

12th Common Review Mission Dissemination

Key Findings and Challenges

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Five days Schedule



Field visit **started at Village level**

2 days spent at village conducting **Community level Group and Individual interactions** to identify health needs and gap (if any) in demand and supply



Nearest Sub Centre/ Health & Wellness Centre



Nearest PHC/ UPHC to which the villagers/ slum dwellers go
(half the team visited the slums before going to UPHC)

Nearest CHC, Sub District Hospital/ District Hospital/ Medical College to which villagers go.

Tracing the continuum of care



States Visited

19 States visited: 2 district in each state (Aspirational District/ Health & Wellness Centre District / Population based NCD Screening district to the extent possible) selected

Bihar

Chhattisgarh

Jharkhand

Madhya Pradesh

Rajasthan

Uttarakhand

Uttar Pradesh

Andhra Pradesh

Gujarat

Himachal Pradesh

Jammu & Kashmir

Karnataka

Punjab

Maharashtra

Tamil Nadu

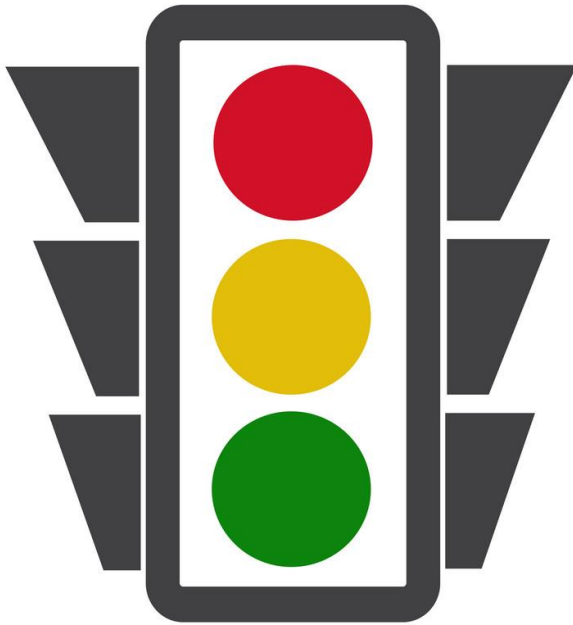
Telangana

Arunachal Pradesh

Assam

Tripura

The Matrix



Areas of Concern

We can do better

Good and Satisfactory

** The matrix colour coding may differ but we are sure that though RED may become YELLOW if wider geography is consider, but it wont become GREEN and likewise*

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RMNCH+A

RMNCH+A: Positives

Institutional delivery in public facility increased in all states

Innovative practices like **Birth waiting homes** (AP and Maharashtra) and **“Hirkani Kaksh (Breastfeeding room)”** (Maharashtra)

Community is well aware about early and exclusive breastfeeding

Mission Indradhanush has contributed to **scaling up full immunization**

Functionality of SNCU, NICU and PICU services established in all states; however, **quality could be improved further**

Family Care Centre: Mothers of new-borns admitted in SNCU are provided information and counselling on hand washing practices, feeding of low birth weight babies, KMC etc: Rajasthan

Good awareness and knowledge on Adolescent Health amongst community
– Andhra Pradesh, Karnataka and Telangana

Reproductive Health: Areas of Concern

Early age of marriage and teenage pregnancy still a major issue

- Jammu & Kashmir, Tripura, Andhra Pradesh & Bihar

Poor awareness about Comprehensive Abortion Care

- J&K, Tripura, Telangana, Uttarakhand, Andhra Pradesh, Arunachal Pradesh, Gujarat

Advocacy for acceptance of male sterilization is needed in all states

FP-LMIS (Family Planning Logistics Management Information System) **was not implemented** in most states except in Uttar Pradesh and Karnataka

Gap between Knowledge and Practice: Demand for family planning among the states is highly diverse

Maternal Health: Areas of Concern

High OOPE during Child Birth

- Arunachal Pradesh, Punjab, Bihar, UP, Chhattisgarh and Rajasthan

VHND sessions limited to immunization services. ANCs weak in most states largely due to lack of privacy, trained personnel and quality testing

PMSMA is implemented in all states but the **quality of service provision remains an issue**

