional in the district of Bolangir is online SNCU application. This is innovative software which is not being utilised optimally and data updation is incomplete and needs adequate monitoring by the concerned programme officer dealing with it.

- Data entered in MCTS server is better with 82% entry in Bolangir and 73% in Kendrapara for both mother and child .Data updation is more than 70% in both the districts by weekly updation and monitoring at sector level. Work plans are being generated and used by ANMs and this was visible in the field . MCTS Tracking registers – both mother and children are available and properly filled. Data entry in urban area is weak Urban area data entry is an issue , eg in SDH Titlagarh only 20%
- Name based tracking of pregnant women and children are being done as per the national guidelines.
- The degree of completion and timeliness of entry of details and feedback provided to the ANM's / LHV's regularly is good.
- MCTS data is being analysed and is being used optimally at state level, however analysis at district and block level is compromised. There is the SMS system to alert beneficiaries, ASHAs, ANMs etc. on services due.
- The ADMO (FW) has been appointed as the nodal officer for MCTS at the district level.
- Line listing of severe anaemia in pregnancy has been started and action is being taken to correct it.
- The other IT system in the state for HR management is HRMIS, drug logistics is OVLMS, payments is CPSMS and for disease control program IDSP is IDSP PORTAL DATA ENTRY

RECOMMENDATION

- The SIHFW needs to build partnership with some centre of excellence for improving their capacity for clinical and non clinical training and also initiating some good courses.Roadmap with timeline needs to be developed for revamping functioning of SIHFW for quality outcome.

- District and Block Data Managers should analyse the HMIS and MCTS data for planning programme monitoring and tracking of performance. The analysis of data needs to be presented before the CDMO and DC by the 7th of every month.BPM need to ensure regular updation of MCTS data, MDR and line listing of severely anemic cases.

X.FINANCIAL MANAGEMENT

SHS Head Quarter-: Good practices

- Strong Finance Team in position at the State & District level.

- CPSMS: - Out of Total Target of 55666 bank Account, registration done for 45822 which is 82% completed.

- The State is developing new accounting Software which is ERP based Accounting System .
- Stock registers for Computer/Fixtures, Fixed Assets, Stationery, Printing Materials, Misc office Stationery other than consumption are being maintained properly.
- The State has released funds to the Districts under RCH Flexi-pool and Mission Flexible pool after considering the uncommitted unspent Balances with the respective Districts.
- The state has good MIS report on Financial Management i.e. Status of Submission of FMR, SFP, BRS, Concurrent Audit Report.
- The SHS is Booking Expenditure on the basis of the SOE/FMR received from the peripheries.

Observations

- **Absorption of funds:**Over utilization of the fund for the Financial Year 2011-12**; The** SHS has utilized more than the approved PIP under the Mission Flexible Pool for e.g. in B-11 Mobile Medical units Rs.2267.61 Lakhs have been utilised against approved budget of Rs.2092.38 which is an excess of Rs.175.23 Lakhs. However the overall utilization is under the approved Budget (79.91%). **Financial Utilization** of Fund up to 30th Sept 2012 shows an overall utilization under NRHM is 17 % of the Approved Budget and the committed unspent balance. Activities having low/Nil utilization of fundare : ASHA (13.02%), Hospital Strengthening (3.31%), New Construction/Renovation and Setting up (5.02%), Referral Transport (0.00%) and Support Services (1.33%). Under RCH Flexible Pool utilization is 25.92% and the activities having low utilization of fund are Adolescent Reproductive and Sexual Health/ARSH (9.17%), Tribal RCH (8.28%), Training (10.05%), Venerable Groups (3.98%) and JSSK (Maternal Health & Child Health) (6.08%).
- **Releasing of Funds: -** The State has released funds to the Districts under RCH Flexi-pool and Mission Flexible pool after considering the uncommitted unspent Balances with the respective Districts.
- **Auditing procedures: Concurrent Audit 2011-12:-** The concurrent audit is being completed up to 31st March, 2012; however the report is not as per C.A TOR.The Bank balances of the SHS account are as per Statutory Audit Report and the Concurrent audit report is not being tailed. Also the expenditure of the District level are not being taken in to account .The concurrent auditor has not given any comment about the concurrent audit of the district level in his report
    - The Auditor has been appointed on 17th oct, 2011 for the year 2011-12, but the Audit fees @ 17900.00 is being paid from 1st April 2011 to 31st March,2012(which is the whole financial year). But as per agreement the auditor should be paid after submission of Audit report by 28th of the every month.
    - As per the agreement the attendance of the concurrent auditor is to be maintained but no such protocol has been followed for the financial year 2011-12.
    - Theconcurrent auditor should perform the audit after all the Expenditure, Receipts and adjustment voucher have been entered and the auditor provide comments about the status of concurrent audit at the district level which should include whether auditor has been appointed or not and if appointed whether the audit

report is being submitted or not if submitted then the comment on the same district wise should be in his report.

- **District Level 2012-13:**- Appointment of the concurrent Auditor has beencompleted inall 30 districts, but still 20 Districts have not submitted any report (Balasore, Bargarh, Bhadrak, Boudh, Dhenkanal, Ganjam, Jagatsinghpur, Jajpur, Jharsuguda, Kalahandi,Kandanamal, Keonjhar, Khurda, Koraput, Malkanagiri, Nawarangpur,, Nayagarh, Rayagarh, Sambalpur, Sundargarh).
- Audit reports have been submitted by 10 District for April,2012, 9 districts have submitted for May,2012, 9 districts has submitted for June,2012, 6 district has submitted for July,2012 and 2 district has submitted for August,2012.

- **Human Resources: -**Directorate of Finance has the following positions: - Joint Director Finance, Finance Manager & State Accounts Manager.
  - **Vacant Positions:**
    - **District Accounts Manager:-**Out of 30 Sanction Post one post is Vacant.
    - **Accountant at DPMU: -** Out of 77 Sanctioned post 20 post is Vacant.
    - **Accountant at CHC:** - out of 377 Sanctioned post 59 post is Vacant.
    - **Sub District Hospital: -**Out of total 26 Sanctioned post 4 is vacant.
- **Financial Books of Accounts: -**NRHM financial books and Accounts are kept in Tally software but the data entered are incomplete. Only the Advances/fund transfer to the peripheries areentered in to the account, without any mention of opening balances for the financial Year 2011-12 &2012-13. The Books of accounts should be completed at SHS level and the adjustment entries should wait for the statutory auditors adjustment entries.
- **Vouchers:** - As there is no voucher for the each Receipt, payment and adjustment are being kept by the Society and it is not being signed by the accounts personal.
- **Booking Expenditure in FMR:-** The SHS is Booking Expenditure on the basis of the SOE/FMR received from the peripheries, but the SOE from District are not kept by the Society and also the expenditure are not incorporated through the Journal Voucher for the Financial 2011-12 and 2012-13. As two quarter expenditure is being reported to GoI and it is also observed that the expenditure booked by the SHS is not tallied with District FMR .
- **Financial Management Training: -N**o Financial Management Training is being conducted for the current financial year 2012-13.
- **High Cash in Hand:-** The SHS is has kept high cash in hand as on the date of our visit of Rs.61.59 Lakhs and during the financial year 2011-12 the total advance given to the Accountant for various programmes was Rs. 20.79 Lakhs, no information was sought regarding pending advances before providing the cash. As on 1-4-2012 out of Rs.43.06 Lakhs expenditure adjusted was of Rs.2.26 Lakhs.
  - The accountant was also holding a Bearer's cheque of Rs.6.33 lakhs.
- **Adjustment of Advances:** The adjustment of advance is not as per the as per our visit verification the drawing and disbursing authorities are not worried about the pending advances before giving the further advance and there is no fallow up is being made by the drawing and disbursing authorities for adjustment of the same

- The drawing and disbursing authorities are requested to drawing any advances for any programme the old advances may be adjusted and as per our verification there is advances with more than one year are not being adjusted.

- **Interest earned on All NRHM Account :**The SHS is also not taken in to the account the interest earned on different pool wise bank account as SHS level and also from the all District level Bank accounts .so that the bank balance of SHS and advances of the reporting units can be tallied with they are books of accounts.The interest earned on all bank account to be taken in to account at SHS, District levels. so that balance of the concurrent auditor and the statutory auditor can be tallied.
- **Tally ERP-9 :**TheSHS has not purchased the software till date. They have being developed new accounting software which is ERP based accounting system. as per the discussion the software will be finalized up to end of this financial year.
- **Committed Liabilities for 11-12 :-** The SHS is reporting the committed liabilities for 2012-13 on an estimated basis without taking the committed liabilities from the district level .As per our verification the committed liabilities under civil construction are not as per the records of the engineers.
- **FMR format & Physical reporting in the FMR:-**The SHS is reporting the physical data in FMR to GoI but theFMR submitted by the district is not having the physical data and the budget allotted to the respective district. The FMR format used at district level don't match with the formats circulated by the SHS to the districts.
- **Unspent balances :**There areunspentbalanceunderRCH- I of Rs. 1.14 Crore which is part of the interest.
- **TDS Returnsfor 2012-13 :-** The SHS has submitted the TDS return up to June,2012 but the return for Sept,2012 is pending **.**
- **State share contribution:-** The State matching share contribution for the year 2012-13 is Pending as the SHS has received the State Share of Rs.90.00 Crore for the financial year 2012-13 but that is adjusted for the old adjustment .
- **Training on CPSMS:-** Training for the Bank account tracking registration is being carried. Out of Total Target of 55666 bank Account 45822 have been registered, which is 82% completed.

- **Fixed Assets and Stock Records :-**Stock registers for Computer/Fixtures, Fixed Assets, Stationery, Printing Materials, Misc office Stationery other than consumption are being maintained properly but there is no Physical verification being carried out by the internal auditor as on 31st March,2012.

- **MIS Report: -** The state has good MIS report on Financial Management which includes Status of Submission of FMR, SFP, BRS, Concurrent Audit Report, however the analysis of the same is not being followed up.

RECOMMENDATION

- State should maintain minimum cash in hand or as per the State's Financial Rules.
- Vacant posts at Accountants at DPMU, BPMU and Sub District level needs to be filled urgently.

- The Books of accounts should be completed at SHS level and the adjustment entry may be done after adjustment entries made by the statutory auditor.
- The State Health Society (SHS) should keepall the voucher for each payment, receipt and adjustment with proper supporting (or reference of the supporting vouchers / the files or note sheet for the same) which should be signed by the Accounts personal/ either of the joint signatory of the cheque.
- Before sending the FMR to GoI for any quarter the SHS should incorporate the expenditure of the District in State level Accounts and any adjustment entry if made at SHS level for District FMR the SHS should take the revised FMR from the respective district.
- The adjustment of any advance to any person should be noted on the note sheet by the drawing and disbursing authorities and the same should be adjusted within 15 days or completion of the program which ever earlier. Security point of view if it is in practice to hold huge cash due to loads of programme, the adequate insurance for holding cash and also for the transit insurance should be there.
- Drawing and disbursing authorities should note the old advances may be adjusted prior to drawing any advances for any programme.
- Interest earned on all bank account to be taken into account at SHS, District levels so that balance of the concurrent auditor and the statutory auditor can be tallied.
- The concurrent auditor should audit onlyafter all the expenditure, receipts and adjustment voucher being entered and the auditor should give detailed comment about the concurrent audit status of the district level appointment of auditorsubmission of the audit report.
- Committed liabilities of the SHS should be the compilation on the basis of the committed liabilities figures taken from the district level and SHS level.
- A training calendar on Financial Management for the District Accounts Manager should be made by SHS.
- SHS should provide FMR format to all the districts and ensure that the same format is being submitted by the district and complete information should be compiled with the both physical data and budget.
- Refund the unspent balances to GoI of RCH -1 to GOI at the earliest.
- Ensure that the TDS return should be filled timely to avoid penalty clauses.
- State matching contribution to be deposited by the State against the total releases up to date, So that the second trench of the fund can be released from the GoI.
- Need to have proper planning for better utilization of fund under the activities on which low/nil utilization.
- Ensuring that at the end of the financial year all the fixed assets should be physical verified by the internal management team.
- The analysis of MIS report on Financial Management i.e. Status of Submission of FMR,SFP, BRS, Concurrent Audit Report needs to be done

