



12th COMMON REVIEW MISSION REPORT 2018



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Facilities Visited

ABBREVIATIONS



AGCA	-	Advisory Group on Community Action
AMTSL	-	Active Management of Third Stage of Labour
ANC	-	Ante-Natal Care
ANM	-	Auxiliary Nurse Midwife
ANMTC	-	Auxiliary Nurse Midwife Training Centre
APHC	-	Additional Primary Health Centre
API	-	Annual Parasite Index
ARC	-	ASHA Resource Centre
ART	-	Anti Retroviral Treatment
ASHA	-	Accredited Social Health Activist
AWC	-	Anganwadi Centre
AWW	-	Anganwadi Worker
AYUSH	-	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BCC	-	Behaviour Change Communication
BEmONC	-	Basic Emergency Obstetric & Neonatal Care
BMO	-	Block Medical Officer
BMWM	-	Bio-Medical Waste Management
BPHC	-	Block PHC
BPM	-	Block Programme Manager
BPMU	-	Block Programme Management Unit
BPL	-	Below Poverty Line

CAH	-	Community Action for Health
CBOs	-	Community Based Organizations
CEmONC	-	Comprehensive Emergency Obstetric & Neonatal Care
CHC	-	Community Health Centre
CMO	-	Chief Medical Officer
CMOH	-	Chief Medical Officer Health
CRM	-	Common Review Mission
CT-Scan	-	Computed Tomography Scan
DH	-	District Hospital
DHAP	-	District Health Action Plan
DLHS	-	District Level Household Survey
DOTS	-	Direct Observation Therapy – Short course
DPM	-	District Programme Manager
DPMU	-	District Programme Manager Unit
DTC	-	District Training Centre
DWCD	-	Department Women & Child Development
EDL	-	Essential Drug List
EmONC	-	Emergency Obstetric & Neonatal Care
EMRI	-	Emergency Management and Research Institute
FMG	-	Financial Management Group
FP	-	Family Planning
FRU	-	First Referral Unit
GNM	-	General Nursing Midwife
HMIS	-	Health Management Information System
HMRI	-	Health Management & Research Institute
HR	-	Human Resource
HRD	-	Human Resource Development
HRIS	-	Human Resource Information System
HSC	-	Health Sub-centre



ICDS	-	Integrated Child Development Scheme
ICTC	-	Integrated Counselling and Testing Centre
IDSP	-	Integrated Disease Surveillance Project
IEC	-	Information Education Communication
IMNCI	-	Integrated Management of Neonatal and Childhood Illnesses
IMR	-	Infant Mortality Rate
IPD	-	In Patient Department
IPHS	-	Indian Public Health Standards
ISO	-	International Organization for Standardization
IUCD	-	Intra-uterine Contraceptive Device
JE	-	Japanese Encephalitis
JPHN	-	Junior Public Health Nurse
JSSK	-	Janani Shishu Suraksha Karyakram
JSY	-	Janani Suraksha Yojana
LHV	-	Lady Health Visitor
LLIN	-	Long Lasting Insecticide Treated Nets
LR	-	Labour Room
LSAS	-	Life Saving Anaesthesia Skills
LT	-	Laboratory Technician
MB	-	Multi-bacillary cases
MCTS	-	Mother and Child Tracking System
MDR	-	Multi-drug Resistant (TB)
MIS	-	Management Information System
MHW	-	Male Health Worker
MMR	-	Maternal Mortality Ratio
MMU	-	Mobile Medical Unit
MO	-	Medical Officer
MoHFW	-	Ministry of Health & Family Welfare
MOIC	-	Medical Officer In-charge

MoU	-	Memorandum of Understanding
MPW	-	Multi-purpose Worker
MTP	-	Medical Termination of Pregnancy
NFHS	-	National Family Health Survey
NGO	-	Non-Government Organisation
NHSRC	-	National Health Systems Resource Centre
NICU	-	Neonatal Intensive Care Unit
NIHFW	-	National Institute of Health & Family Welfare
NIPI	-	Norway India Partnership Initiative
NPCB	-	National Programme for Control of Blindness
NLEP	-	National Leprosy Eradication Programme
NRC	-	Nutritional Rehabilitation Centre
NRHM	-	National Rural Health Mission
NSSK	-	Navjat Shishu Suraksha Karyakram
NSV	-	Non-scalpel Vasectomy
NUHM	-	National Urban Health Mission
NVBDCP	-	National Vector Borne Disease Control Programme
OPD	-	Out Patient Department
PCPNDT	-	Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex-selection) Act - 1994
PHC	-	Primary Health Centre
PHN	-	Public Health Nurse
PIP	-	Programme Implementation Plan
PMU	-	Programme Management Unit
PPP	-	Public Private Partnership
PRI	-	Panchayati Raj Institutions
PWD	-	Public Works Department
RCH	-	Reproductive and Child Health
RDK	-	Rapid Diagnostic Kit

RHFWTC	-	Regional Health & Family Welfare Training Centre
RHP	-	Rural Health Practitioner
RKS	-	Rogi Kalyan Samiti
RKSK	-	Rastriya Kishor Swasthya Karyakram
RMP	-	Rural Medical Practitioner
RMSCL	-	Rajasthan Medical Services Corporation Limited
RNTCP	-	Revised National Tuberculosis Control Programme
RSBY	-	Rashtriya Swasthya Bima Yojana
SBA	-	Skilled Birth Attendant
SDH	-	Sub Divisional Hospital
SHC	-	Sub Health Centre
SHSRC	-	State Health Systems Resource Centre
SIHFW	-	State Institute of Health and Family Welfare
SIMS	-	Softline Intelligent Micro Systems
SNCU	-	Special Newborn Care Unit
SPMU	-	State Programme Management Unit
STG	-	Standard Treatment Guideline
TB	-	Tuberculosis
TNMSC	-	Tamil Nadu Medical Services Corporation Limited
VHND	-	Village Health and Nutrition Day
VHSNC	-	Village Health and Sanitation and Nutrition Committee

EXECUTIVE SUMMARY

The Twelfth Common Review Mission (CRM) is the first one to be undertaken after the announcement of Ayushman Bharat – Health and Wellness Centres, earlier this year. Ayushman Bharat builds on the health systems strengthening platform, which started as the National Rural Health Mission in 2005 and with the addition of the National Urban Health Mission in 2013, became the National Health Mission.

The National Health Mission, of which the Common Review Mission is an integral part, was intended to strengthen primary and secondary care services with substantial investments in maternal, newborn and child health and nutrition, focused on strengthening these services through building a robust health systems platform. In addition, the NHM also provided significant support to enabling states to address communicable diseases and a range of programmes that related to chronic diseases. Support to the latter two components were focused on rationalizing Human Resources, financial incentives, reporting systems, access to medicines and diagnostics, laboratory support and engaging frontline workers, all building on the health systems platform intended to integrate services with a people centred focus.

In April 2018, the Prime Minister launched the first Health and Wellness Centre (HWC) in Bijapur, Chhattisgarh, signalling a strong political commitment to comprehensive primary health care delivered through Health and Wellness Centres, in keeping with the mandate of the National Health Policy, 2017.

The 12th CRM was organised from September 5 to September 12, 2018 in eighteen states, and the visit to the nineteenth state, Karnataka took place from October 8 to October 14, 2018. The preceding eleven Common Review Missions were focused on assessing the inputs provided to states through the Programme Implementation Plans and correlating them with the broad outcomes. The approach of the 12th CRM was to assess community perceptions of the key interventions of the NHM, and to understand the organization of service delivery from community to district levels, so as to assess the readiness of health systems to undertake delivery of comprehensive primary health care through Health and Wellness Centres.

Six of the nineteen visited states belonged to High Focus category; Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Rajasthan, Uttar Pradesh. All three hill states, namely, Uttrakhand, Himachal Pradesh, and Jammu and Kashmir were included, and three were from the North Eastern region - Assam, Arunachal Pradesh, and Tripura. Of the Non High focus states, seven states: namely Punjab, Tamil Nadu, Gujarat, Andhra Pradesh, Telangana, Maharashtra, and Karnataka and were visited.

Members of the Mission included senior officials from the Ministry of Health and Family Welfare, (MoHFW), including programme divisions and from the office of the Director General of Health Services (DGHS), National Health Systems Resource Centre (NHSRC), public health experts from civil society organizations, academic institutions, other related departments, NitiAayog, representatives



of the Mission Steering group of the National Health Mission, National ASHA Mentoring Group and Advisory Group on Community Action, and development partners.

The nineteen state teams were provided with a briefing on the variation in approach to the 12th CRM and to the various Terms of Reference by concerned nodal officers. As has been the pattern, two districts in each state were visited, and the district teams presented the findings and recommendations emerging from the rapid review and assessment, which were subsequently distilled into a report, incorporating the state's feedback. The state and district visits were guided by almost 18 ToRs, with accompanying checklists. The findings across the 18 ToRs have been synthesized into 11 ToRs, for the purpose of analysis and developing recommendations.

This report is structured as follows. Chapter 2 describes the mandate and methodology, districts and states visited, and details of the Terms of Reference. The remaining chapters, from Chapter 3 to Chapter 13 discuss the 11 ToRs with key observations and recommendations, followed by state specific findings.

TOR 1: READINESS FOR THE DELIVERY COMPREHENSIVE PRIMARY HEALTH CARE THROUGH HEALTH & WELLNESS CENTERS

Ayushman Bharat, with its two components of Health and Wellness Centres to deliver comprehensive primary health care that is universal in coverage, and the Pradhan Mantri Jan Arogya Yojana to address secondary and tertiary care for about 40% of the population.

The HWC represent a platform for the delivery of Primary Health Care that encompasses preventive, promotive, curative, rehabilitative and palliative care for twelve service packages that include all of the components supported by NHM. Ayushman Bharat- HWC represents an effort at consolidating the interventions and reorganization of service delivery at community, HWC-Sub Health Centre

levels, HWC-PHC level and referral, thus ensuring continuum of care. In addition, the implementation of HWC represent moving towards a team based approach to delivering comprehensive primary health care.

One of the objectives of this CRM was to assess the planning and implementation readiness of states and districts to operationalize HWC. While it may appear that the findings for the services of HWC focus largely on non-communicable diseases, this was deliberately highlighted in the ToR, since there is sufficient evidence that substantial progress has been made in the area of Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH). Also, findings related to the delivery of RMNCAH are captured in ToR 2.

KEY OBSERVATIONS

- ▶ Currently, states are at varying stages in operationalizing HWCs. So far, about 2913 HWCs have been made functional, as defined by a set of input criteria, against the target of 15,000 for FY 2018-19. This represents a slow pace of operationalisation vis a vis the target.
- ▶ All states visited, had begun operationalizing Health and Wellness Centres, with 70% of HWC being in aspirational districts, under the Extended Gram Swaraj Abhiyaan, an important measure for reaching the unreached. As operationalisation of HWCs, is dependent on multiple factors (eg-HR, infrastructure, medicines, diagnostics etc), most states were in the process of completing initial requirements at the time of the CRM.
- ▶ One gap noticed in the planning process was that the facilities to be upgraded as HWCs in most states were not based on the principle of continuum of care, with little connection between SHC/PHC or linkage to secondary care referral and were reported to be scattered across districts/ blocks. This has limited coordination between PHC and SHC and is largely on account of the lack of a team to manage HWCs and limited understanding among programme managers at state and district levels on the vision and complexity of the programme; this

was reported in Arunachal Pradesh, Jammu Kashmir, Rajasthan, Telangana, Tripura and Uttrakhand.