Increased episiotomies

- Andhra Pradesh and Assam

and C sections

- Tripura, Andhra Pradesh, Assam, Punjab, Karnataka and Tamil Nadu

New-born and Child Health: Areas of Concern

Gap between Knowledge and Practice related to **breast feeding**

- Jammu & Kashmir, Rajasthan, Tripura, Assam, Bihar and Jharkhand

Practice of Kangaroo Mother Care (KMC) was found **lacking** in most states, both at community as well as facility level

Suboptimal awareness of mothers and family members **on childhood illnesses** such as signs and symptoms of diarrhoea and pneumonia

- Bihar, Uttar Pradesh, Maharashtra, Arunachal Pradesh & Andhra Pradesh

Lack of skill development trainings for ENC, NSSK, SBA & IYCF, KMC etc

- Jammu & Kashmir, Madhya Pradesh, Uttarakhand and Bihar

Summary of Findings: Maternal Health

SDH/ DH	CHC/ UHC	PHC	Sub Centre	Community Level	
					AP
					Arunachal
					Assam
					Bihar
					Chattisgarh
					Gujrat
					HP
					J&K
					Jharkhand
					Karnataka
					MP
					Maharashtra
					Punjab
					Rajasthan
					Tamil Nadu
					Telangana
					Tripura
					UP
					Uttarakhand

Case Study: Jharkhand

Home deliveries in villages located near Bokaro (Chas and Nawadih block):

Home deliveries conducted by local *elderly women/ Dais* (non SBA trained) is still observed in villages of two blocks of the district visited. **First visit of a home delivered mother to a health facility happens only when the child or the mother falls sick.**

The *Dais* mentioned that in case of any **haemorrhage**, the mothers are taken to the **local doctors (quacks)**. In case the quacks are unable to provide treatment, the mothers are then taken to local private hospital.

PMSMA: Cases of 8-month pregnant woman accessing the services for the first time was observed. She heard about this initiative in radio. Services available at DH level leading to overcrowding. USG services are available free of cost only on 9th, rest of the days a cost of INR 350 is levied.



Communicable Diseases

Communicable Diseases: Positives

RNTCP

- ✓ **Community** in most of the states were **aware of symptoms of TB and knew where to get tested**
- ✓ **Annual TB notification rates in public sector** met target in most states but low in private sector. Maharashtra has initiated JEET project to improve the same
- ✓ **Schedule H1 data reporting** was done well in Himachal Pradesh: “**Mukhya Mantri Kshay Rog Niwaran Yojna**”

NVBDCP

- ✓ **Vector control measures** such as use of LLINs, IRS, fogging and spraying in place across most states. MP has linked vector control with ‘**Swachh Bharat Abhiyan**’.
- ✓ **Adequate supply and infrastructure for malaria testing** e.g. microscope, stain, trained staff found in most states

RNTCP: Areas of Concern

Poor Knowledge of Nikshay Poshan Yojana (NPY) amongst the community as well as the health workers (ASHAs/ANMs)

Capacity on Extra Pulmonary-TB, Drug Resistant-TB and newer Rx guidelines of TB for the healthcare providers(MO, MPHs) and ASHAs is inadequate

**Underutilization of CBNAAT centers in few states like AP & Gujarat.
Universal DST percentage to be improved in all States**

OOPE incurred in traveling to CBNAAT centers, a deterrent in getting the tests done

Functional X-ray facility to be provided and utilized in most of the states

NVBDCP: Areas of Concern

Private consultations with quacks for treatment of malaria and dengue:
Madhya Pradesh, Uttarakhand, Tripura

Dengue showed increasing trend with recent outbreaks: Jharkhand, Telangana

ASHA/ANMs lack skill to do RDT/prepare slides (thin and thick) **of suspected malaria cases.** Active screening and testing of symptomatic cases needs emphasis

Supply of short expiry anti-malarial medicines reported in some states.
In some high endemic areas and states, supply of medicines/ACT kit for paediatric age group found inadequate

Documentation of malaria tests done and positive cases to be improved.
Format of documentation to be revised

Communicable Diseases: NLEP

- ✓ **Community awareness about signs and symptoms of leprosy was adequate:** Chhattisgarh, MP, Jharkhand and Arunachal Pradesh
- ✓ Adequate supply of drugs found in most of states