ANNEXURES

ANNEXURE 1 : FACILITY WISE REPORT-6TH CRM

DISTRICT KENDRAPARA

Population : 10 lakhs ; 9 blocks with a health infrastructure of 9 CHCs, 45 PHCs, other hosp -1, 227 Sub centres 227, Ayurvedic dispensaries 12, homeopathic dispensaries -15

PHC RAMNAGAR, BLOCK: MAHAKALPADA; DESIGNATED L 2 FACILITY

- HR : 1 MO (AYUSH), 1 SN (contractual) , 1 pharmacist. Mo is trained in BEmOC and immunization. The Allopathic MO in this facility has been promoted to MOIC and posted in Ramnagar CHC
- Beds : Non bedded
- Service delivery :
    - OPD : 30 per day ; Normal deliveries – 68 (October)
    - The AYUSH (Lady) MO does not conduct deliveries. All deliveries are done by the Staff Nurse.
    - Family planning services are not provided in the facility and no FP stock are available; clients have to go to either the Sub centre or the CHC Ramnagar for availing services (spacing in SC and permanent methods in the CHC through camp mode). Good performance on IUD insertion, done by the LHV in the PHC; 25 insertions in Oct and 19 removals . 232 achievements for OP, against a target of 248
    - The LHV is trained in IUD, NSSK, and MCTS.The ANM in the SC is not trained in IUD insertion. Meticulous record keeping of immunization and FP by this LHV. Consent forms for IUD insertion were maintained .
- Labour room : Neat and well maintained , one bed , labour room register maintained .
- New Born care corner , with radiant warmer and equipments was in place in the labour room
- P forms for IDSP filled and sent to CHC Ramnagar ; enteric fever cases, ARI, diarrhoea, dysentery and pneumonia are the common cases reported in the P forms.
- Drug list for allopathic drugs and a separate drug list for AYUSH drugs were displayed . Adequate stock of drugs in the store.
- IEC : IEC material on MH and CH displayed in the facility.

PHC KURTUNG : BLOCK MARSHAGHAI; (DESIGNATED L-2 FACILITY)

- HR : 1 MO, (AYUSH) , one MBBS MO deputed to CHC Marshaghai , trained in SBA , doing deliveries , also does episiotomy. The facility has 4 staff nurses and all the staff nurses had undergone NSSK , ARSH training, one had undergone training in waste management, IUD, and SBA . 1pharmacist and HW (f), 1 dresser , attendant and 1 grade IV
- Service delivery : 4 beds (but considered non bedded) , OPD - 120 average per day , recently declared as delivery point ; Deliveries – 20 deliveries per month , AYUSH OPD around 70 , AYUSH medicines available .
- Immunization: An immunization plan was in place and well displayed in the room. The ANM was aware of the work plan and activities in her outreach centre. Cold chain equipments were functioning and in order, separate stabilisers were functioning for both deep freezer

and ILR . Sufficient vaccines carriers were available. Record keeping and temperature was well maintained. They had their emergency plans in case of power shut down displayed for more than 12 hours cut off and it was displayed. The ANM was aware of the quarterly preventive maintenance of the cold chain equipment. Linkage with refrigerator mechanic was evident, but he couldn't do the quarterly maintenance due to heavy load. Immunization days are held on Wednesdays in PHC and outreach . Vaccine packing begins at the PHC and starts by 7.15 , so that they reach early and vaccines are sent by AVD by cycle. The last point of vaccine delivery is just 4 kms away from the PHC and vaccine wastes are brought to the PHC and disposed in the evening in the PHC.

- Family Planning : No family planning services provided – IUD insertions not done in spite of all SNs trained in IUD (one SN had removed IUD)
- Disease Control programmes: The weekly reporting of diseases in 'P' form under IDSP is not regular. The reports are sent without the signature of the medical officer. In some forms the dates of the reporting period is missing. No feedback has been received by the facility in this regard.
    - The pharmacist of the PHC prepares the blood slides for Malaria testing and sends to the nearby CHC Marsaghai for microscopy. The blood smears are of various shapes and sizes and quality of the slides has never been monitored. The pharmacist who is making the slides is not trained in NVBDCP.
    - There is no mechanism of tracking the cases by the PHC once they are found positive for Malaria parasite.
    - Chloroquin tablets (no ACT drugs are available at the centre) are available for the presumptive treatment of suspected Malaria cases but there is no drug stock register.
    - The medical officer of the PHC is not involved in any activity of vector control.
    - ASHAs associated with the PHC are engaged as DOTS provider.
- Infrastructure: Labour room was well maintained and had adequate stocks of emergency drugs. Adequate space and good quality construction. Privacy seems to be an issue. Residential quarters were available for pharmacist and staff nurse.
- The facility does not have a laboratory for diagnostics.
- JSSK: Referral registers were not maintained .Registers for JSSK was not maintained (except food). Record of Referral transport and drop back was not maintained.
- Utilization of RKS money is good – on daily labour, photocopying and electricity maintenance. RKS minutes and financial transaction maintained and meetings held quarterly.
- JSY : Cheques received immediately by beneficiaries , but encashment takes times up to 3 months' time
- HMIS: No evidence of facility level data entry (compiled data was not available).
- **Waste disposal is an issue** –water stagnation on the way to the deep burial pit; general waste was strewn behind the labour room.
- ANC are not done in the facility.
- Security is an issue - dogs roaming around and inside the facility.
- IEC: ASHA incentives displayed, however no display of information on JSSK and FP. EDL was not displayed .

CHC MARSHAGHAI; BLOCK MARSAGHAI ; DESIGNATED [1]L-2 FACILITY

- HR : 3 MOs , 1 AYUSH MO, 1 obg gyn , MO IC is a paediatrician
- Service delivery : Conducts 14-15 normal deliveries per month , case load low
- Infrastructure: The facility had a spacious labour room well stocked with drugs and equipment.
- Disease Control programme: The CHC has a Designated Microscopic Centre for tuberculosis which also acts as a hub for examining the blood slides for Malaria collected from other facilities. The Lab Technician is a trained person in RNTCP and Malaria. However, the facility has no medical officer in-charge for the DMC.
- The centre has a well functioning microscope. Containers for sputum collection, required reagents for testing the slides and chemical for disinfection are available.
- Frequent visits are made by the STLS for quality check-up of sputum slides.
- There was lack of consumables like gloves, masks, apron etc required for infection prevention.
- Standard operating protocols and guidelines for handling Bio-medical wastes are not available at the centre.

CHC PATTAMUNDAI ; BLOCK PATTAMUNDAI ; DESIGNATED L-3 FACILITY

- This is a high load facility with a large catchment area staffed with 1 paediatrician, 1 Obs gyn, 1 surgeon, 1 medicine specialist,1 MO (LSAS trained), 9 SNs
- Sanctioned bed strength – 30 and functional too
- Service delivery : OPD of 300-400 per day , serves 5 blocks ; deliveries 180-200 per month , only normal deliveries conducted since there are no anaesthetist. There is an LSAS trained Asst surgeon , but he not providing services and moreover the gynaecologist is not confident); gynaecologist handles all complication – PPH, vacuum and forceps, also does abortions (60-70 , incomplete abortions –improper use of ECp) ; not preparing partograms coz no time, no dedicated staff for LR; Monday fixed day for sterilization (gynaecologist does sterilizations); surgeon joined recent and handles cases of hernia, piles, fissure
- Facility based care for sick new born : 3 bedded NBSU , started a few days earlier , 3 new born admitted – jaundice(outborn), pre term (inborn) and sepsis (outborn) – the facility is yet to maintain register for newborn . protocols for complications were displayed ; however, no masks or gowns or gloves are used for the NBSU; currently dedicated SN not available for the NBSU. The paediatrician has been trained in PALS, NALS(in medical college) , NSSK and SBA. Interview of mother showed that all medicines were brought (from outside , not available in facility); mother not aware that these are to be supplied free (OOP approx – Rs. 149)
- **Infrastructure:** OT was well equipped with o2 cylinder. There is no system of disinfecting the OT or the ward.
    - The OB&G OPD had no privacy (no screen for examination table- it was open from 3 side)
    - There were in campus quarters for doctors and nurses (in good condition)
    - Toilets in the gynae OPD were dirty.

[1]Facilities which are delivery points and categorized into Levels(L) 1,2,3 based on standards of performance

- NBSU is newly started (3days old) staffed with a paediatrician but the prescribed drugs were not available in the hospital

- Referral transport, JE was well utilised and record maintained. There seems to be a delay of more than one hour between seeking health care (time of calling JE) and receiving care at the CHC. JE travels average 22 to 24 km (one way) to pick up ANC/ delivery cases. CHC has a functional ambulance with driver
- There is a system of autoclaving but done through untrained staff. The autoclaved drums didn't have any information on the history of autocaved.
- Bio medical waste disposed through land pits
- Cleanliness of the CHC needs improvement, however RKS has outsourced all the cleaning activities.
- Immunization: Cold chain equipments fully functional and well maintained .The preventive maintenance of cold chain equipment which needs to be done once in a quarter with the district level technician. But it was observed that it has not been done quarterly, only one visit was made since April. On interviewing the technician, he agreed to do quarterly maintenance but was unable to cover all the centers.
- Lab technician trained in RNTCP and malaria but not in IMEP. Disposal of sharps is not proper. All the reagents including chemical for disinfection available. Buffer drugs for anti TB drugs available. SOP and guidelines for lab services not available.
- Gloves, masks , aprons and disposables not supplied regularly (Lab)
- Diet of 2 eggs, bread, biscuit and 2 banana and ground nut (50 Rs) were provided.
- The pharmacy is well stocked with drugs , receiving JSSK medicines since April (monthly indent from Central store at DH), vit k, delivery kits, betadine, amoxy , inj diclofenic and spasmodian used max)
- JSSK Interview with 3 pregnant women in the gyn ward : spending in USG in a certain clinic – all three spent Rs. 350 ; tests all done outside , JSSK signange displayed though patients not aware of free items).
- Total 141 cases of TB have been detected in this DMC and all are on anti-TB treatment.
- The DMC has sufficient availability of reagents, containers, glass slides but no consumables, guidelines, bio-medical waste management protocol.
- Buffer stocks of anti-TB medicines are available at the centre.

PHC RAMNAGAR -N ;BLOCK MAHAKALPADA ; DESIGNATED L-2 FACILITY

- HR : 1 AYUSH MO; 1 SN
- Service delivery: Deliveries per month : 50 per month
- Located in a Bengali community dominated area.
- No sanctioned beds
- Frontline workers not receiving MCH books , MCH cards
- Visited VHND : registrations happening in VHNDs and also in sub centres , but registrations are delayed hb tests are being done and are done in the pvt sector entailing out of pocket spending
- BCG birth dose not given

DAMARPUR SUB CENTER

- Sub center building provided by rural development department
- Infrastructure :. The LHV conducts 1 to 2 cases per month. The labour room is well equipped and maintained .However the labour room does not have an attached toilet. The nearest available toilet is in the rear of the next building .
- Sub center had sufficient drugs like ORS, IFA, Vit A, Albindazole Syrup, Paracitomol, Metrozel etc.
- MCH, ANC, Child tracking and delivery registers were updated
- The LHV was aware of various programmess like bi-annual vit A round, menstrual hygine, WIFS but did not have full knowledge of ORS preparation and usage of Zinc.
- VHND plan was demonstrated
- Interacted in the community with a TB patient. The patient was given regular anti TB drugs. The TB card is well maintained. The ASHA has got incentives for the treated cases.
- HW (f) is not regularly reporting through IDSP. She does not have the copy of the IDSP S form and hence not being able to report on the S form regularly.
- Cycle was provided to ASHAs
- All ANCs done through VHNDs
- The ASHAs have received the incentives for the cases of TB she ensured complete treatment.