- ▶ The main addition to the primary health care team at HWC-SHC is the Mid-Level Health Provider trained through a six-month Certificate Programme in Community Health (CPCH). The certificate programme is operational in all the states visited. Except for two states, J&K and MP, most MLHP were in position at HWC- SHC to which they had been allocated and displayed high motivation levels.
- ▶ While largely following the principle of delivering services closer to home and enabling treatment adherence for selected chronic diseases, a few state variations were recorded. Tamil Nadu, in a variant of the MLHP model, is using Village Health Nurses trained in a state specific module to dispense medicines and enable improved follow up for hypertension and diabetes, at the HWC-SHC. Chhattisgarh and Assam have had in place for several years, a cadre of providers, akin to MLHP, referred to as Assistant Medical Officers and Rural Health Practitioners respectively. In Assam they are positioned at SHC, and in Chhattisgarh, they are posted at PHCs but visit SHC twice a week.
- ▶ Reports from Jharkhand and Rajasthan indicate lack of clarity among the MLHPs about concept of CPHC and in several states the perception of MLHP is that their role is in the provision of curative care, indicating a need for orientation of MLHP when they join the HWC-SHC.
- ▶ A positive finding highlighted in across states, except Tamil Nadu, was that there was no shortage of Frontline Workers (ASHAs and MPWs- female). The focus of training in most states was on training these providers on common NCDs, except in Bihar and Punjab. In Rajasthan, Andhra and J&K training duration was reduced substantially, compromising knowledge and practices.
- ▶ Activities for health prevention and promotion were limited to display of IEC material and counselling by individual service providers on lifestyle change. Only Jharkhand has initiated



yoga classes. Rooms for yoga have been established in Bihar, Madhya Pradesh and Uttar Pradesh, but activities are yet to commence.

- ▶ Population enumeration and completion of a community-based risk assessment (CBAC) are the first steps for implementing screening, prevention and management of common NCDs. AP, J&K, Rajasthan, Assam, Jharkhand, Tamil Nadu, Rajasthan, UK and UP have initiated these activities. A key challenge in Jharkhand, Rajasthan, UK and UP was the poor quality of data. Population enumeration has not been initiated in Bihar, pending ASHA training, HP and Chhattisgarh.
- ▶ Roll out of universal screening of NCDs was reported from states Maharashtra, AP, Chhattisgarh, Tamil Nadu, Rajasthan and Assam. The services were limited to screening of Hypertension and Diabetes in Rajasthan while in Maharashtra, Assam and Chhattisgarh screening for Hypertension, Diabetes, Oral and Breast Cancer was reported. Screening for cervical cancer at PHCs was only reported in Tamil Nadu, Chhattisgarh and AP (as part of Mahila Master Health check-up). In Tamil Nadu high drop-out from screening at home to reporting to PHC for diagnostic confirmation was reported (over 70%).
- ▶ CPHC cannot be realised without the uninterrupted availability of medicines and diagnostics. Availability of medicines and diagnostics at PHC- HWCs was reported to be satisfactory in most states except

Bihar and UP. In J&K and HP, medicines were being made available but diagnostic services were deficient. However, shortages were observed in Jharkhand, UP, Chhattisgarh and J&K.

- ▶ Another finding linked to medicines was that despite availability of medicines (including antihypertensives and antidiabetics) in Rajasthan, the medicines were not being used due to lack of clarity in the state about dispensing rights of MLHPs.
- ▶ The most common diagnostic tests available at the HWCs-SHCs included urine pregnancy rapid test, malaria smear, rapid diagnostic test (RDT) kit, blood pressure, random blood glucose via glucometer, haemoglobin test. Additionally, some facilities were the collection points for sputum under RNTCP. In case of HWC-PHCs, all the 19 tests as per the IPHS guidelines for PHCs were being conducted.
- ▶ In almost all PHC-HWCs visited, infrastructure with basic amenities like drinking water, toilet, power supply and back up was adequate except in Jharkhand and Rajasthan. In Bihar, Chhattisgarh, Jammu & Kashmir and Jharkhand, HWCs have provision for a “Wellness Room” for conducting Yoga sessions. Branding of HWCs in most of the states except states like Tamil Nadu was in accordance with national guidelines. Andhra Pradesh, Arunachal Pradesh, Punjab, and Uttarakhand were yet to complete gap analysis of selected facilities.

- ▶ Use of IT, as expected, is still at a nascent stage, with procurement just beginning in most states.

RECOMMENDATIONS

- ▶ The first key action for all states should be the recruitment and designation of nodal officers to provide support to districts in undertaking this complex paradigm shift. The nodal officers should also be responsible to ensure that district and block teams are oriented to the nature of planning and implementation support required by HWC teams.
- ▶ To realize the promise of delivering people centred care and build community trust in HWC, especially at the level of SHC to deliver CPHC, ensuring quality and continuum of care is critical. As states move towards meeting the targets for operationalizing HWCs, it is essential that quality of care is ensured through regular skill building, improving supply chain logistics and building strong referral linkages.
- ▶ States need to expedite action on the procurement, supply and training in IT since the IT application is important tool for service providers and frontline workers to ensure continuity of treatment, life-style modification and identify “loss to follow up.”
- ▶ HWC teams should purposively, in addition to the screening and curative services being provided at HWCs, focus on health promotion activities including wellness activities like yoga. Extensive IEC campaigns are also required to create awareness among community about the expanded range of services being provided at HWCs.
- ▶ Given that the Mid-Level Health Provider is a new cadre district and block teams should enhance support to HWC teams to manage the process of change and enable regular meetings so that issues related to team dynamics are dealt with in a timely manner.



- Since the shift from selective to comprehensive primary health care is exemplified by the delivery of services for common NCDs, states should ensure that medicines and diagnostics are supplied regularly so that the HWC are seen as providing care for chronic disease in addition to services for pregnant women and children.

TOR 2: ACCESS TO CARE (AMBULANCES, MOBILE MEDICAL UNITS & EMERGENCY SERVICES)

One of the key achievements of NHM is the patient transport ambulances operating under Dial 102/108 ambulance services. Currently, 33 States/UTs have the facility where people can dial 102 or 108 telephone number for calling an ambulance. 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims etc. 102 services essentially consist of (but not limited to) basic patient transport aimed to cater to the needs of pregnant women and children. JSSK entitlements e.g. free transfer from home to facility, inter facility transfer in case of referral and drop back for mother and children are the key focus of 102 service. Currently, 9305 ambulances are being supported under 108 emergency transport system. 9985 ambulances are operating as 102 patient transport.

Support to Mobile Medical Units (MMUs) under NHM, is a key strategy to facilitate access to public health care to the doorstep of populations particularly to people living in remote, difficult, under-served and hard to reach areas. MMU services are envisaged to meet the technical and service quality standards for a Primary Health Centre through provision of a suggested package of services under 12 thematic areas.

Deployment of MMUs is based on a population norm with 1 MMU per 10 lakh population subject to a cap of 5 MMUs per district. However, further relaxation of norms is available on a case to case basis, where patients served through existing MMUs exceeds 60 patients per day in plain areas and 30 patients per day in hilly areas.

Medical Emergency is a situation, which requires urgent medical or surgical interventions to restore normal health, failing which it can result in loss of life or limb and/or permanent disability. The first 60 minutes of an emergency have been termed the “Golden Hour” as evidence show that the survival/success rate of emergencies managed within this Golden Hour is substantial. Therefore, it is necessary to ensure availability of comprehensive emergency services on a 24x7 basis.

Currently in India, most of the emergency services are confined to tertiary level only with limited access to secondary care and assured advanced referral transport systems. The absence of organized emergency care at primary and secondary health care level has a significant adverse effect on health outcomes. Therefore, to ensure timely intervention and better survival, comprehensive emergency services should be made available at primary, secondary and tertiary level with robust referral and transport network.

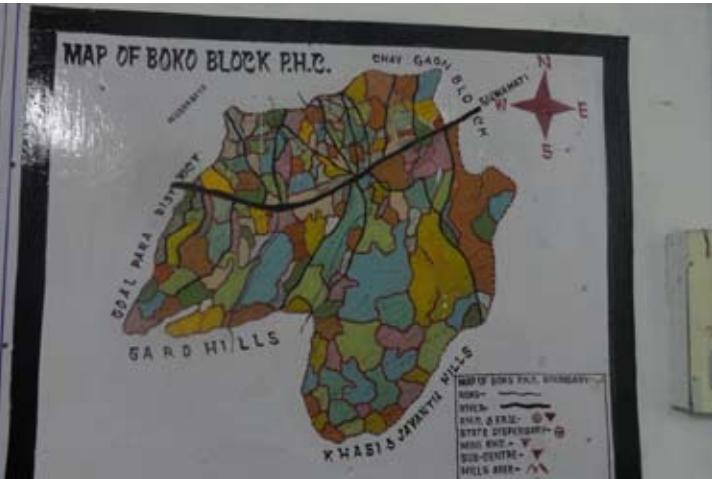
2.1: AMBULANCES AND REFERRAL SERVICES

KEY OBSERVATIONS

In Community

- Ambulance services have shown growth amongst the community. Majority of the community had knowledge of 108 and 102 Ambulance services. The availability of ambulance services was





found excellent in states like Madhya Pradesh, Maharashtra, Punjab, Gujarat, Tamil Nadu and Chhattisgarh.

- ▶ Community was aware of 108 & 102 ambulance service and reported that the responsiveness of the ambulance service was good. States like Himachal Pradesh, Arunachal Pradesh, Jharkhand and Karnataka reported instances of call drop in emergency.
- ▶ In Bihar, the IEC for generating community awareness for provision of transport services was found to be lacking and needs to be improved.
- ▶ In Bokaro, Jharkhand, no government ambulance is available in the slum. They were unaware of the 108-ambulance facility.

In Service

- ▶ An overall improvement was seen in ambulance service. Availability and accessibility was seen in all the states. However, the timeliness of service, quality of training of EMTs, equipment maintenance varied across states.
- ▶ The service is reportedly better as observed in states like Madhya Pradesh, Maharashtra, Punjab, Tamil Nadu and Chhattisgarh, with availability of both BLS and ALS supported vehicles and functional equipment.
- ▶ In Maharashtra and Tamil Nadu, ambulances were covering 120 km with 4-5 trips per day. A good response time of 30 minutes was reported in all the cases. All the drugs and equipment were

found functional in BLS supported ambulances in Maharashtra.