Inadequate reporting and availability of forms

- Chhattisgarh, Maharashtra, Rajasthan, Uttar Pradesh

Follow-up visits to the leprosy patients by the supervisory staff found lacking

Formal records for contact investigation activities **to be maintained and monitored** at most states. Entries in the master treatment register, individual patient treatment card and disability register were **inadequately filled**

Communicable Diseases: IDSP

- ✓ Weekly data analysis to identify potential outbreaks being done in Punjab
- ✓ **Use of S (Syndromic), P (presumptive) and L (Laboratory) forms for reporting found optimal in most states**
- ✓ Outbreak Investigations along with constitution of Rapid Response Teams found to be adequate in most of the states

Periodic data analysis (epidemic monitoring and forecasting) to be emphasized

Engagement of private labs/facilities in reporting found suboptimal in majority of the states except Assam & Chhattisgarh

Inadequate reporting and availability of forms

- Chhattisgarh, Maharashtra, Rajasthan, Uttar Pradesh

Summary of Findings: RNTCP

SDH/ DH	CHC/ UCHC	PHC	Sub Centre	Community Level	
					AP
					Arunachal
					Assam
					Bihar
					Chattisgarh
					Gujrat
					HP
					J&K
					Jharkhand
					Karnataka
					MP
					Maharashtra
					Punjab
					Rajasthan
					TN
					Telangana
					Tripura
					UP
					Uttarakhand

Case Study: Tripura

A 65 years old man complained of knee pain for more than 5 years and has visited the nearby health facility several times. He complained of pain and restricted movement and has history of fever & cough. There is no history of any other major illness.

The team observed swelling on his left knee joint and examined his test reports. The team found that his ASO titre, S. uric and R.A. factor are within ranges. X-ray of the knee joint indicates osteoarthritis and bursitis.



It was observed that the person was never explored for probable E.P-T.B. though CBNAAT facility is available in the district.

Case Study: Tripura

The child of the **same family** complains of swelling in the neck for more than a year. There is associated pain complain by the child. The swelling did not subside even after the complete courses of antibiotics prescribed. Along with the antibiotics some other medicines like analgesics, trypsin /chymotrypsin were also prescribed to the child. Few routine blood tests were also prescribed.

However, the child was never explored for extra pulmonary tuberculosis. WHO TB consultant in the CRM team suspected EPTB. Team tried sending them for tests but they returned from SDH; they need specialists to draw sample, would have to go to Agartala





Implementation of CPHC

Functionality of HWCs: Key Findings

Training of CHOs in Certificate Programme was initiated in all CRM states except Himachal Pradesh

No shortage of frontline workers (MPWs and ASHAs)

- Women Health Volunteer (in place of ASHAs) from Women's Development Corporation supporting population-based screening of NCDs in Tamil Nadu

Trainings in Universal Screening of NCDs started in Assam, Chhattisgarh, Jharkhand, Maharashtra, Telangana and in one district of MP

Universal screening of NCDs Rolled out in Maharashtra, AP, Chhattisgarh, Tamil Nadu, Rajasthan, Assam

Screening for cervical cancer at PHCs

- Tamil Nadu, AP (as part of Mahila Master Health check up), Chhattisgarh

Availability of medicines and diagnostics: Found to be satisfactory at PHC-HWCs across states

Functionality of HWCs: Key Findings

Limited understanding among **programme officials** especially at the district level about the overall concept of CPHC and HWCs

State universities and Institutes running the 6 months course in Community Health: Maharashtra, B.Sc. Community Health in Jharkhand (IPH)

Chhattisgarh and Assam: CHOs trained in BSc Community Health and posted at SHCs (Assam), at PHCs (Chhattisgarh) -Bi-weekly OPD services provided by CHOs at HWCs-SHCs in Chhattisgarh

Lack of clarity among CHOs on the principles of CPHC and their roles: Jharkhand and Rajasthan

No orientation of front-line workers about CPHC and delivery of CPHC services was reported across all states

Functionality of HWCs: Key Findings

Rajasthan, Bihar and Jharkhand **did not fulfil the criteria of a functional PHC HWCs** due to paucity of necessary staff:

- Bihar and Rajasthan did not have pharmacists; while in Jharkhand staff nurses are not available at PHCs

Availability of medicines and diagnostics:

- Gaps observed at SHC- HWCs level in Jharkhand, UP, Chhattisgarh and Jammu and Kashmir
- CHOs with BAMS background are prescribing Ayurvedic medicines

HWCs with provision for a “Wellness Room” for conducting Yoga sessions: was functional only in Jharkhand

Basic amenities like drinking water, toilet, power supply and back- up was unavailable in few SHC- HWCs: Jharkhand and Rajasthan

Functionality of HWCs: Key Findings

Poor use of IT systems in all states:

- Issues related to supply of IT equipment and installation of IT application in Bihar
- Non-availability of user IDs with passwords and final version of application and internet connectivity in Jharkhand
- Non-availability of tablets in Chhattisgarh, MP and Rajasthan.