CHC RAJ NAGAR ; BLOCK RAJNAGAR ; DESIGNATED L-3 FACILITY

- Service delivery: Facility conducts normal delivery- 162 per month. It does not have a blood storage unit, infrastructure is being developed and registration process underway. Hence no C-section is conducted.
- No system for drug indenting and store keeping
- Time lapse to get a drug in the facility .Drugs intended manually
- The JSSK list provided by district to the facility didn't had Oxytocin. But they had Oxytocin in the facility
- Good system of maintenance of equipment, the equipment gets repaired easily and timely through untied fund
- Gloves, masks , aprons and disposables not supplied regularly (Lab)
- Lab technician is trained in RNTCP and malaria but not in IMEP. Disposal of sharps is not proper. Blood sugar, TLC and RBC not available. All the reagents including chemical for disinfection available. Buffer drugs for anti TB drugs available. SOP and guidelines for lab services not available.
- Lab technicians workload increased with multi skilling and tasking (TB, malaria, HIV.)but no incentive were paid.
- Drug distribution through CHC, PHC picks it from the CHC.
- Bio medical waste management is satisfactory and is burnt locally.
- Lab sputum waste is disinfected using bleaching solution and then disposed (satisfactory)
- JE records not satisfactory, does not record the time of call.
- Vaccine delivery through NGO (hired vehicle)
- Urban area (outreach) by CHC by headquarter ANM . 4 ANMs and 4 ASHAs for urban health
- Interview with 4 mothers who had just delivered, all 4 had breastfed the kids. No Yoshada available and the newborns were not completely covered. All of them were getting food and

drugs free of cost. All of them registered under MAMTA scheme and this is cause of registration in AWC, so all ANC checks were done, they were weighed, counselled, IFA and TT provided. Regular check ups were done by ANM including Hb test.

- Interviewed FP (sterilization camp) clients, some of them were aware of the incentives while others were not. ASHAs were very active, some of the ASHAs were able to get around 45 clients in a month. Clients were not counselled by the ASHA on the procedure or other FP services apart from sterilisation
- The facility has a trained LT (in RNTCP, Malaria) preparing Sputum slides, Blood slides for Malaria and doing the microscopy for detection including the pathological testing.
- The Lab remains over-burdened due to heavy patient load.The reports are given in a time period of one day.
- There is sufficient availability of reagents, anti-TB drug boxes, containers for sputum collection, glass slides but no consumables, guidelines, bio-medical waste management protocol.
- Disposal of sharps is not according to the guidelines.
- Treatment of the sputum positive cases is through ASHAs.(7 cases of Cat-I & 2 cases of Cat-II, all are under treatment)
- Weekly reporting of diseases under IDSP is done regularly by the MPHW male but analysis of the reports is not being done.
- The facility has an Adolescent Health Friendly Clinic but working in the same room with ICTC. There is no separate counselling room for suspected clients of HIV/AIDS and adolescents leading to compromise on privacy.

KOROWA PHC ; BLOCK GARADAPUR ; DESIGNATED L-2 FACILITY

- HR :3 SNs , 2 MOs (1 MBBS, 1 AYUSH)
- MO stays in residential quarters
- Service delivery : Normal deliveries conducted ;25 deliveries from April to November.
- Diet given to 3 patients (started recently) , registers maintained
- Functional lab ;Hb , urine albumin tests done
- No anti rabies, anti venom in spite of cases of snake bites which are common
- JSSK signage displayed
- IDSP P forms reported

PARESHWARPUR SUBCENTER, MAHAKALPARA CHC

- No records were available at the centre
- Equipments like stethoscope, BP instrument, measuring tape were not available.
- IEC, BCC material not displayed,
- No proper records, vouchers for untied fund lost, not reported to the concerned authorities.

CHC PATAKURA- L 3 DESIGNATED (BLOCK : GARADAPUR)

- HR : MO -2 , LSAS -1 , Paid -1, Obg -1, SN-4 , Lab tech -1 , Phramacist-1

- Service delivery : 120 deliveries per month (no C-sections), IUD -3 per month, sterilization : 200 (from April);OPD per day : 100 IPD : good bed occupancy
- Sanctioned beds : 16 Functional beds : 16
- Infrastructure
    - Located in a scattered building, old construction , space adequate but planning inadequate .
    - Staff quarter available , old buildings , new construction sanctioned in this year.
- OPD: Space adequate for consultation room, no separate examining room or privacy for female patients . 82 cases were examined on the day of the visit. 42 were paediatric OPD.
- Good display of IEC- wall paintings include citizen's charter, Doctors duty, ASHA incentives, and other IEC information but insufficient display of JSSK , neither adequate display for any type of grievance redressal mechanism.
- Drugs: EDL displayed, 38/ 58 drugs available, record for distribution of drugs not maintained , no expiry register.
- Drug store: Records poorly maintained; no expiry register maintained. 10-12 types of antibiotics were available; however all of them were not entered into the display (EDL) list. There is no systemic approach for supply and inventory management of medicines; many drugs are pushed from above. Many items for condemnation were present.
- Some of the surgical instruments, post vertically from the state / district were lying unused and unnoticed.
- Dressing room: No sterilised gauge or dressing material. Cleanliness compromised, staff trained in IMEP, but protocols for infection prevention not being followed .
- Labour room :
    - Three beds in the LR with functional NBCC and radiant warmer , partograph being maintained
    - 6-7 out referrals per month
    - all the staff are trained in SBA ; however, NSSK and IUD trainings were not yet done.
    - Protocols displayed , but not being completely followed (e.g. conducting of normal delivery, practising infection prevention ,technical knowledge and skills needs further improvement).The confidence level of SNs on ENBC and resuscitation protocols were not up to the mark.
    - Manorama Malik admitted at 6 A.M. on 6th November delivered after two hours by giving injection Oxytocin for augmentation without indication.
- OT : No surgery, no C-sections. LSAS MO has been posted recently, but surgeries not initiated due to non availability of Boyle's apparatus , cardiac monitors and functional BSU.
- Wards: Poor lighting and dark , untidy and not adequately cleaned . Space was a constraint.
- Lab : Single lab technician doing all routine tests (40 lab tests per day) and also tests for malaria, TB , etc. needs encouragement and appreciation from the district/ state. Lab was maintained neat and clean.
- BSU : equipment available , but licensing not yet done .
- Three admitted labour cases interviewed – no out of pocket expenses on drugs, diet, transport. All came by JE.
- Immunization : Cold chain well maintained ; micro plan available ,generator in working condition

- FP : No fixed day services , IUD insertion 3 per month , sterilization only done in camp mode . On the day of visit , about 50 cases were registered although the in house facility in terms of equipment, beds and sanitary environment were limited and could cater to only 8-10 patients. The in charge was advised to call the patients on different days in limited number.
- Others
    - MCTS : Entry poor and not matching even with HMIS
    - Line listing of severe anaemic women not done
    - Single window service for issue of JSY cheques, birth registrations and zero day dose is being practised and all facility level births were issued birth certificates.
    - Monitoring of VHND through AYUSH MOs
    - AYUSH MO DR. Kailash Ch. Sahoo had just come from field after monitoring VHND.On interaction, a filled in check list with supervisory comments were available with him. He is doing a sincere job although not getting either a vehicle or POL for monitoring VHND.

CDMO office

- CDMO office and NRHM staff functioning in building belonging to ANMTC
- Separate land has been allotted , construction not yet initiated
- 22 delivery points (L-3 -7, L2 -11 , L1-4)
- Performance monitoring of delivery points not being done
- MCTS entry and service delivery not being followed for achievement for ELA
- Tracking of severely anaemic women not being done
- 154 Eye screening camps conducted by Opthalmic assistant
- 2353 cataract surgeries done by NGO and 10% verified by eye surgeon who reported satisfactory performance
- NO IN HOUSE cataract surgery being done (eye surgeon on the verge of retirement and hence not confident enough for doing surgeries)

ANMTC Kendrapara

- The ANMTC has its own building but , first floor taken by CDMO for office
- Five Faculty, 40 students , one teaching room , 1 practical room , library located in another building
- Dummy and mannequins available although in limited number
- Due to constant in availability of rooms , teaching and practical rooms were sealed by DC for a week for conducting examination of private training centres.
- SBA guidelines, posters, teaching and training materials were not available
- None of the Faculty were recently trained / oriented on RMNCH protocols
- Have full potential for conducting good quality training subject to giving adequate infrastructure , training the Faculty and provision of teaching and training AIDS

District Hospital, Kendrapara

- HR : MO sanctioned 26, 13 in position ; obg-1, EmoC -1, Anesthe-1, paediatr-1, medicine-1, eye surgeon-1, surgeon -2, ortho -1, dental -1; SNs-25 ; LT-4
- Beds : 195 sanctioned, 130 functional ; bed occupancy 76%
- Service delivery : OPD : 792 per day ; IPD -3000 per month; delivery -700 per month , C sections -60 per month
- Infrastructure: Good infrastructure but space crunch , building scattered in the campus .100 bedded MCH wing has been sanctioned for the DH , but the dilemma is where to construct.
- Good display of IEC- wall paintings include citizen's charter, Doctors duty, ASHA incentives, and other IEC information but insufficient display of JSSK , neither adequate display for any type of grievance redressal mechanism.
- OPD: Adequate consulting rooms with waiting area and OPD counters (especially for RSBY and User Fee) .
- Only 17 type of OPD drugs available out of 52 notified drugs.
- Drug distribution counter maintaining all registers except expiry register
- One X-ray technician conducting 15-20 X-rays
- Emergency room: No emergency facility such as emergency drug, consumables, O2, suction, ambu bag, ECG, etc.The room is limited to conducting dressing and giving injection.
- Blood bank: Well maintained Blood bank, BBR -3 , stock in hand – 60 blood bags ; 150 blood bags being issued every month , all in house ; generator available , 24 camps conducted till now.
- Lab : well maintained , 8 LT including malaria and HIV / AIDS, all routine tests being done , 150 samples collected every day , all LTs doing comprehensive testing , round the clock in house availability of at least 1 LT beyond normal duty hours.
- ICTC: 205 positive cases, all on regular treatment and follow up . 10 counselling being done by counsellor.
- Wards : Crowded , reasonably clean , toilets not clean , running water available .
- Client interaction : out of 7 delivered mothers, 2 came by her own transport ; however, none of them had spent on drugs and diet .
- Labour room
    - A delivery was watched being conducted by a SBA (SN) . RL was initiated on the pretext of dehydration. Cord was cut immediately after putting the baby on mother's abdomen. CCT was initiated without giving injection Oxy tocin , neither signs of separation was watched.
    - 4 beds in LR with adequate privacy (curtains)
    - Drug tray , tray for ENBC and resuscitation , tray for delivery equipment , etc were not maintained . The cotton and gauge being used were kept in unsterilized conditions.
    - Competency on technical skills and knowledge needs much improvement
    - Partographs being maintained; however, the Obg never reviews for its correctness
    - Paediatrician never visits and supervises the ENBC and resuscitation protocols being followed.

- Infection prevention protocols not being followed. Lack of adequate consumables and gloves.

- OT : Good infrastructure, well maintained , however, the sterilization and sanitation of OT and Labour room as per GOI protocols not being adhered.

Family Planning

- No pregnancy test kit was available
- Fixed day IUD services not being provided ; concept not clear ; however, IUD , condoms , CC, OP being given through regular OPDs.
- 24 IUD last month

PP centre

- 4 staff including 1 male worker catering to 42 , 409 population through PP centre
- Having 16 immunization centres
- Additional Director , FW has no idea on the functioning of PP centre
  Immunization : Cold chain well maintained, micro plans available , generator available .

OUTREACH SERVICES

Village Health and Nutrition Centre (VHND), AWC Baharsobala (under Mahakalpada CHC)

- Of the total planned 8 VHND, all were held and records of all 8 were available
- Timing and date of VHND was displayed;
- Staff: an ANM, ASHA, AWW ,HW(M) and helper of AWW were present
- Records of ASHA, ANM records of pregnant mothers, ANC, immunization, malnutrition, high risk pregnancy , TB patients and treatment were not being maintained at all
- Records of AWW worker was incomplete. MCTS register was incomplete
- 10 registered pregnant mothers
- Immunization is done on Wednesday- which we did not observe
- Though facility for ANC check-up(bed, BP & Hb instrument) was available we could not observe any ANC being conducted as ANM did not seem confident(and has not undergone training)
- No growth monitoring and systematic referral of SAM children to Prustikar Diwas.
- Hygiene being maintained while preparing food for children and tasted good.
- All children washed hands with soap before eating.
- Except for Cotrimoxazole, anti TB drugs, Albendazole syrup, gloves and measuring tape rest of the other drugs, supplies, equipments and instruments were available.
- IEC/BCC: Entitlements including THR, Weekly menu and Quantity and ASHA's entitlements charts were displayed but JSSK entitlement were not displayed.
- Trainings and Capacity building of frontline providers
- AWW: immunization, malaria, NSSK
- ASHA: RNTCP, malaria, IYCF
- ANM: CSSM, immunization, malaria(however she was not confident of using the RDT)
- Focus group discussion with the beneficiaries- 8 women(most women from other AWC) including expectant mother and mothers with newborn.
- All women were registered under MAMTA scheme; hence registered for ANC in the 1st trimester, availed the ANC package (TT, IFA, counselling), delivered in the CHC.