- ▶ Also in Tamil Nadu, 104 is being used for counseling for mental health with a special focus on suicidal tendency and to the survivors, against an undertaking signed by the client.
- ▶ In Bihar also, the functioning of referral transport is being monitored and as per the records, recently the number of trips per day per ambulance has increased to 6.1 (from 3 in the financial year 2017-18). The average transportation of patients is around 4000 per day. However, there is a need of refresher training of EMTs and drivers.
- ▶ Gujarat had boat ambulance service for fishermen also. In Jharkhand, the drop back service was provided by the local vehicle owners through a district level engagement.
- ▶ In Himachal Pradesh, response time for the 108 Ambulance service was satisfactory (considering the difficult terrain) at an average of about 30 minutes.
- ▶ States like Chhattisgarh, Arunachal Pradesh reported delay in services and thus need improvement. None of the visited states were getting ambulances checked in month by a designated technical official / specialist in the district.
- ▶ In Arunachal Pradesh, the time lag between calling an ambulance and its arrival is about 3 hours (in east Siang). Therefore, communities are not availing ambulance services. Also, the ambulance at the PHC Bilat is being used for vaccine delivery and transportation of staff from one facility to another.
- ▶ In Chhattisgarh, there were 239 Ambulances; of which 229 were BLS & 10 were ALS. Additional 100 BLS have been sanctioned in the current year.
- ▶ In Jharkhand, the Mamta Vahan services are partially running in some districts and are closing down in many districts as vehicle owners feel the remuneration is very low for the services. Also, these services are not functional in the urban areas.

- ▶ In Punjab, there are no Advanced Life Support ambulances in the district to cater to high emergency cases.

RECOMMENDATIONS

- ▶ There is an immediate need to ensure quality emergency care in Advanced Life Support ambulances and building the capacities of emergency medical technicians.
- ▶ There is a need for ensuring uniformity in trainings of providers, scaling up emergency response teams, and solving the last-mile concerns in hilly and difficult regions especially in states like Uttrakhand, Himachal Pradesh and Arunachal Pradesh.
- ▶ The response time of Ambulance service needs to be improved in the states to ensure timely intervention and care.

2.2: MOBILE MEDICAL UNITS

KEY OBSERVATIONS

In Community

- ▶ The community reach of Mobile Medical Units and its utilization is gradually increasing in all states. MMUs are primarily being used for ANC, PNC, Neonatal Care.
- ▶ MMUs are also being utilized for Health Education and generating awareness on communicable diseases and NCDs screening.
- ▶ Basic laboratory tests like MP slide, Hb estimation etc. are being done, apart from general treatment of the catered population.
- ▶ In district Annathapuramu in Andhra Pradesh, screening for hypertension and diabetes in community was done through Mobile Medical Units on a regular basis.

In Service

- ▶ The OPD load of Mobile Medical Unit has improved but the inconsistent follow-ups were seen as a key challenge in most of the states.

- ▶ The consultation services by the MMU in all states were reported to be 70+ per day with an average number of 20-25 trips per month. Better range of services was provided through MMUs in states like Chhattisgarh, Tamil Nadu and Maharashtra. Monthly micro plan is prepared in consultation with CMO and is shared with area ASHA/ANM prior to the visit. In Tamil Nadu, MMU was also conducting screening of ICDS children as a mandate. Also, in Tamil Nadu, a regular cadre Medical Officer is posted in MMU, thereby improving the quality and accountability of the services in outreach areas.
- ▶ In Maharashtra, an MMU was functional in Satara, catering to a difficult area covering 60 villages with high footfall (OPD- 204/day, tests- 87/day). In Gadchiroli district, also OPD was about 84/day and tests nearly 58/day.
- ▶ States like Andhra Pradesh, Arunachal Pradesh, MP and Punjab were observed with improved MMU services in terms of increased number of vehicles, OPD & investigations. MMU service was found absent in Himachal Pradesh.
- ▶ In Andhra Pradesh, The MMUs are functional under the name of 'Chandranna Sanchara Chikitsa' in the state. 23 vehicles have been earmarked for MMUs and are being run in a PPP mode.
- ▶ In Uttarakhand, 10 districts catering to a population in the range of 25-30% have severe problem of access to the health facilities due to geographical conditions. This makes operationalisation of Mobile Medical Unit a critical area for improvement.
- ▶ In Chhattisgarh, the average OPD observed is 1000-1200 per month. Each MMU plans 25 trips in a month.

RECOMMENDATIONS

- ▶ States must ensure that MMU services are made available in areas where service delivery is unreachable. Further, there is a need for robust

monitoring mechanisms for review of range of services provided through MMUs.

- ▶ Like Tamil Nadu, a Medical Officer needs to be posted in MMU, to improve the quality and accountability of the services provided through MMUs.

2.3: EMERGENCY SERVICES

KEY OBSERVATIONS

- ▶ The emergency services were found suboptimal in all the states visited. The services available were confined to the basic first aid care at most of the states visited.
- ▶ The quality of service was suboptimal due to unavailability or non-functionality of necessary equipment. Several activities 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.
- ▶ In states like Maharashtra, Chhattisgarh and Himachal Pradesh, basic first aid, stabilization, management of common medical emergencies - chest pain, MI, shortness of breath, poisonings, animal bites (dog and snakes), convulsions, suturing of wounds and fracture management -were in place and functional. Anti-rabies vaccine and anti-snake venom were available and being administered at these facilities. Records of Medico Legal cases were also maintained well.
- ▶ A good practice of use of **Smart Card, issued by the state government**, by community people was observed in Chhattisgarh. Each card provides coverage for 5 family members and a cumulative coverage of five lakh that includes coverage for minor illnesses and injuries, for major surgeries/operations and for normal/LSCS delivery. Community can avail the services in all the government facilities and empanelled private health care facilities. However, Assured Emergency Services were seen as an area of improvement at all facilities since the reports lack the element of Assured Emergency care services in all states.

RECOMMENDATIONS

- ▶ The number and adequacy of existing Trauma Centres needs to be re-assessed. Current centers could be converted to Comprehensive Emergency Departments to cater to all kind of emergencies including medical, surgical & trauma cases.
- ▶ These should have close collaboration and referral links with District Hospitals and Medical Colleges. The recent GoI Emergency Services guidelines should be used to adequately resource these departments with the requisite HR, drugs, equipment and protocols.
- ▶ Knowledge partnerships with the center of excellences in emergency & trauma services such as JPNATC, AIIMS to be done in to improve trauma care units in other states.

TOR 3: MATERNAL, NEWBORN & CHILD HEALTH REPRODUCTIVE HEALTH/FAMILY PLANNING AND ADOLESCENT HEALTH

Improving the well-being of mothers, infants and children is an important public health goal for Government of India (GOI). India's Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) Strategy, launched in 2013, was a milestone in the country's health planning. The strategy recognized the interdependence of RMNCH+A interventions across the life stages ensuring for continuum of care. This also adopted a comprehensive approach to address inequitable distribution of healthcare services for the vulnerable population groups and in poor-performing geographies of the country.

There is significant progress in reducing the maternal mortality ratio (MMR) from 556 per 1 lakh live births in 1990 to 130 per 1 lakh live births in 2015 (77% decline compared to the global MMR decline rate of 44%).¹ India's present MMR is below the Millennium Development Goal (MDG) target and

¹ SRS 2014-16

puts the country on track to achieve the Sustainable Development Goal 3 (SDG 3) target of a MMR below 70 by 2030. It is even more heartening to note that socio-economically backward areas referred to as the Empowered Action Group (EAG) States have registered the maximum decline in MMR over the last decade.

Similarly, Infant Mortality Rate (IMR) reduced by 59% during the same period. As per Sample Registration System (SRS) 2017 released by Registrar General of India (RGI), IMR is 33/1000 live births.

Despite a one-third reduction in MMR, India still accounts for 15% of the global maternal deaths. Moreover, for every death that takes place, there are many more with varying degrees of morbid conditions. Pregnancy-related mortality and morbidity continue to have huge impact on the lives of Indian women and their newborns. While the progress has undoubtedly been impressive, in order to achieve the SDG targets, systematic efforts need to be made to eliminate disparities in maternal, newborn, child and adolescent health outcomes across the country.

KEY OBSERVATIONS

- ▶ The percentage of pregnant women (PW), who received ANC in the first trimester, has increased considerably in all the CRM states visited, except Karnataka (70% to 64 %) and Tamil Nadu (76% to 68 %). (source NFHS)
- ▶ The percentage of PW who received any ANC in the first trimester increased from 19 per cent in NFHS-3 to 35 per cent during NFHS-4 in Bihar, while it has declined from 71 per cent in NFHS-3 to 66 per cent in NFHS- 4 in Karnataka.
- ▶ The percentage of PW who had an institutional delivery in a public facility increased in all states from NFHS-3 to NFHS-4. The increase is particularly significant in Madhya Pradesh (from 18% to 70%), Uttarakhand (from 16% to 44%) and Bihar (4% to 48%). This is consistent with the CRM findings of high footfall in public health facilities for ANC and deliveries.
- ▶ Programmes like Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram



(JSSK) that provide free entitlements along with ambulance facility to the expectant woman (under National Ambulance Services) have helped in scaling up the institutional delivery rate from 38 % in 2005 to 79 % in the year 2015.

- ▶ Women were found aware about the importance of the ANC in states like J& K, Andhra Pradesh, Telangana, Uttrakhand, Punjab, Chhattisgarh, Maharashtra, Gujarat, and Madhya Pradesh and ASHAs were actively mobilizing pregnant women and maintaining records.
- ▶ In the states like Tripura, Arunachal Pradesh, Rajasthan the community was not aware about the range and quality of services to be rendered under ANC. Similarly the pregnant women were not aware about the danger signs during pregnancy in states like Tripura, Assam, Arunachal Pradesh, Jharkhand and Rajasthan.
- ▶ Identification of high risk pregnancies (HRP) was a major gap in all the states except Tamil Nadu, Maharashtra and Gujarat. Newer initiatives like screening for Gestational diabetes mellitus (GDM), thyroid and provision of calcium supplementation & deworming were mostly missing in almost all the states except Tamil Nadu.
- ▶ With the launch of PMSMA, there has been an increase in the identification and line listing of high-risk pregnancies however its management remains inadequate in most of the states. Also, the quality of service provision under PMSMA still remains a challenge.



and Kashmir, Tripura, Telangana, Uttrakhand, Andhra Pradesh, Arunachal Pradesh and Gujarat. Medical methods of abortion were found to be prevalent in most of the states and pills are taken over the counter from pharmacists.