Tablets with NCD module: operational in one district of UP and J&K

Tablets with ANMOL app and Desktop: Provided in AP and Telangana for the PHC-HWC

CPHC-NCD: Key Findings

Trainings in Universal Screening of NCDs:

- **Not conducted** in Bihar and Punjab
- **Training conducted for lesser number of days against specified five days:** reduced to one – two days in AP, Jammu and Kashmir and Rajasthan

Universal screening of NCDs: Outreach activities not rolled out due to lack of coordination between PHC and SHC

- Bihar and Telangana

Principle of continuum of care and strong referral linkages to secondary level health facilities was **not followed** in most states

CHC NCD clinic non-functional: Rajasthan, Jharkhand, Punjab (one district)
Cancer confirmatory diagnostics available only at tertiary level across all states

CCU non-functional: Jharkhand, Maharashtra, Punjab, Bihar, Gujarat, J&K

Summary of Findings: NPCDCS/ NCD

SDH/ DH	CHC/ UCHC	PHC	Sub Centre	Community Level	
					AP
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					HP
					J&K
					Jharkhand
					Karnataka
					MP
					Maharashtra
					Punjab
					Rajasthan
					TN
					Telangana
					Tripura
					UP
					Uttarakhand

Case Study: Madhya Pradesh

In Madhya Pradesh, HWC (named as Arogyam) are rolled out in PHCs. The team visited 2 PHCs Arogyam: Machalpur and Arogyam Kurawar in Rajgarh district.

It was observed that the district team, MOs and Staff Nurses of the PHC Arogyam were not very well versed with the concept of CPHC. No training were provided to MPW/ANM and ASHAs (Machalpur Block) on NCD Screening.

Population enumeration and NCD screening was conducted in another block instead of HWC blocks where the ANMs and ASHAs were given just 2 days orientation on NCD Screening.

ANMs were asked to procure tablet on their own and the amount was being reimbursed by health society. ANMs who are facing economic hardship found it difficult to buy. Delay in reimbursement was also reported.

The community members, PRIs and ASHAs were not aware about the concept of HWC and the service available at HWC.



Other Non-Communicable Diseases

NPCB+VI (Blindness Control): Key Findings

NGOs have been playing a major role in organizing the screening and surgery camps of cataract across different states. Most visited states were providing surgical services at the district hospital level

Linkage between RBSK and school screening camps have been strengthened Punjab, Tamil Nadu, Uttarakhand, Madhya Pradesh and Karnataka

Community awareness about eye donation and availability of services for common ophthalmic conditions was good in Punjab, Chhattisgarh, Telangana and Uttarakhand

Inadequacies in the HR (vacancy) were observed in Rajasthan at the district level while DH in Bihar was not equipped with a functional Operation theatre.

NMHP (Mental Health): Key Findings

Specialist services by a qualified psychiatrist were available

- Bihar, Rajasthan, Maharashtra, Tamil Nadu, Telangana, Tripura and Karnataka

Significant efforts made to procure drugs for mental health care:

- Bihar, Gujarat

Well-functioning Drug deaddiction centres and rehabilitation facility at DH

- Punjab, Tamil Nadu

Outreach activities (camps and motivational talks particularly for school students) conducted

- Bihar, Gujarat, Rajasthan and Tripura

Tele-psychiatry services in Udupi district of Karnataka

Toll-free helpline “Mansamwad” 1800-180-0018 started in October 2017 in Rajasthan

NMHP (Mental Health): Key Findings

The frontline workers in most of the states have **received no orientation** with the exception of Rajasthan

Awareness on mental health issues as well as availability of services at community level is lacking