- None aware of JSSK
- All of them paid JSY payment (Rs 1400) on time. However had to pay for drugs, food, diagnostic through their pockets.(could be all of them delivered before June)
- All of them were satisfied with the services at AWC from the other centres.

Village Health and Nutrition Centre (VHND) Tankivelari, Chhapali Subcenter

- Population 1340
- 10 registered pregnant mothers
- Of the total planned 8 VHND, records of only 5 were available
- Timing and date of VHND was displayed;
- Staff: an ANM, ASHA, AWW and helper of AWW were present
- Records of ASHA, ANM records of pregnant mothers, ANC, immunization, malnutrition, high risk pregnancy , TB patients and treatment were not being maintained at all
- Records of AWW worker was incomplete. Though the recordS of pregnant mother was available but the information was only restricted to the first ANC checkup.
- Immunization is done on Wednesday- which we did not observe
- Though facility for ANC check-up(bed,curtain for privacy) was available we could not observe any ANC being conducted(may be at the time of visit all women had left the facility) .ANM was using instruments and seems well informed about mother and child health.
- Except for Cotrimoxazole, anti TB drugs, gloves and measuring tape rest of the other drugs, supplies, equipments and instruments were available.
- IEC/BCC: Entitlements including JSSK, THR, Weekly menu and Quantity and ASHA's entitlements charts were displayed,s

Trainings and Capacity building of frontline providers

- AWW: immunization, malaria, NSSK
- ASHA: RNTCP, malaria, IYCF
- ANM: IMNCI

VHND : Village Medinipurpara

- AWC serves population of 900, 5 PW , recent deliveries 4
- VHNDs held on Wednesdays , good collection of community, mostly Bengali,
- Most ANC registrations done in SCs instead of VHND
- No MCH card, all women using photo copied cards
- Frontline workers not aware of MCH booklets including state level MCH nodal persons.
- Exit interviews with recently deliveries women (2 present) shows that they were doing urine tests, Hb tests outside
- Examination of MCH cards show ANC registrations happening late (4-5th month) which is a concern considering that women can register in VHND and SC.

SUB centre and AWC : Manikpur (Meeting with GKS members and 2 ASHAs)

- GKS with 11 members all women except one Male member

- Active committee , using funds well for tube well repair, cleaning of village , chlorination of wells
- Prepared a plan for the untied funds , hold meeting in the AWC every Thursday. Minutes are recorded by ASHA and AWW.
- AWC has 25 children ; diet provided all days with a set menu; AWW is doing meeting with adolescents along with the male workers. WIPS distributed well, AWW distributes it at home; good response to menstrual hygiene – freedays , both ASHAs mentioned that first time they asked for 16 packets , then 52.Some are of the opinion that the napkins were thin and problem in aborption, number of napkins is also adequate . Sanitary napkin stored at SC
- MPW (M) was not undergone any training , not even malaria (currently does record keeping, prepares malaria slides, goes for school health and also does chlorination of wells and awareness meetings in the community).
- SC functioning in the same building as AWC, no electricity , no generator : population of 10904,covered by 10 AWCs and 2 Mini AWC (400 population) ; 9 villages – 10 ASHA , 2nd ANM is there , but on maternal leave MCTS tracking was done well ; ANM had good knowledge the system and she had received training on malaria, TB, SBA, immunization , NSSK , MCTS and IDSP. Irregular salary, delay to three to four months. Well stocked SC/ AWC with drugs and Nischay kit. However, Hb testing is not done by her, though it was entered in the MCTS (PW getting HB testing done in DH)
- ASHA : ASHAs on 1400 and 1800 population (distribution as per norms), active ASHAs, both trained till module 5 , receiving Rs. 2000-3000 and the award winning one earned Rs. 5700 in OCT, through institutional delivery, sterilization, DOTS case, salt testing , leprosy. ASHA kit was stocked well, refilling from sub centre. District Community Mobiliser is in place.

INTERACTION WITH GKS AT MULABASANT

- 8 GKS members – 3 male + 5 female
- Meeting are held every 4th Thursday of the month
- Printed records and registers
- Works undertaken: Construction of toilets through TNCs, tube well repairing, road cleanliness, chlorination of community well, IEC of malaria, Hand washing demonstration
- GNC had a village health plan specifying month wise activities to be undertaken along with budget and person responsible.
- Emergency planning and budget reallocation is done committee meeting
- GKS members suggested to increase the fund fm 10k to 25k
- GKS members received training on: Dengue, tubewell repairing, ARSH from Pattamundai CHC (by the MO)
- ASHA's activities: Preparation of malaria slides, identification of suspected leprosy cases and referral

ANM

- ANM had good knowledge of all her progs. The supply of vit A was regular and available with her. ANM didn't have any knowledge or supply of Zinc.
- Large IFA tablet available with her, IFA small not available

AWW

- Sanitry napkin available and good response from the community
- Good register keeping for WIFS
- Good knowledge of prevention and management of childhood diarrhoea management

SCHOOL HEALTH PROGRAM AT NAPANGA URNITA SCHOOL

- Health cards are available but not utilized
- No nominated teacher for eye screening
- Record keeping restricted to weight and height measurement
- 2 children were provided spectacles

District Bolangir

Population :16.48 lakhs ; 14 blocks

Health infrastructure :1 DH, 2 SDH, 15 CHCs, 42 PHCs, 2 other hosp -1, 226 SC , 28 MHUs.

Blood Bank: 4 Blood bank (DHH, SDH Titlagarh, SDH Patnagrah, Kauntabhanji CHC)

DHH Bolangir- L 3 designated (Block : Bolangir)

- HR : LSAS -1 , Pead -1, Obg -4, Lab tech -12.
- Very high case load of deliveries. 750 per month. 150 C-sections (of which 50% are referrals). Based on 34000 annual deliveries (3000 deliveries per month, this is constitutes 25% of the load of the district). Epidemiological data reveals that diseases are very high during monsson, at what time the load in the hospital is considerably higher that what was observed during the CRM.
- Deliveries : 700- 800 p.m, (125: C-sections)
- SNCU: 12 bedded having 2 MOs, 11 SNs
- Bed strength : 184
- Infrastructure
    - Located in a scattered building, old construction , space adequate but planning inadequate .
    - Good display of IEC- New visible, physical upgrades: New signs, electrical wiring for power to light and essential equipment.
- Drugs: EDL displayed, record for distribution of drugs not maintained , no expiry register.
- Drug store: Records poorly maintained; no expiry register maintained. 10-12 types of antibiotics were available; however all of them were not entered into the display (EDL) list. There is no systemic approach for supply and inventory management of medicines; many drugs are pushed from above. Many items for condemnation were present.
- Stock management / stock outs and expiration of medicines. Poor registries are kept. No separate registry for by expiry data kept for ease of management. Limited supply of contraceptives kept at the hosp.
- Labour room :
    - One OBG round the clock is available
    - Kunti Devi came at 4 PM: BP 164/100 – Eclampsia case, shifted to emergency room, injection Mag sulp was given,
        - Pateint was lying on floor in a well lit room and 4 relatives sitting with her, room was not neat and clean.
    - All SNs were NSSK, SBA trained
    - All equipments kept were functionaL
    - ANC ward: Toilets not clean,Infection prevention protocols not followed
- Labor room: 4 delivery tables in one room – only one screen= poor privacy for delivering mothers. Protocol posters displayed.
- Partographs often not done (reason cited: mother arrives too late to institution).
- Only one Anaesticiologist. Retired doctor retained, doing good work, but high risk situation /untenable given the high load.

- OT appeared well kept with proper conditions and equipment. Culture swap checks for hygiene not conducted routinely.
- Ultra-sound machine not working. Out of order for 1 year. Kept in storage. Not reparable. Procurement not initiated. Patients are referred for sonography at outside private clinics. Recent change in permissions to allow Gynae to perform ultra-sound scanning has been given by the state.

Eclampsia Room

- It's a part of the maternity ward. Witnessed a beneficiary from Kalahandi District who had been brought in by an ASHA from Budhikhamba village. The beneficiary was a 8 months Primi with pre eclamptic fit. Patient was made to lie down in an separate room and with relatives around. No protocol of treatment of eclampsia was followed, to start of no one was monitoring

- Case Study:
    - Saraswati: JSSK benefits received, came with ASHA
    - Raibhais Daughter in law: G2,P3, admitted today, no medicines prescribed, no OOP incurred
    - Jagayseeni: admitted since 5 days, delivery CS, Paid for transport, no expenditure on medicine
    - 2 other beneficries spent on transport
    - Niloni Manjhi: G5, prolapsed and ruptured uterus, manged for shock and operated, condition was stable and saved, spent Rs 800 on drug, no reported expenditure on medicine, reffered from Area hospital (OBG present), 500 spent there on medicines and consumable,
    - Mostly all exit interviews reported expenditure on transport
- SNCU:
    - New SNCU. Well equipped. Teething problems and staff training requirements. Neo natal mortally is still high in the district and neo-natal care should continue to receive priority. SNCU death rate reported very high = 14%
    - 8 infants,case study: Baby Jashoda: Inbrn did not cry, asphyxia with convulsion, on antibiotic and ambu support and oxygen.
    - Baby Padmini: Inborn on 1.11. 12 at 3.20 pm , meconium stained reffred to SNCU at 6.20 pm with feeble cry, diagnosed as birth asphyxia, developed convulsions after 4 hrs, was put on gardinal, antbiotic and O2 inhalation, convulsion continued for next 2 days, developed aponea and convulsions again on 4th, after a day gap, conditioned deteriorated, HR-48/min. SPO2-58/ min, Despte resusticative measures baby died on 4.11.2012 at 4 pm.
    - Deaths: Sept: 139/25, Oct: 171/30, august: 154/43, July 146/28
    - Toilet dirty
    - Sterlisation instruments supplied but not functional since received
    - Neeta , Yashoda(drugs), Sitaya Spend on transport
    - SNs and Staff needs further orientation and training

- 3 nurses on duty all passed from pvt institutes , receioved 4 days training, not fully competent, need further training of longer duration-2 weeks
- Interaction with ASHA: ANM conduct proper ANC which includes abdominal examination, hb%, prepare the malaria slides.

- Blood Bank: 600 BT / month, 3 BB
- Annual transfusion of 6000-7000 unit
- Able to meet the requirements of the catchment areas
- Free blood to JSSK beneficiaries, Thalesemia Major as well as sickle cell patients
- Average issue daily: 20 bottles
- Doesn't have a tube sealer and blood collection monitor, though already order is issued for providing these two months ago 23 August 2012 by MD,NRHM
- Non functional ELISA reader , AMC contractor came after 2 months of complaint from Kolkata and still non functional as some parts need to be replaced
- No donor couch
- Rapid method with internal control
- Generator back up is missing in the BB , since 1st Oct
- Infrastructure is not accordance to guideline
- 2 technicians, 3 attendants are ther. More technician required
- Blood bank is well run and well stocked. Proper patient pre-screening and registry is kept.

ANMTC: 1 Princi, 6 tutor, trainee 36, having basic mannequins but computer lab, skill lab, equipment, lib, teaching needs strengthening, salaries of 5tutors not received since 3 months, INC team did a recent inspection, the admissions are delayed due to inadequate infrastructure, skill lab is planned to be made operational on the 1st floor of the building.