- ▶ In most of the CRM states, USG services are provided at the DH level only, leading to overcrowding at District Hospitals.
- ▶ Interaction with beneficiaries particularly in the states of Arunachal Pradesh, Punjab, Bihar, Uttar Pradesh, Chhattisgarh, and Rajasthan, revealed high out of pocket expenditure under PMSMA since services are not available under one roof and people are going to private hospitals for lab investigations or USGs. The quantum of payment however varies.
- ▶ The CRM findings also indicate that with an increase in the number of deliveries there is an increase in number of episiotomies (Andhra Pradesh and Assam) and C sections (Tripura, Andhra Pradesh, Assam, Punjab, Karnataka, and Tamil Nadu).
- ▶ In states of Uttar Pradesh, Madhya Pradesh and Jharkhand, diagnostics and drugs are mostly limited to Hemoglobin, Urine, Blood sugar and USG and that too only at DH level. Moreover, availability of such facility is observed mainly on the PMSMA day.
- ▶ Inappropriate deployment of specialists was observed in most of the states (except states like Tamil Nadu and Karnataka). Lack of specialists and inappropriate deployment negatively impacts assured services and leads to access to private sector, thereby leading to high OOPE.
- ▶ Awareness regarding safe abortion facility is lacking in most of the states like Jammu
- ▶ Early age of marriage, leading to teenage pregnancy is a matter of concern in states like Jammu and Kashmir, Tripura, Andhra Pradesh and Bihar.
- ▶ Community in general has no knowledge or orientation on the basket of choices available under family planning programme. In fact, this knowledge is lacking even amongst ASHA and other community health workers.
- ▶ The most preferred method of contraception amongst community is female sterilization, condom and oral pills. Awareness and usage of EC Pills, injectable contraception, spacing and economic benefits of a small and healthy family appeared to be low in the community.
- ▶ Adequate resources were found to be available at DH and CHC level for interval IUCD, PPIUCD and post-partum sterilisation in states like Madhya Pradesh, Tamil Nadu, Maharashtra, Punjab and Uttar Pradesh.
- ▶ Family Planning Logistics Management Information System (FP-LMIS) has not been implemented in most of the states except for states like Uttar Pradesh and Karnataka, where the indenting process has reached till sub centre levels.
- ▶ New-born services have shown improvement and essential new-born care is operational in most of the states. The community awareness on importance of early and exclusive breastfeeding and complementary breastfeeding has been steadily increasing after the initiation of the MAA(Mothers Absolute Affection) programme, but the practices of the same varied across states. Specifically, in states like Jammu & Kashmir, Rajasthan, Tripura, Assam, Bihar and Jharkhand, use of ghutti, honey, juice and boiled water was prevalent.
- ▶ Telangana and Tripura had delayed breastfeeding for new-borns due to high number of caesarean section deliveries in the state.

- ▶ KMC services varied across states. States like Punjab, Gujarat, UP, Telangana and MP, KMC was practiced as an essential component of care of LBWs in health facilities, whereas inadequate practices at DH Uttarkashi in Uttarakhand, J&K, Tripura and Jharkhand were observed.
- ▶ Most of the states have established NBSU services at the facilities but the utilization rate varied across the country. States such as J&K, Assam, Uttarakhand, Bihar, UP, Chhattisgarh and Tripura exhibited underutilization or non-functional NBSUs, reason being untrained staff or inadequate manpower to manage the facility. States like Jharkhand, Bihar, Tripura, Himachal Pradesh, Assam, UP, Gujarat have established the NICU services at their respective medical colleges.
- ▶ All states reported “Zero” dose administration of OPB, BCG & Hep B as satisfactory except Jharkhand. Cold chain management, Open Vial Policy and Alternate Vaccine Delivery were observed as being adequately followed in all the states except in states like Tripura, TN & J&K.
- ▶ Adolescent health being a very important component of the continuum of care approach still remains neglected in most of the states except for Andhra Pradesh, Karnataka, Chhattisgarh, Gujarat, Telangana and Uttar Pradesh. The role of the peer educators and ASHA in community mobilization for adolescent health has been negligible.
- ▶ The Adolescent Friendly Health Clinics (AFHC) were functioning well in Tripura, Telangana, Maharashtra, Jharkhand, Karnataka, Uttarakhand, Arunachal Pradesh, Jammu & Kashmir, Himachal Pradesh, and Punjab but lacked facilities in states like Assam. Attendance in these clinics however was not found to be adequate. The setup of the clinic itself was not found to be friendly to attract adolescents in most of the states. Some innovations have been initiated in MP.
- ▶ Knowledge amongst adolescents about common health problems e.g. substance use, nutrition, healthy lifestyle, age of marriage,



menstrual problems, acne, teenage pregnancy, emotional, psychological issues, was suboptimal in most of the states.

- ▶ Weekly Iron Folic acid Supplementation (WIFS) implementation was seen in states like Telangana, Tripura, Assam, Himachal Pradesh, Uttarakhand, J&K and Andhra Pradesh. Uttarakhand, Himachal Pradesh & Punjab reported frequent stock outs of IFA tablet.
- ▶ Generally the analysis of the report indicates that there is lack of serious effort in the states to bring the adolescents in the fold of continuum of care by provision of preventive and promotive health for adopting a healthy lifestyle and behaviour.

RECOMMENDATIONS

The states need to prepare a comprehensive plan to ensure delivery of assured and quality services to achieve desired maternal, new-born, child and adolescent health outcomes.

- ▶ Strengthen line listing and follow-up of High-Risk Pregnant women including severely anemic women for providing special attention and care at referred centre.
- ▶ There is a need to develop a definite plan for integrated IEC and communication activities to create awareness on the importance of early registration of pregnancy and ANC and also generate demand for institutional deliveries at the community level.



- ▶ Quality of clinical care can be improved through continuous refresher training for medical officers and prioritized service providers.
 - ▶ Conduct referral audits to identify corrective action at referring and referred facilities.
 - ▶ States to develop/implement a comprehensive Supportive Supervision plan resulting in robust feedback mechanism and action plan including regular periodic visits from state and district and follow up on the action suggested.
 - ▶ Rational deployment of trained specialist up to CHC level to prevent overcrowding at district hospitals. A district data of the empanelled doctors to be formed for regular updation
 - ▶ There is a need for sensitization of doctors and nurses for rendering quality abortion services with respect and care. Simultaneously, health facilities need to be strengthened in terms of infrastructure, trained manpower, drugs, and consumables.
 - ▶ A target-free approach based on unmet need for contraception; equal emphasis on spacing and limiting methods; and promoting 'children by choice' in the context of reproductive health are the key approaches to be adopted for the promotion of family planning and improving reproductive health.
 - ▶ States need to ensure fixed day services for family planning at all facilities below district hospital level as well. FDS calendar to be displayed at facility levels so that the people are well aware about the fixed days.
- ▶ Monthly review of critical care units: SNCU, NBSU, NICU, PICU at district and facility level to identify critical factors, service quality by using SQCI (SNCU Quality of Care Index), action planning and ensure timely gap filling and corrective measures.
 - ▶ The district and state should monitor critical indicators for service delivery like percentage screened, percentage referred, percentage completed treatment at various levels and also the performance of the team.
 - ▶ Use of standard registers and reporting formats. ASHAs and registration system of RGI is to be utilized optimally for improving death reporting.
 - ▶ Prioritizing community awareness regarding nutrition: complementary feeding along with early & exclusive breastfeeding upto 6 months of age, growth milestones and common childhood illnesses such as diarrhoea and pneumonia by increasing IEC activities, access to JSSK entitlements etc.
 - ▶ States should strengthen the monitoring mechanism of the RKS programme, its outreach activities and also its linkages with RBSK for diagnosis and treatment.
 - ▶ States should take steps for training of manpower and delineate clear roles and responsibilities for the staff members for effective implementation of RKS at facility level.
 - ▶ Better ARSH training for counsellors which focuses on all aspects of Adolescent health care including SRH services.
 - ▶ Intensive IEC campaign including digital campaigns in social media, to educate adolescents on menstrual hygiene and nutrition should be organized in the schools. A special plan should be in place for out of school youth and adolescents.

TOR 4 : COMMUNICABLE DISEASES

Major communicable diseases like Tuberculosis, Malaria, Leprosy have witnessed a sharp decline owing to the recent and intensified actions under

several National Health Programmes such as the National Vector Borne Disease Control Programme, National Leprosy Eradication Programme, Revised National TB Control Programme, under the umbrella of National Health Mission (NHM).

Public health facilities continue to show increased utilisation on year-on-year basis. However, certain newer challenges such as scourge of Drug-Resistant Tuberculosis (DR-TB) and Anti-Microbial Resistance need newer strategies and interventions.

This section highlights the key observations of the CRM visit related to Integrated Disease Surveillance Program and its reporting, gaps identified in implementation of various national health programmes for tackling communicable diseases at community and health facility level both and lastly, the key recommendations suggested by the team of experts.

4.1: INTEGRATED DISEASE SURVEILLANCE PROGRAMME

KEY OBSERVATIONS

- ▶ In Punjab, a good Surveillance system is established from sub-district to district level and with a functional rapid response team. S, P, and L forms are duly filled and submitted regularly. Data are analyzed weekly to identify signs of outbreaks.
- ▶ Formation of Rapid Response Team along with leadership from the district administration and other inter-sectoral departments has resulted in a coordinated outbreak control response of Dengue in Himachal Pradesh. Convergence between different departments (e.g. IPH, WCD) was reported to be good during outbreaks. A Dengue Death Audit Committee has not been formed to investigate Dengue deaths in the state.
- ▶ In Korba district of Chhattisgarh, good reporting (95%) was seen under IDSP, however, in Raipur, the same was found inadequate.
- ▶ In Arunachal Pradesh, IDSP is functioning well and implemented in all 20 districts through

DSUs. All HR is in place. The unit established at the district level are reporting at the state level regularly.

- ▶ In Uttarakhand, State, districts, and blocks have formed Rapid Response Teams (RRT) to investigate and mitigate the impact of epidemics. However, Most of the Medical Officers were found to be untrained under IDSP and whosoever was trained has not undergone refresher training in the recent past.
- ▶ In Maharashtra, epidemic outbreaks are being identified and investigated by the Rapid Response Team under IDSP. Jharkhand also reported an outbreak of Chikungunya and Dengue in the Ranchi district. Timely response to the outbreak was taken and necessary activities like the house to house surveillance, community awareness, and various IEC activities were conducted.
- ▶ In Gujarat, disease surveillance feedback is instituted, under IDSP, from the State & districts to the periphery and private facilities are included for reporting.

RECOMMENDATIONS

- ▶ Improvement of data reporting is required from all level of health facilities including private establishments. This needs to be ensured across all reportable diseases. Implementation of Epidemic Diseases Acts for improvement of notification from the Private sector.
- ▶ Adequate training of the medical personnel and field workers is essential and needs to be done across all the states. Timely refresher training needs to be organised as well.
- ▶ Vacant posts to be filled at the earliest to ensure smooth functioning of the programme and desired outcomes.
- ▶ Periodic data analysis and review at PHC and CHC level needs to be stressed upon and monitored for early detecting of impending outbreaks & timely intervention.
- ▶ Approved District Public Labs to be made functional.