NOHP (Oral Health): Key Findings

Dental fortnight introduced in Punjab as part of community outreach activities. **Regular camps** conducted in Punjab, Jammu & Kashmir and Rajasthan. **Mobile dental vans** utilized to improve the community outreach in Maharashtra and Rajasthan

Awareness regarding oral health conditions and health seeking behaviour of the community was poor

- Bihar, Maharashtra, Telangana, Tripura, Chhattisgarh, Madhya Pradesh, Rajasthan, Gujarat

Orientation and training of front-line workers was observed to be deficient in all states

Private and unorganized sector catering to a significant number of patients in the community

- Uttar Pradesh and Jammu & Kashmir

Shortage of dental equipment such as dental chairs

- Bihar, Maharashtra, Punjab and Andhra Pradesh

NPHCE (Elderly Care): Key Findings

Dedicated geriatric beds in the District hospitals

- Maharashtra, Tamil Nadu, Tripura, UP (Farrukhabad district), Uttarakhand, Madhya Pradesh, Rajasthan and Karnataka

Fixed day services to the elderly in Rural Hospital in Maharashtra

Rehabilitation services with physiotherapists were available

- Karnataka, UP and Rajasthan

Social protection scheme for single elderly women whose annual income is less than Rs. 2 lakhs: Telangana

Health problem in old age is considered to be a non-issue at community level

- Bihar, Maharashtra, Telangana, Uttarakhand, Chhattisgarh, Madhya Pradesh and Rajasthan

Non-functional geriatric wards

- Bihar, Jharkhand, Telangana, and Arunachal Pradesh

NPPC (Palliative Care): Key Findings

Palliative care unit was available in District Hospital

- Maharashtra, Telangana, Tamil Nadu, Rajasthan, Karnataka

Roll out of NPPC is in a nascent stage and the services are underutilized

Lack of awareness about the programme and its services among the community, ASHA and ANMs and even service providers in most of the states

NTCP (Tobacco Control): Key Findings

IEC activities conducted for school students in Jharkhand

Mitanins in Chhattisgarh are involved in counselling on tobacco non-use

Greater Emphasis on IEC activities was observed in District hospitals and PHCs in Bihar

Statutory warnings have been displayed at public places under COTPA in Gujarat. COTPA is being implemented in Jharkhand and Punjab

Functional Tobacco cessation clinics were reported in Tripura, Farrukhabad in Uttar Pradesh, Korba, Chhattisgarh

Consumption of tobacco products was high

- Bihar, Rajasthan, Tripura (also among service providers), UP, Chhattisgarh (tribal population)

NPPCF (Fluorosis Control): Key Findings

Korba district in Chhattisgarh has **combined outreach activities for fluorosis, dental screening and tobacco addiction**

Water samples are being analysed in

- Jharkhand, Telangana, Madhya Pradesh, Chhattisgarh and Karnataka.

Telangana is also **conducting urinary analysis for fluoride levels** from school and community surveys to identify patients of dental and skeletal fluorosis

Despite completion of mapping of endemic villages , no activity was initiated in Uttar Pradesh, Andhra Pradesh and Jammu & Kashmir

Provision for safe drinking water or alternate source of potable water not yet available

- Assam, Chhattisgarh

Training of district nodal officers and lab are yet to be conducted

- Jharkhand, Jammu & Kashmir and Uttar Pradesh

NPPCD (Deafness control): Key Findings

Hearing aids are provided through the Ministry of Social Justice and Empowerment and strong collaboration established with NGO in Rajasthan

Community awareness towards common ENT problems was lacking

– Jharkhand, Maharashtra and Rajasthan

Frontline workers have not received any orientation on NPPCD and lacked knowledge about availability of services under the programme

Basic ENT equipment not available in DH Ranchi, Jharkhand

NIDDCP: Key Findings

Use of iodised salt found in most of the States

Trauma and Emergency Services: Key Findings

Services were found to be suboptimal in all the states visited due to unavailability or non-functionality of necessary equipment.

Services available were **confined to the basic first aid care** at most of the states visited

Several factors such as non-rotation of critical area staff members, equipment maintenance, and availability of specialists, round the clock need further strengthening for assured emergency services

The logo consists of a large orange rounded rectangle with a white border. Inside the rectangle, the text "NATIONAL URBAN HEALTH MISSION" is written in white, bold, uppercase letters. Below the text is a thin horizontal line.