District Call centre(Janni Express Call Centre)

- Call centers getting calls from patients give directions to vehicles to move and collect patients
- Paid calls
- 3 on duty
- By NGO- National peace UNION(India)
- AHSAs aware of the number.
- Number -06652234555
- Number not advertised sufficiently
- Operational since last 9 month
- Record of only pregnant women calls were being maintained
- 22 Janani express and 22 govt for 14 blocks ambulances are being regulatyed
- Empanelled vehicles under procurement
- Average 15 calls/day
- Mostly Delivery related
- As per records only data till 2/10/12 was recorded, recent datas were maintained in the draft notebooks
- Drop back not being ,maintained
- JE are maruti vans and boleros

- Works 24 hrs, 3 Staff
- One computer which is not being optimally utilised.
- Works on PPP NGO- peace unison

RSBY: DH

- RSBY counter set up with 2 stations. Hospital accredited under the scheme and reimbursements and draw downs are taken place.
- Rs 30/-card
- Documentation of the Process of getting the services is not mentioned
- 6 ASHAs
- Had conducted 4-5 deliveries last year, very active ANM, interested to conduct deliveries
- Staff-4, 1 Protocol manager(pharmacy graduate), 3 DEOs(M.A+ diploma holder), Salary - 4000 Approx.
- Underutilization of HR
- 4-15 Cases per day
- Working 7 am to 10 Pm
- 464 cases registered
- Grievances are being handled by the Protocol Manger
- Rates: ND-2500, CS-4500, LSCS-6000
- Placed at 17places in Bolangir district

Immunization Point:

- 5 ANMs present
- 1ILR and 1 Deep Freezer in working condition, temperature maintained
- OPV vaccine short supply

Regional and District Vaccine Store:

- RVS – 4 districts (Kalhandi, Nuapad, Sonpur, Bolangir)
- DVS- 18 Points(14 blocks and 4 PPC**)**
- ILR points- 31
- New Infrastruture for RVS under construction, presently both in the same store
- Walk-In – Cooler maintained at 2-8^{o}C
- Supply indented within 1-2 months
- Power backup with autocut generator
- Different vaccines supplied at different point of time
- Short supply OPV
- Stock Registered maintained
- RI Microplan available
- 1District Cold chain Manger, 1 District Vaccine logistic Manger, Regional Cold chain Manger, +4 staff.
- Lack of regular supportive supervision and monitoring visits
- Checklists filled but not signed, not dated
- OVLMs software initiated for vaccines logistics is not functioning upto the mark
- Mobility support insufficient

Infection Prevention/Biomedical Waste Management

- Lavatories and latrines are in terrible shape. Cleaning and new construction would be required.
- Very poor latrine facilities. Broken toilets. Lack of water. Soap unavailable. Porous cement surface, which is not hygienic. New construction would be necessary to bring the facilities to an acceptable standard.
- Outside : uncovered sewer drains, which are breading grounds for mosquitoes (dist hosp). Question is why necessary repairs are not done immediately. It appears that Hospital management need to be strengthened to ensure acceptable level of physical conditions. Quality standards are not in place and exercise to establish quality norms has not taken place.
- No dedicated water supply for the district hospital. Water very intermittent adding to to unhygienic and unsafe conditions and risk of infections.
- Cleaning was poor; consists of sweeping. Floor washing not observed in the general wards. Floor tiling was appropriate in OT, Maternity wards and other treatment areas to ensure proper hygienic conditions.

Other Important areas:

- Bio metric attendance system (as introduced by the state) not observed to be in place.
- ASHA Gruha in place.
- Recently appointed FP councellor
- Hospital Manager post has high turnover. Hospital manager seems to lack authority and needs to be empowered further in hospital management and to have executive powers. Post needs to be made more attractive to ensure retention.
- PCPNDT act records were kept. Form F collected and kept for 18 registered private clinics with ultrasound machines. Further cross checking of records in suspicious cases not performed. Quarterly meetings (mandated?) not conducted. CDMO felt that it was too much paper work not leading to any results.
- In Sub-district hospital cases of Maternal Death are 2-3 per month and 6-7 neo-natal deaths per months.

Day-2:-5th November 2012

SUBCENTRE JOGIMUNDA

Excellent performance.30 deliveries per month. (356 since April 2012). However referral record is not available.High quality performance by ANC. Good feedback from community representatives.Recording & reporting is good

- HR: 1 ANM, one additional ANM is proposed, 6 ASHAs
- Total population catered to-7789 and covers 6 villages. Presently running in Government Building.
- Deliveries-40 per month
- 2nd ANM sanctioned but not post lying vacant, as residential arrangement for 2nd ANM is not present. Due to high load, new ward to be constructed, manpower to be added and empanelled JE vehicle to be located by facility.
- It's a delivery point and from April 2012 total number of deliveries conducted are:-356

- Training done by the ANM- SBA trained.No IUD training received.One IUD insertion done. No record of FP, spacing methods available. No copper-T in stock. No stock of OCP and Condoms there.
- Focus of facility is on deliveries. Due to high load other community outreach activities may not be fully attended to Eligible Couple register maintained. Counseling and follow up is weak.
- JSY payment being done timely.
- IEC material flashed on the wall
- No Fetoscope,No Zinc supply,IFA syrup not present and No NISCHAY KIT present.
- Bag supply for disposal of syringes after immunization session is a problem.
- No overhead tank present, instead tubewell present.
- Patient taking placenta along after delivery due to culture belief attached to it.
- SBA protocols not displayed
- MCP cards were being issued at the AWC.
- No recording of new born cases referred to nearest facility. Referral slip to be maintaintained
- Reported spontaneous abortion as MTP >12 weeks.
- Inj Taxim is being issued to Subcentre, but as per norms it should not be a part of Differential EDL.
- Dedicated room for labour room absent.
- NBCC provided 5 days back ,Labour Table,Ambu bag present.
- JSSK Entitlements not displayed.
- New infrastructure under construction.
- Untied funds being utilsed rationally at the subcentre. Opening and closing balance are matching.
- School health programme along with MHUs being done
- IFA will reach by December since last 6-7 months under procurement.
- Referral mechanism maintained as the numbers of local rickshaws are available with the ANM.
- Eligible couple register maintained. Counselling and follow up is weak.
- MCTS tracking done,columns filled in for delivery record .
- Untied grant register maintained, with vouchers.
- Uristicks and Hb kits available and the ANM was able to use the Haemoglobinometer.
- ANM able to explain the steps of 3rd stage of labour and she also explained functioning of radiant warmer.

Interaction with the public:-Village Jogimunda

- Pradhan, Sarpanch and other villages
- Delivery patients are not coming by JE by their choice since vehicle is at 16 Kms.Village is about 8 Kms.
- Small building needs new building.

School Health:

- Jogimunda Govt primary School
- 176 Children, health checkup done in August 2012, Register did not indicate the day of health Check up,
- Only few children were provided dose of worm infestation tablets, one child identified as anemic but not provided with IFA supplements
- Wt, Ht, worm infestation, checking of teeth, eye, ear, stomach, skin, resp system, lembs, disability, other problems, referrals

Salt Testing:

- Subcentre and school salt were tested and it had the required ppm of Idoine.

SDH PATNAGARH

- HR:-Medical officer-13, O & G Specialist-02,Paediatrics-1,No LSAS trained doctors, MD Medicine-01,Surgery-01,Opthalmic-01, Blood Bank-01
- Data:- Delivery-300/month, C.S-35-40/month,Bed-70,OPD-300,IPD- ,S.N-15,IPD-55/day,Opthalmic-15/20 per day
- Cataract Surgeries not taking place, No screening camps being held.
- DOTS initiative noted.
- Duty chart displayed.
- OPD EDL – out of 55, 26 types of medicine available.
- 127 cases but medicines issued to 25 patients.
- The facility has citizen charter and prominent IEC material flashed.
- Medicine, paed, surgery OPD seen about 120 cases but medicines given to about 25 OPD cases.
- **Paediatric ward:**
  - Case Study Baby of Shravahi:- 15 days came with fever
  - Spent Rs. 1000 on the patient.
  - No expenses on medicines. Free diet being given by hospital.
  - 2 other infants getting rational treatment.
- **ANC/PNC ward:** Suryakanti came by JE and C- Section –No expenses on medicines. Diet being received.
- JSY beneficiary: on interaction with few JSY beneficiaries it came to notice that all were being accompanied by ASHAs and most of them were travelling to the institution by hired vehicles. They had delayed JSY payment as they did not have relevant papers required for claiming money immediately after delivery.
- SBA training:CHC,SDH all conducting training, the trained-2 SNs are not proficient and they themselves need 3 weeks training
- **Labour Room:-**No referral out, Partogram wrong plotting , 2 SNs SBA trained.
- **Stores:-**
  - Drug ledgers not maintained systematically.
  - Short expiry drug list not available.
  - Deficiencies and weaknesses in stock registration systems. Expiry dates not entered in registers.

- **Rogi Kalyan Samiti-**
  - Total of 6 EB meetings and 2 GB meeting were held. Cash book is updated and maintained. Vouchers were available against purchases made.RKS funds are being utilized for payament of Outsourced activities like Cleaning, Laundry services and Security services
  - The cleaning contract has been given green clean services and Rs 30000/- is being payed as monthly contract charges to them.
  - Minutes of meeting and agenda is recorded.
  - 6 support staff inclusive of attendants have been engaged at various departments in the facility. Female attendant in EYE department is also doing bandaging of patients although she is not trained.
- **Biomedical Waste Management**
  - Dressing room – Infection control highly compromised.
  - No utilization of staff on IMEP activities.
  - Segregation of waste at site is not taking place as per laid down guideline. Although deep burial pits have been constructed at containment area, but still all wastes are being mixed and dumped into the pits. Empty vials and used syringes were lying outside the deep pits .
  - On interviewing the sweeper, he lacked knowledge about the segregation of biomedical waste management and reported that all kind of wastes were being dumped into a single deep burial pit. The sweeper was not wearing gum boots and gloves while handling the waste.
  - Unsterilised gauze kept- No drum.
- **Blood Bank and Laboratory**
  - Laboratory- 4 LTs, 30 tests done daily.
  - Monthly transfusion of 250-300 unit
  - Average issue daily: 8-10 bottles
  - ELISA reader not available, assured to be provided by 22nd August 2012 meeting
  - 2 Technicians working for 24 hrs
  - 2 functional, one non functional storage unit, AMC contractor came and still non functional
- **RSBY:**
  - At Patnagarh working hrs 10.00 am-5.00 pm
  - Total number cases from 23rd August to 4th November -87 cases, on 4th Nov- 4 Cases
  - Timings are not for 24 hrs
  - RSBY is run by NGO
- **Other Observations**
  - JSY Payment:- By check and instant for those who submit the necessary documents**.**
  - All normal deliveries are being discharged within 3-4 hrs of delivery. Confirmed after conducting exit interviews with certain beneficiaries.
  - Weak eye programme.
  - Referrals happen in JE and not in ambulance. Neither JE nor ambulance adequately equipped for referral of high risk cases. Especially Ambulance is very old jeep and not reliable vehicle. Oxygen facility for Ambulance out of order.
  - Errors in the reported MCTS data noted.

- At power failure – generator did not switch on automatically. Long delay.

ASHA INTERACTION 6TH AND 7TH MODULE TRAINING:

- About 40, 6th Module training, High demand of oral pills and condoms.
- R.D.T for all fever cases are done and medicines are given.

GKS CONVENTION

- Interaction with GKS members -ASHA,AWW and PRI members.
- Proactive ASHAs and AWW.
- Huge participation of ASHAs, AWWs and PRIs.

CHC GHASIAN-DELIVERY POINT, L2 DESIGNATED

- 16 bedded facility with 2 Medical officers inclusive of 1 AYUSH (Ayurveda)doctor,1 SN,1LHV and 2ANM.
- OPD load- 150 per day and AYUSH OPD-30 per day.
- Total deliveries conducted 25-30 per month.
- Separate room for conducting AYUSH clinic. Common cases received are Osteoarthritis, fever, gastritis and mainly cross referral cases are received.
- The Ayush MO is attending school health sessions, monthly 4 of them.
- Work plan available and monthly reporting formats available with the MO
- **Labour Room**
  - Staff nurse present is SBA and IUD trained, but lacks technical expertise.
  - Refresher training is required.
  - IMEP activities were compromised and SN lacked knowledge about IMEP activities.
  - Sterilisation highly compromised and the autoclaving drum contained unsterile gauze piece.
  - Delivery register was a maintained, however it was not signed by MOI/C and summary sheet was not made. Recommended record of abnormality using different ink so that it could be highlighted.
  - Referral in and referral out register was not being maintained.
  - Fumigation and carbolisation not being done.
  - Partogram not being maintained.
  - No Magnesium sulphate injections available.
  - New suction machine and Oxygen cylinder not having woulfs bottle.
  - JSY payments being made timely, however length of stay of patients is less than 24 hrs.
  - Equipments placed in the labour room were functioning.
- **BPMU:** HR: 1 BPM,1BAM,1 BDM and 1 PHEO
- RKS meeting including 02 GB meetings and 03 EB meetings have taken place. Activities like cleaning and laundry services have been outsourced. Recording of minutes of meeting and agenda not recorded properly.