4.2: REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

KEY OBSERVATIONS

- ▶ High level of community awareness on signs & symptoms of TB and how & where to get tested was found in Chhattisgarh, Jharkhand, Arunachal Pradesh, Punjab, and Himachal Pradesh but it was sub-optimal in Tripura, MP & Maharashtra.
- ▶ Good utilization of Cartridge Based Nucleic Acid Amplification Test (CBNAAT) centres was reported in Andhra Pradesh and Karnataka but the same were found underutilized in Bihar, UP, Maharashtra, and Tripura.
- ▶ Patients are reported to be travelling to CBNAAT Lab from distant places for giving their sample for testing, resulting in out of the pocket expenditure. Lack of organized mechanism for sputum collection & transportation was reported from majority of the states.
- ▶ Awareness about NikshayPoshan Yojana wasn't high in the community except that in Andhra Pradesh. DBT Status of TB patients under Nikshay Poshan Yojana is less than adequate in Bihar, Jammu & Kashmir, Uttarakhand, Himachal Pradesh, Uttar Pradesh, Arunachal Pradesh, and Madhya Pradesh.
- ▶ In Chhattisgarh, Maharashtra, Rajasthan, Punjab, and Himachal Pradesh, knowledge of ASHAs, and MPWs regarding signs and symptoms of pulmonary tuberculosis was adequate. However, information regarding extra-pulmonary tuberculosis is inadequate.
- ▶ HR shortage was a major finding across all states and health facilities visited.

RECOMMENDATIONS

- ▶ Training of the healthcare providers (MO, MPHW- Male, and Female) in new treatment guidelines for the management of TB and Drug-Resistant TB.
- ▶ Strict enforcement of the Gazette Notification mandating TB notification from private health care providers and private chemists.

- ▶ More intensified Advocacy Communication &Social Mobilisation (ACSM) activities need to be conducted for mass awareness on the newer activities especially NIKSHAY POSHAN YOJNA (Nutritional support) and all diagnostic and treatment facilities available under the programme.
- ▶ All district level vacancies should be filled up at the earliest.
- ▶ Real-time updating of records in NIKSHAY needs to be ensured in all the districts for quality data analysis and feedback.
- ▶ Districts to establish sputum collection and transportation mechanism from the periphery to the CBNAAT laboratories to reduce OOPE.

4.3: NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

KEY OBSERVATIONS

- ▶ Community Awareness was largely high regarding various vector borne diseases, their control mechanisms, and signs & symptoms of the disease and its complications in Madhya Pradesh, Chhattisgarh, Andhra Pradesh, Maharashtra, Uttarakhand, Punjab, Arunachal Pradesh, and Tamil Nadu.
- ▶ Private consultations with non-registered Practitioners, quacks were found quite prevalent in Madhya Pradesh and Uttarakhand and is an area of concern.
- ▶ Awareness about Long Lasting Insecticidal Nets and its correct usage was found good in Arunachal Pradesh, Madhya Pradesh, Chhattisgarh, Tripura (District South Tripura) and Jharkhand but in Maharashtra and Bihar, community lacked knowledge about LLNs.
- ▶ Many states have developed their own innovative ways to create awareness about Vector borne diseases and to reduce its incidence in the community. E.g. MP has undertaken to a link of control of vector-borne diseases with 'Swachh Bharat Abhiyan' for source reduction and vector management. Similarly, Fogging and spraying

were observed to be regularly conducted in concurrence of Gram Sanjeevani Samiti in Gujarat.

- ▶ In Arunachal Pradesh and Rajasthan, the knowledge and skills of ASHAs and ANMs for diagnosis e.g. slide preparation (Thick and Thin) and treatment of malaria was found to be satisfactory.
- ▶ In Madhya Pradesh, ANM/ASHAs are involved in both passive and active surveillance of malaria but lack the skills for performing RDT for malaria as well as slide preparation. Knowledge regarding the treatment of malaria was also found to be inadequate. Wrong diagnosis using RDTs by ASHAs/ANMs and administration of wrong treatment to the patients is a matter of concern which needs urgent attention.
- ▶ Availability of RDTs and anti-malarial medicines with ASHA/ANM and health facilities was found to be adequate in Gujarat, Jharkhand, Madhya Pradesh, and Arunachal Pradesh but District hospital at Raipur, Chhattisgarh, high endemic blocks of Bihar, Uttar Pradesh UPHC Farrukhabad, Unakoti district, Tripura & a few centres in Gadchiroli, Maharashtra reported inadequate availability of the same.
- ▶ In Arunachal Pradesh, available ACT\ Chloroquine\Primaquine drugs were of short expiry in few facilities visited.

RECOMMENDATIONS

- ▶ Sub-centre wise mapping of high-risk areas using epidemiological data for intensifying the control strategy.
- ▶ Awareness activities need to be strengthened and monitored so as to ensure higher utilization rates of interventions like LLINs.
- ▶ Monitoring the use of LLINs for optimal coverage and results and policy decisions regarding further IRS continuation/stoppage in the future is recommended.
- ▶ Assessment, training of ASHAs/ANMs for correct diagnosis and treatment is recommended, non-performing ASHAs/ANMs to be identified

and appropriately retrained or replaced with appropriate frontline health workers for this purpose.

- ▶ Capacity building of all frontline workers, DMOs, MOs, etc. across all cadres of health staff to be considered on priority.
- ▶ Documentation including reporting and recording needs to be strengthened. The monitoring of the programme needs to be intensified. Updated formats for malaria reporting need to be provided to the districts.

4.4: NATIONAL LEPROSY ERADICATION PROGRAMME

KEY OBSERVATIONS

- ▶ Peripheral health workers are actively involved in passive as well as active case detection for leprosy. They are aware of the signs and symptoms to identify a suspected case and are engaged in an appropriate referral in Chhattisgarh, Jharkhand, Maharashtra, and Andhra Pradesh.
- ▶ In Arunachal Pradesh and Gujarat master treatment register, individual patient treatment card and disability register were available at rural and urban PHCs. However, no formal record keeping for contact investigation activities was being maintained and was not being monitored in Chhattisgarh and Uttarakhand.
- ▶ Community was found to be adequately aware of the signs and symptoms of the disease and its complications in Chhattisgarh, Madhya Pradesh, Jharkhand, and Arunachal Pradesh.
- ▶ IEC/BCC activities for Leprosy & various national programmes/campaigns have been reported to be inadequate in Madhya Pradesh, Maharashtra, Punjab, and Arunachal Pradesh, Uttar Pradesh & Raipur, Chhattisgarh.

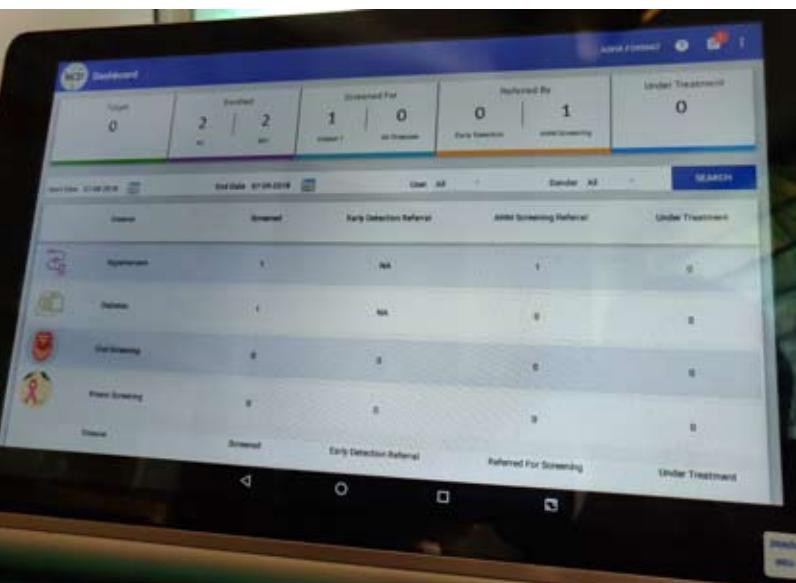
RECOMMENDATIONS

- ▶ The sensitization of MOs/AMOs and responsibility for diagnosis and treatment of leprosy cases is required.

- ▶ Follow-up visits of the leprosy patients by the supervisory staff needs to be done.
- ▶ Implementation of contact investigation with proper recording mechanism to be ensured.
- ▶ Cases with Grade II deformities need to be identified and services to be provided.
- ▶ Integration of screening services to avoid duplication and to improve efficiency (e.g. LCDC+ACF). TB screening may be included in the upcoming LCDC campaign and vice versa.
- ▶ The involvement of private practitioners for strengthening surveillance and appropriate care of Leprosy in the private sector is recommended.
- ▶ Intense IEC for removal of stigma around Leprosy & create awareness about the various national campaigns esp. to cover the unreached communities is crucial.

TOR 5: NON-COMMUNICABLE DISEASES (NCD)

This section covers interventions related to the National Programmes for the Control of Diabetes, Cardiovascular Diseases and Stroke, Oral Health, Tobacco Control, Fluorosis, Blindness Control, Deafness, and Mental Health. This section also covers programmes related to care for the Elderly,



and Palliative Care. As discussed earlier, one of the key objectives of this Common Review Mission was to review each of the key components from the point of view of the community and assess how services were organized at every level of the facility to meet community needs and provide quality service delivery. All these programmes for non-communicable diseases that have been implemented for varying periods starting from 1976 onwards, and are now integrated into the NHM. With the launch of the HWC, all programmes have also been included in the expanded service delivery packages.

5.1: NATIONAL PROGRAM FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE

The Universal Screening of Non-Communicable Diseases for individuals 30 years and above, was envisioned as a step to expand the range of services to be delivered under Comprehensive Primary Health Care (CPHC) and complement the existing National Programme for the Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke (NPCDCS). Under the NPCDCS programme, opportunistic screening was being undertaken at facilities, and treatment facilities for stroke, kidney disease and cancer being provided at DH and tertiary centres. Death from the four major NCDs for nearly 60% of all mortality and the sequelae of NCD impose a high fiscal cost, indicating the need to focus on primary and secondary prevention, strengthen community, outreach and primary health care facilities, improve care seeking behaviour and expand access to screening and early detection and improve treatment adherence.

Services under the universal screening effort for NCDs integrated with NPCDCS, intervention are organized by various levels of care- community, primary health care at sub centre and PHC and secondary care at DH. Key components are Population enumeration, community-based risk assessment through use of a checklist by ASHAs,

Health promotion, sub-centre level screening by ANMs and treatment initiation by PHC-MO, and ensuring continuum of care through referral, medicine dispensation and a two way follow up at Sub Health Centres. This is supplemented by care provided through NCD clinics at CHC and DH, Cardiac Care Units, cancers chemotherapy, and dialysis facilities at DH/tertiary level facilities.