NATIONAL URBAN HEALTH MISSION

NUHM: Positives

Increase in community outreach via UHNDs and camps (however it is RCH centric). NCD screening are gaining pace

Andhra Pradesh is offering **4 specialties via telemedicine in PPP mode**

Tamil Nadu provides **weekly specialist services through polyclinics**

H.P. launched '**Tele Stroke Project**' to provide **thrombolysis services** within the 'golden hour'

All UPHCs mapped in Pregnancy, Child Tracking and Health Services Management Systems (PCTS) in Rajasthan

PICME software is used to upload **RCH data and CRVS** in Tamil Nadu

Convergence: ULB ownership was good in Tamil Nadu & Karnataka

- ULB sanitation dept. staff are placed in UPHC premises
- UPHCs in Madurai have set up biogas plant in the premises, which is fed by garbage from nearby slum and market areas

NUHM: Areas of Concern

Low community awareness and confidence in health facilities

High OOPE in Uttarakhand, Bihar, Jharkhand & Punjab

NUHM facilities were found non functional in Uttarakhand during visits. As a result, services, including RI were halted

Significant vacancies in various positions in almost all states

Ambulance services for urban slums are **uneven** in many states

Convergence has been weak across most states, esp. Andhra Pradesh, Bihar, Jharkhand, Punjab & Uttar Pradesh

None of the States have convergence with Medical Colleges



Community Processes

ASHAs: Key Findings

ASHAs role in linking public health systems with the community was **acknowledged** in all states

All CRM states report having over **90% ASHAs in rural areas**

No or minimal delay in payment of incentives

- Assam, Chhattisgarh, Madhya Pradesh, Rajasthan, Himachal Pradesh, Uttar Pradesh, Punjab, Bihar, Maharashtra

ASHA payment software: ASHAs database present up to the block/village level and has facilitated auto-computation of incentives based on entry of online reports and vouchers

- Assam, Madhya Pradesh, Rajasthan

Social welfare measures, career opportunities, support in educational equivalence, higher education, etc.

- Chhattisgarh, Jharkhand, Jammu and Kashmir

Post-graduate ASHA Sahyoginis are being skilled to serve as **District Trainers**

- Madhya Pradesh

ASHAs: Key Findings

Regular replenishment of ASHA drug kits from PHCs

- Andhra Pradesh, Rajasthan, Madhya Pradesh, Jharkhand

HBNC kits have been made available to ASHAs in all states

Delay in release of payment; usually related to incentives provided under vertical programmes

- Arunachal Pradesh (3-6 months), J&K (3-4 months), Tripura (5-6 months), Uttarakhand (6 months), Jharkhand (6 months)

High vacancies in the support structure for ASHA: Bihar

High attrition of trainers: Bihar, Madhya Pradesh and Uttarakhand

Lack of clarity on functionality of ASHA Facilitators due to dual function of ASHA facilitator as an ASHA

- Bihar and Uttarakhand

ASHAs: Key Findings

Availability and replenishment of Drug and Equipment kit of ASHAs remains a challenge

- Himachal Pradesh, Jammu & Kashmir, Uttarakhand, Uttar Pradesh, Punjab, Arunachal Pradesh
- **Non-functional equipment kit:** Rajasthan, Himachal Pradesh and Chhattisgarh

Lack of adequate residential training facilities within health department and delays scheduling of ASHA trainings

- Andhra Pradesh, Arunachal Pradesh, Bihar and Jammu and Kashmir

Need for strengthening on-job mentoring and guidance to ASHAs so as to upgrade their skills in counselling and health education

VHSNC: Positives

Andhra Pradesh **demonstrated good model of VHSNCs**: regular monthly meetings (99% of the expected target) and utilized nearly 90% of the funds

Uttarakhand and Madhya Pradesh **started training ASHA Facilitators in PLA-linked activities** to revive participation of VHSNC members

VISHWAS (Village based Initiative to Synergise Health Water And Sanitation): Rolled out in Jharkhand and UP

VHSNC: Areas of Concern

VHSNC: Wide variation in the performance across the country; yet to emerge as institutional platforms

Fewer VHSNCs functional and lack of clarity amongst the committee members regarding their roles and responsibilities: Punjab, MP, Arunachal Pradesh, Uttarakhand

VHSNC meetings are irregular in most states except Andhra Pradesh, Telangana and Jharkhand