SC JOGISUGUDA

- HR: ANM 1 , SBA trained, Conducted home deliveries till 2010-11
- Total population covered by the SC 6372, 7 Villages,6 ASHAs. Nearest CHC Loisinghi
- Newly constructed facility, water and electricity supply has not yet been established.
- 1 maternal death reported on 14/09/2012.
- Untied Funds have not been utilized since 30/11/2010 due to drifts between the sarpanch and the ANM.
- Documents were maintained including maternal and child tracking registers. However workplans did not mention the due list for the month of October and November.
- Display of entitlements were done at the subcentre.

Day 3:

CHC SAINTALLA- DELIVERY POINT

- HR:-3 MOs, 1 O & G specialist and 1 AYUSH, No LSCS trained, No pediatrician
- SN- 1 regular, 2 contractual, 1 additional ANM: All are NSSK trained and none SBA trained.
- Bed Strength:- 16 bedded, 4 maternity beds OPD- 70-80/day, IPD-3-4/day
- Case Load:-Deliveries- 100/ month, C-Sec : 5-6/ month, No anesthetist ,hired from outside.
    - Maternal Deaths- 1/month
    - Infants deaths- 10-14/ month
- Blood Storage unit / BB not present
- 1 Ambulance, 2 drivers, 1 empanelled Vehicle
- In the block only 2 facilities conducting deliveries: For 1,18000 population
- No power back up: 2 Invertors
- User charges being taken from patients. All diagnostic tests for Pregnant women being charged, PDK- Rs. 30
- Gyane is not performing MTPs

- **BPMU**
    - HR:- BPMU-1 BPM, 1 BAM, 1 BDM.
    - Concept of Delivery Point is not clear to the BPM
    - The BPMU caters to 3 PHCs, 18 SCs all are not DPs.
    - 3 Maternal Deaths in last quarter, CDMO and DM are revewing the deaths , the MDR formats are incomplete.
    - RKS- recording of Minutes, GB and EB body meeting- 1 in last eight months
    - GB meeting: Proceedings not recorded, Agenda not signed
    - Outsourced – pathology and cleaning services
    - Funds : Huge balances, JSSK ambulance cost is being met through RKS.
    - Call made to a random beneficiary from MCTS number and was verified and found correct except the JE Component
    - BDM – lack of knowledge about monitoinr activities taking place, formats and reports,

- MCTS messages not being sent

- **Eye OPD**
  - Opthalmic assistant; 100 OPD, 741 New cases sinceapril 2012, cataract operation reffered to Titlagarh or Mission hospital, Peepalpada
  - 20/10/ 12- PHC Belagon- one camp
  - No supply of ciproflox eye drop
- **Labor Room:**
  - No Mag Sulp,SN- Technically not sound, Toilets in Filthy condition, seggeregtion OF BMW not as per Guidelines, Hub cutter not utilized properly uncut needles were lying, partograph not maintained, LR protocols displayed.
  - SN could not operate NBCC.
  - No mosquito mesh in LR, windows were open.
  - No fumigation and carbolisation done,Sterliser was there
  - Delivery Register – No summary sheet and abnormality not specificaslly marked.
- JSY payement on time within 24 hrs, with cheque, matched with LR register, Chequebook, Signed by ASHA and Beneficary.
- MCTS- 98% updation of mothers and 82% of children, only 10% had self phone numbers.

Other Observations

- Exit Interveis with beneficiary: Early B/F, exclusive B/F, BCG and OPV -0 dose not given, paid money for transport – 500/-
- BCG, OPV-0 dose not given eventhough ILR point
- No diet under JSSK
- Good IEC
- PW given the least priority as one mother (CS done)in one room with dumped material
- ASHA incentive-per month 1500-2600 Rs approx
- Suggestion Box, No grievance redressal mechanism.
- It was brought to notice that sweepers hired under RKS grants were not being utilized adequately and sometimes technical staff were doing cleaning activities. Informal:PHEO, cleaning

N-PHC- BELGAON

- HR:- – 1MO deputed from Saitalla, 1 AYUSH ayurvedic MO trained in SBA, 1 Pharmacist and 1 Attendant
- Room lying vacant with unutilized Labour table, 1 AYUSH MO is SAB Trained- her services not being utilised
- OPD: Approx 30/day and 10 AYUSH . Timing 8-12 and 2-5, Cases in OPD were mainly fever cases.
- **General Observations**
  - Infrastructure with 6 rooms being underutilized.
  - IFA,Zinc and Magnisium sulphate – Short Supply
  - AYUSH MO visiting SHP on Mondays, but there was lack in clarity on the drugs for school health programme.

- One room was full of unused and condemned items, which included 3 sterilisers,1 ILR.
- Although no investigation is being carried out a lot of acucheck strips were there
- Freshly maintained registers (eg. RKS,NCD,Untied Funds etc.)
- 3 beds were present.
- Expired drugs in large numbers
- No water facility
- No Power back up
- Toilet clean
- Inclusive of ORS packs, ACT malaria, Cotrioxmole

- **RKS –**
  - Register maintained by Pharmacist, gross mismatch between funds in the cash book and that updated in the passbook.
  - Total funds available in UF-Rs 40954.00,AMG-Rs 79878.00, and RKS-Rs.4088.00.Total in cash book was Rs 124920.00, whereas updated passbook showed Rs 118889.00.
  - Nil records maintained for GB and EB meetings held. Vouchers were present against entries in cashbook, however lot of payments were made to the pharmacist as conveyance charges for collection of drugs from the DHH Bolangir.

2 ILR point registers checked which included CHC Kholan and PHC (N) Bhatipada for entry of VVM wastage. High wastage of BCG 40-60 and also DPT vaccines per session were recorded. Short supply of OPV vaccines in the district.LHV not conducting supervisory visits to VHND as well as immunization sessions.

SDH Titlagarh

Staff position Specialist: 2 OG Specialist, 1 PAediatrician,1 Eye specialist, 1 Pathologists, 4 Asst. Surgeons (No Anesthetist), 2 Pharmacists,3 LT, 2 Nursing sisters ,10 Staff nurses ,7 attendants and 2 Additional ANMs

- 90 Bedded Hospital, **Delivery load 250-300 per month**
- Contractual
- Program Officer,Accountant,2 SN and 2 additional ANM .
- **Underutilized Human resource as well as facilities.**

Program Management Unit:

- The Sub Divisional Hospital Manager lacks technical knowledge as well as was inefficient in conveying any information seeked.
- RKS , AMG ,Untied funds and FRU grant @ Rs 5 per bed per Day.RKS fund cash books maintained well, vouchers present against entry in cash book. Pass book updated timely.
- Under RKS outsourcing of activities are done inclusive of Cleaning-08 staff and Security Services-07
- GB not being done on an quarterly basis only 1 meeting held in the current year. Only 4 EB meeting held. Minutes recorded for all meeting held , however no action has been taken on

any recommendations. Pages were vacant in between entry of records maintained. Minimal user charges levied from beneficiaries.

- MCTS and HMIS data updation is 12 % approximately.

Labour Room :

- Delivery load 250-300 per month, C sections being conducted by hiring anaesthetists from outside.
- 10 out of 12 SNs were SBA trained, 3 are NSSK trained.
- Labour room had 2 ANCs with contractions and 2 PNC cases.
- Partograph not being correctly maintained.JSY payments made timely to beneficiaries.
- MTPs are being done.
- Incomplete and MTP average 40 per month .
- More number of incomplete abortions due to self medication by the PW.
- Grievances from ASHA related to length of stay with the pregnant women.
- Delivery registers being maintained, however suggestions regarding summary sheet and highlighting abnormalities during pregnancy was made.
- Newly established NBSU with 4 radiant warmers. SN was unable to operate it properly.
- Short supply of Foleys catheter, they are being boiled and reused for patients.
- No carbolisation and fumigation being done. Only wet mopping being done.
- Magnesium sulphate is short supply. Oxytocin being utilized for induction of patients.
- Privacy being maintained using screens. Misoprostol being given after every delivery.
- **No separate Eclampsia room being maintained, eclamptic patients are being treated in maternity ward along with other patients.**

Other Observations

- Xray machine functioning and minimal user charges being charged. The User charges are timely deposited to the BADA every Monday.
- In Male wards female patients were also accommodated, no privacy maintained.

Case Study:

- A post natal case was interviewed who reported timely JSY payment.However on enquiring about JE ,reported that had hired a private vehicle @ Rs 500/- to come to the facility. The beneficiary was accompanied by ASHA.
- Dry diet being provided to PNC cases under JSSK scheme which includes 200 gms Bread and Parle G Biscuits. No other dietary provision apart from that.

FDG GKS:

Money spent on the activities:

- Cleaning of pond through lime, Purchase of dari, pen, glass of drinking water and Mug, road cleanliness.

- Training in August: On spending money and plan preventive health programmes.
- The expected/ training needs of ASHAs and PRI member is strengthened maintenance of records , Village level conventions, making prevention plan for health problem at village level.
- The expected/ training needs of AWW(convener): How to spend money and proper maintenance of records and registers.

Village:

- FDG conducted in the village
- Villagers had satisfaction over improvement of health services over 3-4 years
- Not aware of functioning of GKS in the village
- RSBY cards were not made for all BPL families, however block health functionarires inform that this is due to unplanned activities of insurance officials without intimation of local health officials
- JE scheme was not availed in the village.
- Mothers /PW Given MCP card without MCTS Unique ID

VHND- DHARAPGARH AWC

- The discussion was not as per the Microplan which stated ARI but on Breast feeding, complementary feeding and immunization
- AWW and ANM And ASHA present
- Weighing session, Nutrition and health education, ANM referred one case to health facility, child was severely under weight.
- MHU was not available.
- 3 PW and other women 10, 7 children.
- CDPO was unaware of the Session plan of VHNDs (which were to be held at specific AWCs).Saintalla block
- JE: Seen the register 1am t 10 am- around 6 trips were made by the JE
- Mothers were aware of weight of the child, encouraged to B/F immediately after the birth and paid, JSY cheque on the spot, nothing was charged from her. Free transport was provided pick up and drop back up.

GKS- BADAMUNDA

- Constituted in March 2009 but not functional for some period and actively stated functioning in August 2012.
- Joint Account – PRI and AWW
- Monthly meeting held
- Money used for purchase of bathroom weighing scale, village cleaning, organising street plays and folklores(pala), examination table and wall painting, training on orientation on GKS, preventive measures for health issues.
- Training needs/ expectation: Maintenance of records
- 166 M-HW sanctioned posts against this 145 in position, their work load need to be assessed and defined

- GKS money can be made differential based on population

SC-DESIL

- 7769 population ,2ANMs and 8 ASHAs
- No deliveries conducted
- Senior ANM there for 15 years. Population covered 7669. Very close to the SDH Titlagarh (3 km) and on the main road. Outside surroundings of facility kept in good condition.
- Register for immunization and ANC kept up to-date. Due-list/work plan was available. ANM would prefer work plan to be organized village-wise.
- Drugs not well organized and likely stock-outs although not fully verified. IFA paediatric syrups available.
- In general, the facility did not seem active, with low service delivery at the facility itself. Posters with Public Health information not displayed in the consultation room.
- Deliveries not conducted as the SDH Titlagarh takes the load.
- Outreach activities such as VHND, ANC training and immunization performed although no ASHAs or clients were consulted on quality.
- On FP the activity is very low. IUD training received. Since IUD training last year only 3 IUD insertions done. 2 were removed due to bleeding and other causes. One remained in use. Stock of IUD not kept. Lack of demand cited. 25 strips of Oral Pills distributed although demand was as high as 90 per month. Additional stock was not requested through the CLMIS system. No awareness of the system.