KEY OBSERVATIONS

- ▶ While overall community awareness across all states on morbidity related to hypertension, diabetes and cancers and their associated risk factors was high, in no state was there an understanding that public health facilities at primary health care level offered services, be it screening, examination or treatment, with the result that those who sought care at public health facilities tended to access CHC or DH incurring higher cost, and the possibility of poor treatment adherence and lack of follow up, resulting in fragmentation of care.
- ▶ Implementation of the universal screening, prevention and management of common NCDs initiative was observed to be at different stages across the states. Mahila Master Health Scheme in Andhra Pradesh and Sampoorna clinic in Uttar Pradesh are notable state specific efforts focussed at identifying NCDs among women.
- ▶ Functionality of NCD clinics at CHC/DH was variable; and HR shortages were reported from all districts except Gujarat. At CHCs, NCD clinic was reported to be non-functional in Rajasthan, Jharkhand and one district in Punjab. In Bihar, NCD related services in NPCDCS districts were provided only at the level of DH and there was no screening or reporting at block PHC and Additional PHC level. Staff for NCD clinics was deployed in other departments in the states of Assam and Bihar, limiting access even for opportunistic screening. MPWs-F were trained in the use of the NCD module of CPHC application in Bihar and Jharkhand. In Assam, CHOs were also trained in universal screening of NCDs. In Jammu and Kashmir, ANMs at the SC-HWCs were trained on NCD module and were well versed with the application. However, they were currently not using the application for entering the data, and requested if hand holding can be done for some time so that they get confident to use the application on their own.
- ▶ MO and staff nurses at PHC were trained in universal NCD screening in Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Jharkhand and Maharashtra, however no such training was conducted in Uttar Pradesh, Madhya Pradesh and Rajasthan, affecting continuum of care.
- ▶ Lack of clarity about Universal Screening of NCDs guidelines was noted among programme officials in few states like Rajasthan, which has affected the planning, training and service delivery. In Jammu and Kashmir; however, the district NCD officials were very aware of the guidelines, but human resource shortages across facilities, hampered service delivery.
- ▶ Tamil Nadu, which has ASHAs in very few remote areas, has one Woman Health Volunteer (WHV) at the level of the SHC, to undertake population-based screening of NCD after a three-day training. In HWCs, a second VHN (MPW-F equivalent) undertakes NCD screening; facility based diagnostic tests, and dispenses medicines against valid prescriptions.
- ▶ Health promotion is an integral part of the Universal Screening of common NCDs. State findings indicates a need for increased focus on IEC and health promotion activities. Gujarat, Jammu and Kashmir and U.P had IEC material displayed in facilities, but in UP the content was not user friendly.
- ▶ Community level health promotion activity related to lifestyle changes was not reported from any state. In Rajasthan and Tripura, high use of tobacco was seen amongst men and women, but no initiative was undertaken to address these risk factors in the community. Community platforms like VHSNC/MAS had not received inputs on their role in addressing lifestyle diseases, through initiatives at the community level to prevent NCDs and promote healthy life style.

- ▶ Population enumeration has been initiated in most of the states, however not much has been reported on line listing of the target population and status of family folders. In Jammu and Kashmir, ASHA diary has been revised by the state to document the information on individuals of age thirty years and above. However, the block level functionaries and ASHAs were unclear on the need for population enumeration.
- ▶ In most states, cancer confirmation tests (biopsy, Fine Needle Aspiration Cytology, PAP smear, and mammography) are available only in tertiary care centres, increasing patient hardship. User fees were being charged in few states like Jammu and Kashmir, Uttrakhand for diagnostics even at PHC level.
- ▶ In many districts, shortages of glucose strips hampered screening for diabetes. In states where community or peripheral facility screening was initiated, suspected individuals were referred to PHC (or MMU as in case of Andhra Pradesh) for confirmation of Hypertension and Diabetes and to DH for cancer confirmation. However, semi auto analysers were not available in any of the PHCs visited, and diagnosis of diabetes was done using capillary blood glucose measurement, which is not in keeping with standard treatment protocols.
- ▶ In all states, medicines were being dispensed for a duration of 5-7 days at the public facilities at all levels, forcing people to buy medicines from private pharmacies and then access private practitioners for follow up. It is not surprising that in all states, Out of Pocket Expenditures for those with hypertension and diabetes was largely on medicines, transport with multiple visits to the health care facility.
- ▶ Availability of antihypertensive and anti-diabetic medicines as per EML was reported in most states like Gujarat, Rajasthan, Chhattisgarh, Assam, Andhra Pradesh, Tamil Nadu and Maharashtra. Antihypertensive and anti-diabetic medicines were available at the sub centre level in only four states- Assam, Andhra Pradesh, Tamil Nadu and Rajasthan. However, in Rajasthan, medicines were not being utilized at SHCs due to lack of clarity about dispensation power by MPW (F) and CHOs.
- ▶ Erratic supply of medicines was also observed in states, which further reduces community trust in public health facilities. Findings from Punjab reported change in treatment plan of patients based on the medicine being supplied. In Madhya Pradesh and Uttar Pradesh, despite availability of medicine utilization was low, with patients, including indigent patients, accessed private facilities because they lacked information on treatment facilities at DH/CHC/ PHC. In Uttrakhand, medicines were being prescribed from outside, despite availability in the public health facility. In Jammu and Kashmir, certain combination medicines for hypertension were prescribed from outside as these were not available in EML leading to high OOPE.
- ▶ Cardiac Care Unit at DH level was reported to be non-functional in Jharkhand, Maharashtra, Punjab, one district of Bihar and one district of Gujarat, due to specialist shortages. Chemotherapy was reported to be available only in Gadchiroli district hospital of Maharashtra and in other states, patients had to travel to tertiary care centres for chemotherapy.
- ▶ Referral and follow up mechanisms was found to be weak in Assam, Chhattisgarh, Bihar, Himachal Pradesh, Uttar Pradesh, Jammu and Kashmir and Tripura. There was poor documentation This includes back referral of controlled/stable cases from higher facilities- CHC/SDH/DH to PHC/SHC, which was not reported in any state.
- ▶ Documentation for identified cases was poor across states at community and sub centre levels particularly. Lack of follow up mechanisms for positively diagnosed case is a critical challenge, and in absence of records for identified cases it is difficult for service providers to follow up for treatment compliance. The exception to this is the state of Tamil Nadu, where Women Health Volunteers were instructed to cover cases missed during the week's screening and also follow up of those who dropped from treatment/

- confirmatory tests at PHC on every Saturday. This is one of the ASHAs tasks for which an incentive has been provided but was not being undertaken in any state.
- ▶ In DH, Gurdaspur, Punjab a pilot under the India Hypertension Management Initiative (IHMI) has developed a mechanism for tracking by the counsellor. One portion of a card is given to the beneficiary and other is kept at the facility, and counsellors are expected to call the patients. This is an innovation to be tested for feasibility at scale, but counsellors were unhappy that they had to use a personal number to call patients.
 - ▶ Reporting and recording were done using formats in most states except in Chhattisgarh and Himachal Pradesh. However, this is used only for reporting facility data rather than for tracking and following patients. An IT based application was reported from Telangana, but the continuum from community to facility needs strengthening.
- ## RECOMMENDATIONS
- ▶ States should expedite the training for all cadres on a priority basis as per the standard guidelines, including one day joint training of ASHAs and ANM/MPWs, to ensure coverage and reach for screening for common NCDs.
 - ▶ For states, where the training for front-line functionaries has been conducted for a shorter duration, a refresher should be planned to cover for the remaining days, with main focus on health promotion, reporting and recording, and follow up mechanisms.
 - ▶ Role and responsibilities of ASHAs and ANM/MPWs in health promotion activities need to be discussed during monthly meetings by the block level officials. Involvement of community-based platforms like VHSNC/MAS/PRI/ULBs to be ensured for health promotion and screening activities.
 - ▶ It should be ensured that the revised CBAC are available at the level of SHCs, and the workforce is reoriented on the format.
 - ▶ States need to ensure that ASHAs do the line listing and population enumeration and are able to mobilize the listed individual to be screened at the SHC or through outreach.
 - ▶ States to expedite the screening of four common NCDs- hypertension, diabetes, breast cancer and oral cancer at SHCs on a priority basis.
 - ▶ There is also a need to plan a simultaneous roll out of the programme in urban areas.
 - ▶ Diagnostic availability to be ensured at SHC, PHCs and also at secondary care facilities to maintain continuum of care after screening.
 - ▶ Availability of medicines to be ensured across levels of facilities especially SHCs to reduce out of pocket expenditure. Clear guidelines to be communicated to block level officials and service providers regarding medicine prescription and dispensation.
 - ▶ Prescription audit is recommended to check on prescription of irrational medicines.
 - ▶ States should ensure procurement and availability of IT hardware, including tablets for MPWs and smartphones for ASHAs. There is need to initiate training of workforce on NCD module of CPHC application.
- ### 5.1: ORAL HEALTH INTERVENTIONS
- The National Oral Health Programme was launched across the country to provide integrated, comprehensive oral health care at the existing health care facilities. The multi-centric survey in 2007 demonstrated a prevalence of dental caries in about two fifths of patients and periodontal diseases in over 90%. Fluorosis was reported as endemic in 230 districts and edentulousness of upto 32% among elderly. Clearly interventions for oral health which if effectively implemented at primary health care levels with health promotion and prevention, and regular screening through the Rashtriya Bal Swasthya Karyakram, school health programmes and community outreach has the potential to improve oral health and hygiene.
- The National Tobacco Control Programme (NTCP) is now over a decade old. The objectives of NTCP

cover increased awareness, regulation, monitoring and enforcement of tobacco control laws, capacity building, multi-sectoral convergence and establishing/strengthening of tobacco cessation facilities including provision of pharmacological treatment facilities at district level. Currently, the Programme is being implemented in all 36 States/Union Territories covering around 612 districts across the country.

The National Program for Prevention and Control of Fluorosis (NPPCF) is also a decade old, and about 190 districts are being covered. Key interventions are the Surveillance of fluorosis in the community; Capacity building; establishment of diagnostic facilities in the medical hospitals; Management of fluorosis cases including treatment surgery, rehabilitation, and Health education for prevention and control of fluorosis cases.

This section covers findings related to the National Oral Health Programme, National Tobacco Cessation Programme, and the National Fluorosis programme, given that in India the consequences of tobacco smoking and chewing and effects of fluorosis are largely on oral health.

KEY OBSERVATIONS

- ▶ The National Oral Healthcare Program is being implemented in all states, albeit covering the District hospital and CHC/SDH components. A direct consequence is that all reports except from Andhra Pradesh, noted widespread prevalence of oral health problems, linked to low levels of awareness about dental hygiene and high use of chewing tobacco. There was limited awareness in the community about dental services available in public health facilities.
- ▶ In Andhra Pradesh, general awareness regarding oral health conditions and high health seeking behaviour with a preference for accessing care at public health facilities. However, in Bihar, Maharashtra, Telangana, Tripura, Chhattisgarh, Madhya Pradesh, Rajasthan and Gujarat, there was a general lack of awareness about availability of oral health services at various facility levels.
- ▶ Relevant IEC material regarding common oral health conditions was displayed in facilities in Maharashtra, Punjab and Chhattisgarh but most of the states had insufficient display of IEC/BCC material. NOHP in Assam was reported to be in the nascent stage.
- ▶ Dental clinics were functional at District Hospitals in most states. In addition to the district hospital, dental clinics and OPDs were functional at the SDH and rural hospitals in the states of Bihar, Punjab, Maharashtra and Chhattisgarh. Uttarakhand had functional clinics only at the CHC and Sub-district hospitals. Dental services in Tamil Nadu are available at all the health facilities from PHCs/UPHCs and above.
- ▶ Range of services provided was limited to dental extractions in Bihar whereas dental surgeons were performing root canal treatment (except capping), fillings, wiring, scaling and extractions in Rajasthan, Tripura and Chhattisgarh.
- ▶ Unorganized sector in the states of Uttar Pradesh and Jammu & Kashmir (street side shops) were reported to be catering to a significant number of patients in the community. Private dentists in Chhattisgarh have been empanelled under the RSBY and engaged on PPP basis in Jammu and Kashmir.
- ▶ None of the states had implemented the programme at the PHC or sub-centre level. Hence orientation and training of front-line workers was observed to be deficient in all states.
- ▶ All requisite equipment for dental OPDs were available in UP and UK whereas gross shortage of dental equipment such as dental chairs was observed in Bihar, Maharashtra, Punjab and Andhra Pradesh. Poor Bio-Medical Waste management was also seen in Bihar.
- ▶ Punjab has introduced a dental fortnight as part of community outreach activities. Camps are regularly conducted in some states such as Punjab, Jammu & Kashmir and Rajasthan. Mobile dental vans are also being utilized to improve the community outreach in Maharashtra and Rajasthan.
- ▶ While there was a high level of community awareness on harmful effects of tobacco,

there were also high consumption of tobacco products in Bihar, Tripura, UP and Chhattisgarh (tribal population).