Long gap in training of VHSNC members (at least 7-8 years)

- Rajasthan, J&K and Jharkhand

Poor utilization of VHSNC untied funds

- Rajasthan, Madhya Pradesh and Tamil Nadu

RKS: Key Findings

Rogi Kalyan Samities: Andhra Pradesh and UP have **developed portal for RKS/HDS, linked to the CM Core Dashboard** for monitoring and evaluation

Regular annual meetings of RKS committee conducted: MP, HP, J&K, Andhra Pradesh, Maharashtra

RKS formed, but non-functional

- Arunachal Pradesh, Punjab

Delay in receipt of RKS funds reported, leading to partial utilization of funds: Himachal Pradesh, J&K

- Need of training on fund utilization: requested by RKS members in J&K, UK and Jharkhand

MAS: Key Findings

Regular MAS meeting conducted; helping ASHAs in her activities; forum used for dissemination of information based on the local health priorities;

Untied funds for MAS mostly used for purchasing equipment / items for AWCs such as BP apparatus, weighing machine etc

MAS groups have been connected to National Urban Livelihoods Mission (NULM): Rajasthan; MAS has been linked with MEPMA; however, **ASHA/ ANM are not involved in the activities of MAS:** Andhra Pradesh

MAS not formed: Madhya Pradesh



Free Drugs and Diagnostics Initiatives

Free Drug Service Initiative: Key Findings

Roll out of FDSI: not done in J&K and Uttar Pradesh

Central procurement organisations: not established in Arunachal Pradesh, Tripura, Uttar Pradesh

EDL (Essential Drug List): Unavailable in J &K

IT enabled inventory management and procurement system: not initiated in Arunachal Pradesh and Uttar Pradesh

High Out of Pocket Expenditure and frequent stock outs complaints: Arunachal Pradesh, Jammu and Kashmir, Jharkhand, urban pockets of Punjab, Uttar Pradesh, Uttarakhand

Unavailability and compliance to STGs and no Practice of Prescription Audit except Andhra Pradesh and Karnataka

Free Diagnostics Initiatives: Key Findings

Most of the States have free diagnostic service at certain level

Mixed model (combination of in-house and PPP resources): A.P, Assam, Jharkhand, Arunachal Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Karnataka, Himachal Pradesh, Rajasthan, Maharashtra

In-house Resources: Madhya Pradesh, J&K, Punjab, Bihar

Quality Assurance

Quality Assurance: Key Findings

Functional Institutional framework – SQAC, DQAC and Quality Teams in the visited states

Quality Certification of the facilities has gained momentum in the visited states

Good progress in the States of Andhra Pradesh, Maharashtra, Telangana, Tamil Nadu

Slow progress of NQAS certification

- Arunachal Pradesh, Assam, Himachal Pradesh, Jammu Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Uttarakhand & Uttar Pradesh

Approved HR under QA was not **recruited** in large number of states

SQAC & DQAC meetings have not been held regularly

- Arunachal Pradesh, Chhattisgarh, Jammu & Kashmir

Quality Assurance: Key Findings

Base-line Assessment of all health facilities has not been completed in all states

Poor BMW segregation and disposal practices as per BMW Rules 2016 (& subsequent amendments) in all states, particularly in the peripheral health facilities

314 out of 545 DH level facilities integrated in 'Mera-Aspataal' in visited states

No integration of CHCs, PHCs and UPHCs except in the states of Gujarat (248 CHCs & 987 PHCs), Rajasthan (117 PHCs), MP (21 UPHCs & 6 others) and Telangana (2 others)

Follow-up actions on 'Mera-Aspataal' feedback at different level remains weak

Kayakalp: Key Findings

Improvement in the level of cleanliness and upkeep of Health facilities

Kayakalp PHCs not selected

- Jharkhand, Maharashtra & Uttar Pradesh

Kayakalp awards not declared

- Chhattisgarh, Jammu & Kashmir and Telangana

Slow progress of CHCs supported under 'Swachh Swasth Sarvatra' to become 'Kayakalp' CHCs



HUMAN RESOURCES FOR HEALTH

Human Resources for Health: Positive Findings

Availability of HR:

- ✓ **Decentralizing hiring process** up to district level: Chhattisgarh
- ✓ **Skill-based competency tests** for recruitments of clinical staff: Chhattisgarh, Punjab
- ✓ Separate **Health and Medical Recruitment board**: Assam
- ✓ **Compulsory service bond** of one year after completion of MBBS from State Medical College: Assam
- ✓ ***You quote we pay*** : Competitive bidding strategy: Jharkhand, Karnataka, UP, Chhattisgarh

Workforce management:

- ✓ MO Transit hostels from district corpus funds: Chhattisgarh
- ✓ **Preference/ weightage** to NHM staff in regular positions: Telangana
- ✓ 9 days **Induction program** for newly joined PM staff: Telangana
- ✓ Yearly free health check up of all Staff (Regular and contractual) organized by SDH Belonia Tripura

Human Resources for Health

**Critical shortages particularly of Specialists and Medical officers.
Sanctioned posts are not as per requirement**

Andhra Pradesh, Arunachal Pradesh, Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Punjab, Telangana, Tripura, Uttar Pradesh

Arunachal Pradesh: Number of sanctioned posts were not revised in line with upgraded facilities

No Specialist Cadre

Madhya Pradesh, Uttar Pradesh, Arunachal Pradesh, Punjab, Telangana, Tripura

Issues of availability of Health workforce further compounded by their irrational distribution

Arunachal Pradesh, Himachal Pradesh, Madhya Pradesh, Telangana, Uttar Pradesh

Human Resources for Health

Lack of robust HR policies:

- » **Frequent transfers at critical administrative posts affecting administrative functions**
- » **Irrational deployment of Specialists at PHCs**
- » **HR deployed doesn't commensurate with existing caseloads at the facilities**
- » **Appraisal system not found objectively linked with performance of staff**

Programmatic HR and common cadre such as LT, counsellors (dedicated to single program especially where there is low case load) leading to overall low service delivery and under-utilization of HR

Human Resources for Health

Program and Management functions (monitoring, reporting, supportive supervision) **disrupted due to long pending vacancies of PM staff at state, district and block level: IDSP, Blindness: Andhra Pradesh, Bihar, Uttar Pradesh**

Lack of integration between Health Directorate and NHM Program Management Units

LSAS and EmOC trainings have got discontinued because of lack of master trainers: Himachal Pradesh

District training sites are not functional: Bihar

Poor physical achievement of approved trainings: Jharkhand, Arunachal Pradesh

Human Resources for Health: HRIS

Assam: HRIS linked to salary disbursement

Madhya Pradesh: Utilised for performance appraisal of staff

Implementation of HRIS

Telangana: Contractual and regular HR information captured separately with no intercommunication

Bihar: HRIS doesn't cover all facilities and cadres

Chhattisgarh and Telangana: Issues related to interoperability with Training Management Information System (TMIS)



Governance and Management

Governance and Management

The Clinical Establishments Act, 2010: 12 states have adopted the Act so far

Coordination and convergence between **ULBs and health** is **weak** across all the states. Involvement of ULBs is largely limited to disease control programmes

Weak coordination and convergence with Panchayati Raj System for DHAP, except in Maharashtra and Kerala

In most places, regular meetings of the State and District Missions not taking place

Convergence is restricted to WCD and Education department

Case Study: Jammu & Kashmir

Rubina ASHA in Tangdar Block, Kupwara, J&K -

- *Living in a block which becomes inaccessible in winters for over four months, community looked up to ASHA for being a continuous support and considered as their first point of contact*
- Chose to become ASHA to cater to the health care needs of her community
- Developed her own registers and was updated on every individual's health needs.
- In addition to RCH activities, ASHA was proactively facilitating NCD (hypertension, diabetes) and Mental Health care
- *Regular community meetings were being organized, where the women were being made aware of NCD and received counselling on life style modifications.*
- *In addition to health care, ASHA was also supporting community from making water connection to toilets available to all households.*

Case Study: Jammu & Kashmir



“ASHA ne kaha ki pressure aur sugar dikhate raho aur khane ka parhez karo. Teeke lagne ho ya dawaai leni ho, hum ASHA par hi yaqeen rakhte hain” – Community member, same block.

“Yeh sab log humara ghar hi hain. Humara mann khush hota hai jab inka kaam ho jata hai. Paisa ehem nahi hai, in sab ki dua ehem hai.” - ASHA, Tangdar block.