SC- BHADRA

- Sub-centre seemed very active. Population 6072. 6 ASHAs.
- Good performance by ANM.
- Recording and reporting is good. Register for immunization and ANC kept up to-date. Due-list/work plan was available.
- Screened for NCD (Hypertension & Diabetes)
- Spacing methods available. No copper-T in stock. IUD insertion training received by ANM on year ago. 13 IUDs inserted since training, of which all had subsequently been removed. Discomfort and "psychological" reasons were cited. 120 strips of oral pills being distributed per month. No report of stock-out. Supply requested through CLMIS system on text message and it is working.
- Outreach activities such as VHND, ANC training and immunization performed. The ANM had been present at the VHND visited by surprise earlier the same day. The ANM showed good pro-activeness in coordinating and collaborating with ASHA, AAW and PRI alike.
- Garden not maintained; very crowded room, examining table with curtain for privacy, windows closed.
- All medicines displayed and stocked. Has registers that are updated, but have not been arranged systematically. Knows how to triangulate between her registers and the work plan printout.
- Wall painted timings and statistics present – recently (few days) repainted.

GENERAL OBSERVATION

- Privacy not being maintained in the Labour rooms and most of the facilities had open windows without mesh doors in the LR.
- Counselling regarding family planning not being done in case of multigravida cases immediately after delivery.
- Awareness regarding breast feeding practices is good among beneficiaries.
- Labour room protocols flashed. IEC/BCC visible in almost all facilities visited. JSSK activities visible.
- Lack of coordination between regular and contractual staff, specially the management cadre.

ANNEXURE 2 : HUMAN RESOURCES FOR HEALTH

Category of Intervention	Examples	Whether in place?	Status of implementation/remarks
Financial Incentives	Quantum of monetary incentives for serving in the difficult, most-difficult and inaccessible areas	Yes	• Incentives: incentives for doctors working in KBK region (Rs. 8,000/- for periphery and Rs. 4000/-Dist. HQ). • Specialist allowance of Rs. 3000/- has been introduced. Remuneration of specialists has been hiked up to Rs. 30,000/-. • Post mortem allowance is introduced. Regular clinical staff would receive a retainership allowance of 10% annually on completion of one year as a special incentive. • Hardship allowance under NRHM for Paramedics serving in Vulnerable areas (V3&V4).
Education	Students from Rural Backgrounds	Yes	• Scholarship for SC/ST students in private nursing schools & colleges.
	Health professional schools outside major cities	Yes	• Training to SN on FBNC observership training to Mumbai. • On international exposure to Bangkok on utilization of SAB skills to one SN. • National level exposure on SAB to rural SNs of 2 districts (Angul & Kandhamal) in the year 2011-12. • For doctors, pg DIPLOMA IN Public Health Management is sponsored by NRHM. • National award on LSAS & EmOC to MBBS doctors.
	Clinical rotations in rural areas during studies		
	Bonus marks in PG entrance tests for serving in under-served areas	Yes	30% of bonus marks is given for 5 years rural services in KBK districts
	Continuous professional development for rural health workers		

Regulatory	Non-practicing allowance		
	Compulsory service in under-served areas	Yes	Recruitment /Placement-Policy • 1st posting in KBK and Tribal sub-plan/ Rural postings
	Other: Enactment of law for Safety		• The act provides safety from manhandling of Doctors during duty • Legislation has been made to prevent violence against Medical personnel and institutions.
Professional & Personal support	Provision of residential quarters	Yes	
	Career development programs, CMEs etc.		• Entry level of Asst. Surgeon has been up-graded from Class-II rank to the rank of Junior Class-I (Rs.15,600/- to Rs.39,100/- with GP Rs.5,400/-) • Retirement age of regular doctors has been enhanced from 58 years to 60 years. Promotional avenues: • PAR compulsory- 3 - 5 years • Based on OPSC seniority list • Gradation • Service particulars • Panel list prepared for a year • Promotion not considered on adverse remark, departmental proceedings and vigilance cases/ non availability of service particulars

KEY CONDITIONALITIES, INCENTIVES, TIMELINES AND ACTION PLAN

Conditionality	Action Taken by the State	Remarks
1. Rational deployment of HR with the highest priority accorded to high focus districts and delivery points/priority facilities	• Deployment of additional staffs (sanctioned under NRHM) only at DPs as per norm. If staffs are not in position at DP, repositioning would be done by **end of August 2012.** • Rationalization of HR is in process as per MCH plan, i.e. deployment of staff as per L1, L2 and L3 Status. Teams have been created at State level for facility based monitoring. • Filling of vacancies of all regular and contractual paramedics to be completed by the stipulated period. • Doctors under order of transfer are to be relieved by the CDMO latest by **31st July 2012.** • The Salary bill of August 2012 is to be attached with the Biometric attendance of all staff at directorate and district hospitals. • Repositioning of staff like Staff Nurse,H.W(F) etc for delivery points is to be completed by **end of August 2012** • Incentives for difficult/Hard to reach areas are performance based. State has developed formats to assess performance, based on which they give performance incentives. • For e.g.-The performance Incentive (PI) to SNCU staff would be paid on fulfilling the following conditions. • Criteria **Condition No. 1**. Monthly bed occupancy (inborn to out born) ≥ 80% **Condition No. 2.** Follow up of discharge cases ≥ 80% due for the particular month **Condition No. 3.** IMEP & FBNC guideline to be practiced **Condition No. 4.** Reporting on 10th of	• Total Health Institutions in the State- 8430 out of which there are 700 Delivery Points which is only 8 % of the total facilities. • Focus of the state would be on these limited performing institutions in the current financial year, so that they are at least well equipped. • There is a huge shortfall of specialists in the district. During the visit it was found that there is a huge shortfall of gynecologists and there are no anesthetist posted in the district. Doctors are being trained in LSAS so as to conduct C-Sections. • Rational deployment of human resources should be done in order to enhance the capacity of the referral centers of the district. **Timelines** • For vacant Posts Issue of Advertisement:- 25th July 2012 • Date of Walk-in Interview • Staff Nurse-6th August 2012 • Pharmacist- 7th August 2012 • Laboratory Technician-8th August 2012 • Radiographer-9th August

Conditionality	Action Taken by the State	Remarks
	every month to the State.	
1.1.1Rational deployment policy which would inter alia include: Posting of staff on the basis of case load (OPD/IPD/Normal deliveries/C-sections),rational deployment of specialists especially gynecologists, anesthetists, EmOC and LSAS trained doctors in teams, posting of trained HR as per the level of the facility e.g. LSAS and EmOC to be posted in the FRUs, and filling up of vacancies in high focus/remote areas on priority basis	• Policy decision has been taken for rational deployment of staff in all 700 DPs. • Special emphasis has been given for posting of O&G / EmOC, Pediatric & Anesthetic/ LSAS trained doctor in all 145 FRUs. • Policy decision has been taken to post doctors not declared as specialist having PG qualification, will be posted in place of specialist. • As per State Govt. Mandate, all CDMOs have been instructed to engage required number of staff nurse/ ANMs in all delivery point through redeployment as well as filling up vacancies.	**Timelines:** Policy notification (copy) and Website posting is in process and state has agreed to comply on the same by November, 2012
1.2.1 Preparation of baseline data for HR including the current place of posting and their productivity/caseload; system in place for updation.	• State has developed online HRMIS to capture details about the Human resources like name, designation, place of posting, date of joining, salary etc. This is available in NRHM Website. • Further, steps have been taken to capture productivity/ output of each trained staff like EmOC / LSAS/ SAB/NSSK trained persons by means of preset performance monitoring indicators made by the state.	Although the data is available but it is password protected and not visible as a part of mandatory disclosures which was laid down in the ROP.
1.2.2 Evidence of corrective action in line with the policy	• Delivery points are in process of being fully staffed as per norms. Current status • 54 % (382 out of 700 insts.) DPs with required no's of SN/ANM • 81% (118 out of 145 insts.) L3 DPS with O&G Specialists • 73% (106 out of 145 insts.) L3 DPS with Pediatric Specialists • 57% (84 out of 145 insts) L3 DPs with Anesthetist/LSAS doctor • 45 out of 66 LSAS trained doctors available in the system (total trained till date-89, left for PG/Senor resident etc.- 23) are posted	During the visit it was observed that there is HR shortage in almost all facilities visited and main cause of huge attrition rate is lack of motivational levels as well as inadequate facilities available for service providers

Conditionality	Action Taken by the State	Remarks
	in L3 DPs • 20 out of 32 trained EmOC trained doctors available in the system (total trained -38, left for PG-6) are posted in L3 DPs.	
2.Facility wise performance audit & corrective action thereon on regular basis	• CDMOs of the districts have been urged to mobilize existing team (constituted for MCH centre monitoring) for regular monitoring & supportive supervision of Delivery Points • Submission of quarterly status report of all DPs duly signed by CDMO & ADMO(FW) • Statutory report & concurrent audit report is to be submitted by the districts by **31st August.** • Appointment & registration of agency is to be completed by **31st August 2012.** • Salary of DPM & DAM is to be withheld, if the physical and financial progress reports are not sent by 5th of every month.	Performance audit of all Delivery Points on 4 Parameters; 1.Delivery Services- avg. delivery load in a quarter must not be less than suggested performance benchmark 2.New Born Services- must have functional New born care corner (equipment / instruments as per norm, trained NSSK/SBA staff & report on monthly basis) 3.Sterilisation Services– On fixed day as per its level 4.Non Clinical Service Provisions -As per suggested standard Appointment of auditor had not taken place till the date of visit.

Conditionality	Action Taken by the State	Remarks
2.1.1 Range of services (as in MNH guidelines for RCH services, OPD, IPD and other services to be determined by the State) specified at least for delivery points	• Comprehensive guideline has been developed to provide range of RCH services in all MCH centres with major focus on delivery points. • For each level of delivery points service mandate are specified.	
2.2.1 Facility wise reporting on HMIS portal by all priority facilities/delivery points for October(SC data if needed be uploaded from PHC)	• Facility wise HMIS data have been captured in DHIS-II, since October, 2010. However, as per GoI direction uploading of facility wise HMIS data in GoI portal has been completed in 12 districts and uploading of data of rest 18 districts will be done during this month.	
2.2.2 Corrective action (priority to be given to high focus districts) based on facility wise reporting.	• Feedback report on HMIS is generally communicated to districts for necessary action in order to improve data quality and timely reporting. • A Committee has been formed at district & block level to validate both HMIS & MCTS data on monthly basis before uploading. • Further, district wise analysis of 16 dashboard indicators are also done and communicated to districts for necessary action to improve the status.	At the district level endeavors are being taken for updating the HMIS and MCTS data, however at block level there is delay in reporting which is affecting the updating of data at the district level.
3. Gaps in implementation of JSSK (May lead to a reduction in outlay upto 10% of RCH base flexi-pool.)		
3.1.1 Government order for coverage of entire State regarding: • Free delivery (including C-section if required) • Free diet • Free treatment to sick new born upto 30 days • Grievance redressal system with specified timelines for redressal	• As per State mandate 382 public health institutions were designated as JSSK institutions during launching of JSSK in the State on 1st November 2011. • However, as per PIP 2012-2013, 700 DPs are now designated as JSSK institutions to provide JSSK services as per its level. • Localized Grievance redressal mechanism is in placed in all JSSK institutions. • There are designated Grievance Redressal Officers at all levels i.e. State, district, block & facility level. • Monitoring of the system is being ensured through complaint and suggestion box as well as centralized through "Sanjog Helpline" – a web based complaint received through Toll free	Copy of Government order has been posted on the state website • During the visit at DHH a complaint box was placed, which was common for dropping all kinds of complaints, including JSSK from user side. As per the hospital in charge the box is opened by staff member of the facility weekly and possible solution is given to complaint. • There is not much awareness among the community about

Conditionality	Action Taken by the State	Remarks
	Number to redress all types of grievances related to service delivery and health entitlement under "JSSK"	sanjog helpline as was confirmed during the interaction with beneficiary in district Rayagada. Some CHCs also have complaint boxes which seem to be unused. • Thus wider dissemination of information about Grievance redressal cell (Sanjog helpline) is recommended. • Also the dietary provision under JSSK at CHC level is not being provided.