- ▶ Statutory warnings have been displayed at public places under COTPA in Gujarat. COTPA is being implemented in Jharkhand and Punjab. On the other hand, in some states such as Uttrakhand and Chhattisgarh COTPA rules were being openly flouted.
- ▶ Community interventions on tobacco cessation were being undertaken by Mitanin in Chhattisgarh, through schools in Jharkhand, and health facilities and the RBSK programme in Bihar. Drug de-addiction services are being provided through the district hospital in Bihar, Arunachal Pradesh, Tripura, UP, and Chhattisgarh.
- ▶ State cells have been established in Bihar, Jharkhand and Arunachal Pradesh. District cells are functional in Bihar, Punjab and have recently been established in Arunachal Pradesh also.
- ▶ NPPCF is being implemented in Jharkhand, Telangana, Andhra Pradesh, Assam, Chhattisgarh, Jammu & Kashmir, Madhya Pradesh and Karnataka. It was launched in Varanasi district of Uttar Pradesh but none of the activities have commenced under the programme.
- ▶ Implementation of NPPCF as observed, except in Korba, Chhattisgarh, is focused on surveillance and water testing. Water samples are being analyzed in the state of Jharkhand, Telangana, Madhya Pradesh, Chhattisgarh and Karnataka. Telangana is also conducting urinary analysis for fluoride levels apart from school and community surveys. The progress was reported to be slow in other states.
- ▶ Korba district in Chhattisgarh has adopted a convergent approach to combine outreach activities for fluorosis, dental screening and tobacco addiction.
- ▶ Although Ananthapuram in Andhra Pradesh and Doda district in Jammu & Kashmir have mapped endemic villages, no programme activity has been initiated in Ananthapuram while in Doda, only equipment has been purchased. Fluorosis lab has not been established in Uttar Pradesh.

- ▶ Assam is yet to enable piped water supply in endemic Kamrup and delays were observed in Korba.

RECOMMENDATIONS

- ▶ Community outreach activities for improving oral health - whether through improved dental hygiene and care, screening and early detection of oral problems, tobacco cessation, and the sequelae of fluorosis need to be immediately prioritised through ASHA, VHSNC/MAS, schools, RBSK and RSK.
- ▶ Increasing community awareness on service availability for various conditions needs to be matched by ensuring adequate HR, and equipment, whether through posting additional staff or allocating additional tasks to existing staff, which would require workload assessments.
- ▶ Where HWC are operational, the PHC team should be trained in ensuring that community awareness is undertaken regularly, screening is organized, appropriate referrals are made and follow up is undertaken. In other areas, training of frontline workers at SHCs and service providers at PHCs should be similarly organized so that there is at least awareness in the community that the public health system offers services for oral health.
- ▶ Tobacco cessation and addressing fluorosis requires multi-sectoral action and the involvement of Public Health laboratories, drinking water and sanitation, PRIs are all needed. The capacity of district and block teams to engage with stakeholders in other sectors needs to be built.
- ▶ Orientation of service providers towards COTPA in order to ensure efficient implementation of the act.

5.3: NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISION IMPAIRMENT

National Programme for Control of Blindness and Visual Impairment (NPCB&VI) was launched in

1976 with the goal of reducing the prevalence of blindness to 0.3% by 2020. Main objectives of the programme are to reduce avoidable blindness; develop and strengthen the strategy of NPCB for “Eye Health for All” and prevention of visual impairment; strengthening and up-gradation of Regional Institutes of Ophthalmology (RIOs) and partners like Medical College, DH/ SDH, Vision Centres, NGO Eye Hospitals; strengthening existing infrastructure facilities and developing additional human resources, enhance community awareness on preventive measures and expand research for prevention of blindness and visual impairment. The CRM ToR emphasizes the community, primary and secondary components of this intervention.

KEY OBSERVATIONS

- ▶ NPCB is being implemented in most states visited and overall, progress has been observed in terms of cataract surgeries, school health camps, screening services etc. It was observed that Community awareness about eye donation, common ophthalmic conditions and health care services was satisfactory and Govt facilities were being utilized by the people in states such as Bihar, Punjab, Chhattisgarh and Uttrakhand.
- ▶ In Maharashtra, UP and Rajasthan, however there was low awareness, and out of pocket expenditures were reportedly high with respect to ophthalmic healthcare services. ASHAs and other FLW had not been trained in any state.
- ▶ This is one intervention where NGOs have been playing a major role in organizing screening and surgery camps across different states. Linkages between RBSK and school screening camps have been strengthened in states of Punjab, Tamil Nadu, Uttrakhand, Madhya Pradesh and Karnataka. Screening camps were being conducted even at the village level in the state of Punjab.
- ▶ The cadre of ophthalmic assistants in SDH and DH has been put to efficient use for rendering the screening services to the community in Bihar, UP, Uttrakhand, Chhattisgarh and Rajasthan.

- ▶ As a general rule, most of the states were providing surgical services at the district hospital level with the help of Ophthalmologist and Ophthalmic Assistant. Inadequacies in the HR were observed in Rajasthan at the district level. The DH in one of the visited district in Bihar was not equipped with a functional Operation theatre.

RECOMMENDATIONS

- ▶ Collaboration with RBSK and training of Mobile Health Teams for identification and referral of children up to 18 years of age also needs to be strengthened.
- ▶ Training of ASHA and ANMs should be planned to equip them with skills to identify and mobilize individuals who require eye care services. Concerted efforts need to be made for regular screening and follow up of cataract cases.
- ▶ Strengthening infrastructure, availability of equipment and functional eye OT needs to be prioritized at all DH.
- ▶ Orientation of HR at primary level facilities also needs to be undertaken to improve the referral and follow up.
- ▶ IEC activities for eye donation and availability of the services in the community need to be expanded.

5.4: NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS (NPPCD)

National Programme for Prevention and Control of Deafness (NPPCD) launched is operational in 384 districts. The key objectives of NPPCD are to prevent avoidable hearing loss on account of disease or injury, enable early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness, medically rehabilitate persons of all age groups, suffering with deafness, strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme and develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

KEY OBSERVATIONS

- ▶ In most states, except Rajasthan no community level interventions for increasing awareness on deafness or undertaking community screening camps were reported. In Rajasthan, there was strong convergence between RBSK and interventions of the National Urban Health Mission.
- ▶ In remaining states, it was observed that the programme is being implemented only at the district hospital level. States like Maharashtra and Rajasthan have appointed an audiologist and a speech therapist in addition to the ENT surgeon in their district hospitals. However, in Bihar, only ENT surgeon was available without any supporting staff.
- ▶ In Rajasthan, the hearing aids are provided through the ministry of Social Justice and Empowerment in the districts and a strong collaboration has been established with NGO Bhagwan Mahaveer Viklang Samiti for the same. The DH in Rajasthan was fully equipped while DH in Bihar and DH, Ranchi was found lacking in the basic ENT equipment.
- ▶ No state reports indicate that key front line functionaries like ASHAs and ANMs had not received any orientation on NPPCD.

RECOMMENDATIONS

- ▶ The NPPCD needs to establish convergent linkages with two programmes- namely the RBKS and the programmes for the elderly.
- ▶ Community level awareness on deafness, preventable causes and treatment availability needs to be improved with involve frontline workers, primary health care teams at SHC and PHC.
- ▶ District hospitals need to be equipped with HR and equipment so that access to ENT surgeries is available at all secondary hospital levels.

5.5 NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY

National Programme for Health care for Elderly was launched in 2010. The basic thrust of the programme

is to provide dedicated health care facilities to the senior citizens (>60 year of age) at various level of primary health care. The programme aims to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population, create a new “architecture” for Ageing; promote the concept of Active and Healthy Ageing and support convergence with other line departments like Ministry of Social Justice and Empowerment.

KEY OBSERVATIONS

- ▶ NPHCE has been implemented in many states, albeit restricted to district hospitals and medical colleges for tertiary level of health care. Overall state findings demonstrate that a little progress has been made in non high focus states where RCH indicators have improved.
- ▶ Limited awareness in the community regarding accessibility of services for elderly care was reported from Bihar, Maharashtra, Telangana, Uttrakhand, Chhattisgarh, Madhya Pradesh and Rajasthan which is also leading to many patients seeking care from private institutions thereby increasing the Out-of-Pocket Expenditure.
- ▶ Understanding of NPHCE was inadequate among the frontline workers, district and block administration in many states.
- ▶ Maharashtra, Tamil Nadu, Tripura, UP (Farrukhabad district), Uttrakhand, Madhya Pradesh, Rajasthan and Karnataka have dedicated geriatric beds in District hospitals. Jammu and Kashmir is providing IPD services even in its Sub-district hospital. However, bed occupancy was low.
- ▶ The Taluk hospitals in Karnataka are also offering OPD and IPD services to the beneficiaries. RH in Maharashtra provides fixed day services to the elderly.
- ▶ Bihar, Jharkhand, Telangana, and Arunachal Pradesh have either not established any geriatric wards or have non-functional ones and hence have no dedicated staff for geriatric care.

- ▶ In Farrukhabad district, UP, CHCs have a rehabilitation worker/physiotherapist. Similarly, Physiotherapy units were reported to be functional in ten districts in Karnataka. Rajasthan is operating its programme at the DH with trained Medical Officer, GNM, rehabilitation workers and a physiotherapist.
- ▶ In Telangana, most elderly population availed medical services through the 104-outreach service mobile van visiting the village on monthly basis. State has also initiated a social protection scheme for single elderly women whose annual income is less than Rs. 2 lakhs.

RECOMMENDATIONS

- ▶ Given that India's elderly population of over 60 years is about 8.5%, a comprehensive plan needs to be developed at the state and district levels to ensure in all interventions for NCD, oral health, visual and hearing impairment, mental health, care for the elderly receives a specific focus at all levels of care.
- ▶ This requires specific orientation of programme managers and service providers at all levels and interventions for the elderly at primary care levels needs to be expedited.
- ▶ The Telengana example should serve as a model that demonstrates the beneficial effect of mobile health services, until such time as HWC at SCH become fully operational and are able to reach all segments of the population.
- ▶ Multi-sectoral convergence is also needed for elderly care programmes so that they are able to access entitlements and benefits from various other schemes.
- ▶ Referral linkages between the primary facilities to the secondary and tertiary care facilities need to be strengthened.
- ▶ Operationalize services for the elderly at block level through regular camps/ MMUs at designated frequency (monthly / fortnightly), orient outreach workers on detecting problems among elderly, facilitating care and compliance.