Conditionality	Action Taken by the State	Remarks
3.2.1 State wide dissemination of GO/policy; visible IEC in facilities and community awareness.	Multipronged strategies have been adopted for creation of mass awareness among the community as well as among the service provide among the JSSK, which are as follows; • Print advertisement in local dailies. • Wall writings/Tin Boards for all health institutions including hoardings in DHH and Block PHCs. • Profiling JSSK in Media with talk shows/phone in/panel discussion. • Spots and Jingles in existing kantha kahe kahani programmes. • Advertisement through Saving passbook of Indian Post Village Contact Drive in media dark areas (integrating with MHUs) • Using Folk Media with a standardized script of JSSK Using 'Suno Bhouni' quarterly handout to promote JSSK among SHG members • Self adhesive pictorial leaflets promoting JSSK entitlements (to be sticked with MCP card during pregnancy regn.) • Promoting among PRI members (Swasthya Samachar) • Wall Hanging for every AWCs to be used as IPC tool by AWW/ASHA during VHND sessions • 30 minute Audio CDs on JSSK scheme for all selected Sub centres of Village Contact Drive programmes • GKS level – Swasthya Kantha Update and wall writing on Grievance Toll free number.	During the visit fixed hoarding placed at block and district level included entitlements related to Citizen Charter, entitlement of schemes and programmes including: • JSY entitlements • JSSK entitlements • RSBY • Diagnostic facility • Family planning related entitlements ➢ Citizen Charter was not visible at all facilities visited. ➢ GKS level – Swasthya Kantha Update and wall writing on Grievance Toll free number was not visible as walls were in the process of being painted for the current financial year. ➢ Ambulances of JSSK had NRHM logo visible on them. Spots and Jingles were being flashed in the waiting room of DHH; however they were basically for common health problems of the area, which included awareness about Malaria and Diarrhea.
3.2.2 No user charges for pregnant women and newborns. Drugs, diagnostics, diet should be available free. Grievance redressal system operational.	• A Govt. Notification has been issued to the districts in this regard.	During visit to the district it was observed that user charges for diet are not being taken from patients, however minimal user charges for diagnostics are being charged.

Conditionality	Action Taken by the State	Remarks
3.2.3 At least 50% of pregnant women and sick newborns coming in should be using assured and cashless means of transport- and getting a similar drop back home.	Various steps have been taken to ensure free referral transport services to JSSK beneficiaries are as follows: A comprehensive guideline on referral transport has been developed and circulated to all concerned. • 466 vehicles points have been identified to ensure response time within 30 minutes in all areas. • Steps have been taken to establish call centre at the State level through single toll free number online with 102. However, at present call centres have been established at the district level with district specific numbers. • In addition to Janani Express 445 ambulances are also used to provide referral transport services to JSSK beneficiaries • For visibility of vehicles branding has been done in all Janani Express. • Special area specific plans have been developed for non-motor able and difficult & hard to reach areas. • Establish linkages for the inaccessible areas (hilly terrain, flooded or tribal areas etc) to the road head / pick up points • Monitor and supervise services at all levels, including utilization of the each vehicle and number of cases transported	At the district level the visibility of the Janani Express is good and they are being utilized adequately. In difficult terrains and hard to reach areas the linkages are not so strong, as response time is more due to inaccessible areas and difficult terrains. The patients often resort to private facilities. The district specific numbers are made available at various health facilities.
4. Continued support under NRHM for 2nd ANM would be contingent on improvement on ANC coverage and immunization as reflected in MCTS. Vaccines, logistics and other operational costs would also be calculable on the basis of MCTS data.		
4.1 Increase in ANC coverage (first ANC and full ANC) as per MCTS data in (1) State (2) High Focus districts	• Strict instruction has been issued to improve uploading of data in MCTS so as to reflect actual coverage ANC.	• The uploading of data in MCTS is not satisfactory in the district and during visit to one of the CHCs the MCTS data had not been updated show causing the reason that there is server problem and regular updating is not possible. • However, as per current data the coverage is not satisfactory
4.2 Increase in full immunization as per MCTS data in (1) State (2) High Focus districts.	• Strict instruction has been issued to improve uploading of data in MCTS so as to reflect actual coverage of full immunization.	
5. Responsiveness, transparency and accountability (incentive upto 8% of MFP).		

Conditionality	Action Taken by the State	Remarks
5.1 Demonstrated initiatives including innovations for responsiveness in particular to local health needs e.g. use of epidemiological data, active participation of public representatives in DHS / RKS meetings, etc.	Several steps have been taken to improve transparency and responsiveness in health care delivery system as well as programme management , which are as follows: • Sensitisation of PRI members through Panchayat Samachar quarterly Bulletins published by PR Deptt. • Steps have taken to sensitise all PRI members especially Palli Sabha & Gram Sabha members on different health schemes and programme and role of PRIs, as a part of State wide campaign on sensitisation of newly elected PRI members. • Village wise comprehensive action plan for all Govt. Programmes including village health plan are being prepared.	• Initiatives like preparation of Village health plan have been done in village Guakana in district Rayagada, it was facilitated by Care India and PRI members, VHSNC members as well as representatives from the village were a part of the same. • It was observed during the visit that in certain VHSNC (GKS) the front foot is only being taken by the AWW who is one of the members of the GKS. Other members are not actively participating in activities being taken up by the GKS.
5.2 Demonstrated initiatives /innovations for transparency e.g. mandatory disclosures and other important information including HR posting to be displayed on State NRHM website, schedule of MMUs and RCH camps etc. to be disseminated among user groups in addition to these being displayed in the State NRHM websites etc.	Several steps have been taken for display f data in NRHM website with regard to following items. • Display of information on Human resource. • Display of information on MHUs, PMU vehicles, Procurement. • Beneficiary wise data base on JSY, JSSK, Sterilization, cataract operation etc. • Necessary web designing and software development is under process.	Currently this information is not visible to general public on the State NRHM website, as per the state it is process and would be displayed shortly.
5.3 Demonstrated initiatives /innovation for accountability: e.g. call centre for integrated grievance handling system, aggrieved party to receive SMS with a grievance registered number; action taken within stipulated time; community monitoring; Jan sunwai etc.	• Processes have been initiated to establish health helpline cum referral transport call centre at the State level with single toll free number. • However, at present a single toll free number has been dedicated to health department through Sanjog helpline to registered complaint with regard to JSSK services and other health entitlements. • Community monitoring system has been renamed as “Gaon Swasthya Samikhya” and implemented in 5 districts of State. A detailed guideline has been developed	The referral transport call centre is not yet functional. • Awareness about sanjog helpline as was confirmed during the interaction with beneficiary in district Rayagada is not much.

Conditionality	Action Taken by the State	Remarks
	and circulated to all concerned districts for implementation of the same. • State Advisory Group for community Action has been formed and a meeting has also been held for successful implementation of community monitoring activities in the State. • Further, a Rajya Swasthya Samiti has been formed under the Chairmanship of Hon'ble Minister, H & FW, comprising of Secretaries of different line depts., public health experts and NGO representatives.	• Wider dissemination of information about Grievance redressal cell (Sanjog helpline) is recommended.
6. Quality assurance (incentive upto 3% of MFP).		
6.2.1 Constitute dedicated teams. Training of state and district quality team and DH quality team completed.	• State and district level quality assurance committees have been formed. • Sensitisation of members is also held with support of NHSRC.	The timelines have been partially met.
6.2.2 Current levels of quality measured for all "priority facilities" and scored and available on public domain. Deadlines for each facility to achieve quality standards declared.	• Guideline has been issued for rational use of drugs and prescription of drugs out of Standard Treatment Protocols etc. • Policy decision has been taken for use of carbon copy prescription and prescription audit. • All State nodal officers are directed to monitor this activity. • In addition, a Standard Treatment (STP) Protocols for pregnant woman and sick newborn has been developed. • STP for labor room, SNCU, NBCC and NRC are also prepared and displayed major health institutions to ensure quality of care.	Processes have been initiated for obtaining ISO certificates for 9 DHHs.
7. Inter-sectoral convergence (incentive upto 3% of MFP).		
7.1.1 Implementation frame work for intersectoral convergence with allied sectors/departments 7.2.1 Intersectoral convergence opportunities identified with WCD, PHED, education, etc. and action initiated.	• Intersectoral convergence with Rural Development, W&CD & PR Deptt. Are being strengthened at the village level through formation of Village Health Nutrition & Sanitation Committees popularly known as Gaon Kalyan Samiti (GKS). These Committees are also actively involved in preparation of integrated village health plan,	Capacity building at GKS is being taken up development partners such as Care India etc, also local SHG are also actively involved in activities pertaining to community mobilization and social development.

Conditionality	Action Taken by the State	Remarks
	addressing all issues related to nutrition, sanitation & safe drinking water. • Capacity building of GKS through involvement of Development Partners/ INGO are being done for strengthening of inter-sectoral convergence. • In order to improve participation of PRI on health, information on different health schemes issues are being regularly included in "Panchayat Samachar", published by PR Deptt., which is circulated to all Gram Panchayats of the State. • In addition a special health bulletins namely "Suno Bhouni" is also published by H & FW Deptt. to sensitize more than 5 lakhs women SHG members on different health schemes and issues in order to improve participation of SHG members on promotion of health, nutrition & sanitation status of the villages • Meetings are being held at various levels for successful implementation of different activities like, school health ARSH, MHM, Immunisation, NRC, WIFS etc.	
8. Recording of vital events including strengthening of civil registration of births and deaths (incentive upto 2% of MFP).		
8.1 A strategy paper identifying reasons and the road map for increasing registration	• Steps are being taken for **online** registration of Births & Deaths in all urban areas rural areas up to block CHC level. • Separate software has been developed by IT deptt and successfully rolled out in 44 urban areas and it will be rolled out across the State by 1st November.	
8.2 Death reports with cause of death (especially any under 5 children or any woman in 15 to 49 age group) shared with district health team on monthly	• Both maternal and infant deaths are being collected through community and facility based reporting systems in line with Maternal Death Review. • Same has been reviewed both at the State & district level on monthly basis.	

Conditionality	Action Taken by the State	Remarks
basis.	• Based on the report necessary feedbacks are given to districts for corrective action.	
9. Creation of a public health cadre (by states which do not have it already) (incentive upto 10% of MFP)		
9.1.1 Stated policy and road map (including career path on creation of a public health cadre)	• Creation of separate public health cadre is under active consideration of Govt. • Different high level teams have been deputed to other States to learn about public health cadre. • Accordingly, a draft policy has been prepared which will be finalised shortly. • A separate Directorate of Public Health has been created with dedicated Director, PH; Addl. Dr. PH & JD, PH. • Likewise dedicated programme officers likeADMO, PH, DSMO, DTO, DLO, DMO, are being placed at the district level to look after all public health issues after restructuring of Odisha Medical Service Cadre. • DPH has been declared as Food Safety Commissioner of the State level & ADMO, PH has been declared as Food Safety Officer for the district.	Presently there is no separate public health cadre existent in the state; however state is in process of developing Policy documents & road map for the same. Timelines: as of now state has agreed to comply with the timelines set by GoI.
10. Policy and systems to provide free generic medicines to all in public health facilities(incentive upto 5% of MFP)		
10.1.1 Clear policy articulation of free generic medicines to all in public health facilities	There is a clear policy for use of generic drugs in the State, accordingly EDL has been prepared. • All types of drugs as per State EDL are being procured and supplied to all public health institutions.	In District Rayagada it was observed that there is shortage of certain essential drugs like Tab Paracetomol, Tab Norflox, Tab Cotrimaxazole, Tab Metronidazole ORS packets, Halogen etc in the subcentres, this particular issue was communicated to the District CMHO during the meeting for necessary action.
10.2.2. Overall procurement and logistics strategy in place. Detailed design and plan for rate contracting, regular stock up dates, indent management, warehousing, promotion of rational drug use,	• A separate State Drug Management Unit headed by DHS, Odisha with Joint Director, SDMU along with required number of staff is in place to ensure procurement and supply of drugs, consumables and equipments & instruments. • There is a State policy / guideline for	

Conditionality	Action Taken by the State	Remarks
contingency funds with devolution of financial powers etc. in place.	transparent procurement of drugs and ensuring quality of drugs. • In order to address the shortage of drugs 20% of drug budget are allocated to districts for decentralised procurement. Rest 80% of budgets are kept at the State level for centralized procurement and supply.	