- ▶ Facilities to be made geriatric-friendly with the provision for Separate waiting lines for geriatric patients at OPD, Availability of Wheel chairs, Ramps, Side railings etc. to improve ease of access.
- ▶ Rehabilitative services for elderly to be strengthened at primary care levels.

5.6 NATIONAL PROGRAMME FOR PALLIATIVE CARE (NPPC)

NPPC was launched in 2012 with the goal to ensure availability and accessibility of rational, quality pain relief and palliative care to the needy, as an integral part of Health Care at all levels, in alignment with community requirements.

KEY OBSERVATIONS

- ▶ The roll out of NPPC is in a nascent stage, even in the few states where it is being implemented. Rajasthan has implemented the NPPC programme in Jodhpur district and trained its medical officers in the programme. Karnataka has also completed the training of some of its staff in order to establish care centres in 5 districts. In Telangana, MO was aware of the palliative care program but none of the programme specific activities were conducted through PHC. In states of Jharkhand, Punjab and UP, the programme has not been rolled out in the visited districts.
- ▶ As was observed with other NCD programmes, there was a general lack of awareness about the programme and its services among the community, ASHA and ANMs in both districts of Maharashtra, Punjab, Telangana, Tripura and Rajasthan.
- ▶ Even where available, it was found that these services were being underutilized. A palliative care unit was available in District Hospital, Satara in Maharashtra which had one counsellor and one social worker but oral morphine was not available for pain relief. At District Hospital in Telangana, a dedicated ward has been constructed for palliative care activities; however, this is yet to become functional.

RECOMMENDATIONS

- ▶ The findings from the field indicate that the programme for palliative care, cannot be implemented as a standalone programme. It requires convergence with programmes for NCD and with elderly care for a start.
- ▶ The understanding of primary health care teams and frontline workers will need to be built on palliative care and pain relief in the community and the ability to provide home based care.

5.7 NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

National Mental Health Programme (NMHP) was launched in 1982, to ensure the availability and accessibility of basic mental healthcare for all, encourage the application of mental health knowledge in general healthcare and in social development; and promote community participation in the mental health service development and to stimulate efforts towards self-help in the community. The District Mental Health Program (DMHP) was launched in the year 1996 and focused on -Early detection and treatment, training of general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist, training of health workers in identifying mentally ill persons, IEC for Public awareness generation and Monitoring.

KEY OBSERVATIONS

- ▶ National Mental Health Program has been implemented partially by most states that were visited.
- ▶ It was observed that the general awareness on mental health issues as well as availability of services in the community was lacking in most states such as Jharkhand, Maharashtra, Rajasthan, Tripura, Uttrakhand, Arunachal Pradesh, Chhattisgarh and Madhya Pradesh.
- ▶ Services were usually available through District Hospitals. NMHP has not been implemented in Bokaro district (Jharkhand), Punjab, South Tripura, Farrukhabad (UP). The programme was

rolled out in Varanasi but activities could not be commenced as no HR has been recruited.

- ▶ Specialist services by a qualified psychiatrist were available in the states of Bihar, Rajasthan, Maharashtra (Gadchiroli district), Tamil Nadu, Telangana, Tripura (Unakoti district) and Karnataka. In addition, Karnataka is also offering tele-psychiatry services in Udupi district.
- ▶ Notable achievements were observed in the form of well-functioning Drug de-addiction centres in Punjab and a rehabilitation facility in the DH in Tamil Nadu. States of Uttrakhand and Chhattisgarh have adopted the innovative approach of training their Medical Officers for providing primary mental health care services including de-addiction, to address the issue of HR inadequacy.
- ▶ Few innovations include ‘Dawa-Dua’ project in Tamil Nadu where NMHP has collaborated with a dargah historically known to cure mental illnesses. A clinic has been set up in the dargah with adequate HR. In Raipur district (Chhattisgarh), virtual Knowledge Network with NIMHANS has been established to link Mental Health Specialists with Govt. community health professionals for incremental capacity building to provide “Best Practice Care” in rural and underserved areas.
- ▶ The frontline workers in most of the states have received no orientation with the exception of Rajasthan which has trained both the FLWs and MOs. In Baran District, ASHAs were trained to screen patients using a checklist, following which, ASHAs and MPW (F) have so far screened 13,000 patients who are then mobilized for PHC level camps.
- ▶ Significant outreach activities have been conducted in the form of camps and motivational talks particularly for school students by the states of Bihar, Gujarat, Rajasthan and Tripura. Chhattisgarh has established college counselling centres for students. A Toll-free helpline “**Mansamwad**” 1800-180-0018 has also been started in October 2017 under NMHP, Rajasthan.

RECOMMENDATIONS

- ▶ Findings from few states have demonstrated the possibility of better community engagement and follow up through training of front line workers, outreach camp and partnering with faith based institutions. These models need to be reviewed and examined for the feasibility of scale up across other states.
- ▶ Strong IEC campaign is required to create awareness in the community about mental health illness and availability of services within the public health systems, but concomitant action on strengthening supply side interventions is critical.
- ▶ Improved coordination with NCD cell, elderly programmes, Drug de addiction centre, and District Tobacco Control Cell is needed for providing services in a holistic approach.
- ▶ Linkages with the primary level facilities need to be developed to enable improved access to mental health services for the community and also to facilitate continuum of care

TOR 6: NATIONAL URBAN HEALTH MISSION

The National Urban Health Mission (NUHM) aims to provide comprehensive primary healthcare services to the urban poor including but not limited to the homeless, rag-pickers, rickshaw pullers, slum dwellers etc. with special focus on residential, occupational and social vulnerabilities. Findings from CRM-11 held last year, had shown significant progress in NUHM implementation across all the participating states, in comparison to the initial plodding years. In contrast to CRM-11 which focused on assessing the programme components, CRM-12 has adopted a slightly different but a more holistic approach, keeping in mind the outcomes in the form of services received by the beneficiaries, while assessing programme implementation.

A specific and significant observation of CRM-12 has been from the community perspective. Various active interactions have been done to look into community awareness and their health seeking

behaviours, popularization of ANM, ASHA and MAS in their areas and understanding other service related factors like out-of-pocket medical expenses, quality of healthcare, emergency transportation etc.

KEY OBSERVATIONS

- ▶ As the States gained more understanding on urban health and its components during the last few years, the activities under NUHM have gained pace.
- ▶ Majority of states visited this year have shown well established and operational urban health facilities in almost all the participating states, both in terms of infrastructure development as well as institutional arrangement.
- ▶ Community outreach activities through UHNDs and special outreach camps have also increased this year and were found to be conducted regularly in Karnataka, Telangana, Rajasthan and Tamil Nadu. However, these activities/camps were found largely RCH and immunization centric.
- ▶ Activities to initiate NCD screening are gaining pace.
- ▶ Urban ASHAs are mostly in place and working except in Jammu & Kashmir, Uttarakhand and Tamil Nadu, where ANM/AWW/UHN is largely handling the community outreach.
- ▶ Community awareness on health facilities, health schemes, services and health determinants was good in Himachal Pradesh, UP, Tripura.
- ▶ The number and performance of urban ASHAs and ASHA-population ratio was found satisfactory in Karnataka, Telangana, Tripura, Arunachal, UP and Gujarat which automatically made the community awareness and community activities of these states better than the rest. In Telangana, ASHAs, MAS, ANMs, and AWWs were actively involved in counselling in schools and UHNDs on Menstrual Hygiene and Sanitation practices.
- ▶ MAS were functional across most states and reportedly conduct regular monthly meetings.

MAS in Gujarat have been reported to conduct exceptionally good work at the field, where all members were acting as drivers of change and a role model for good health practices in urban vulnerable areas.

- ▶ UPHCs across most states were providing general OPDs, maternal and child health services, day care for emergencies and minor procedures, diagnosis, management and follow-up for common NCDs.
- ▶ Population based NCD screening for hypertension, diabetes mellitus and cancer has been started or will be initiating soon in most states, though not much reported from the UPHC areas.
- ▶ With regards to Quality, most urban facilities in Arunachal are Kayakalp certified. They have functional infection control committees and service provision is satisfactory.
- ▶ Adequate HR in line with the GoI NUHM guidelines was found in Arunachal Pradesh, Telangana, Tamil Nadu and Maharashtra. Arunachal in-turn, had surplus HR which was irrationally placed.
- ▶ Drug availability in Tamil Nadu and Himachal Pradesh was satisfactory. EDL was found painted on walls of the UPHCs in these states. In Himachal Pradesh, drugs stock was adequate and was found to be distributed under free drug scheme.
- ▶ Almost all States have initiated work on GIS mapping but have not initiated vulnerability assessment as yet. GIS mapping was found completed in UP, Karnataka and Punjab and under progress in Rajasthan, where they have initiated a process of listing and mapping of notified and un-notified urban poor settlements in identified cities.
- ▶ Tamil Nadu demonstrates most innovative example of multi-sectoral Convergence. In Corporation areas, the ULB sanitation department staff are placed in UPHC premises, while in Madurai, health department was organizing health check-up camps every month in Night shelters for homeless old people.

RECOMMENDATIONS

- ▶ All types of mapping including spatial GIS, facility and slum mapping and vulnerability assessment of the identified slums areas should be completed on priority.
- ▶ States should make sure that all the key positions under the state, district and city programme management units are filled and functional.
- ▶ All the vacant facility positions under management and service provider's category should be filled. State should also focus on rational deployment of HR under all categories. Irrational or extra positions should be appropriately relocated or curtailed as per the GoI-NUHM guidelines.
- ▶ State level meetings for strengthening convergence with ULBs and other concerned departments should be organized regularly and roles and responsibilities of various departments under NUHM should be clearly identified and communicated among all stakeholders.
- ▶ NUHM trainings as per the training module and CPHC guidelines released by GoI should be completed for officials at all levels of implementation, including Secretary, MDs, DHS, SPMUs DPMUs, CPMUs and service providers.
- ▶ UPHCs identified to be converted as HWC across the states should be made as hubs for providing comprehensive primary health care which incorporates range of services in 12 packages including NCDs and national health programs. For this, population screening should be started on priority.
- ▶ States should make sure that all the UPHCs have registered RKS and the state is regularly releasing untied funds to the respective UPHC accounts. There should be clear understanding over the dissemination and utilization of untied grants.
- ▶ Process of drug procurement should be streamlined to ensure assured drug availability at all the UPHCs.
- ▶ There is a need to reinforce coordination among ANM, ASHA and MAS through regular meetings

of ANMs with all ASHAs & MAS of their catchment area. There should be special emphasis on their catchment areas, work profiles and level-wise monitoring.

- ▶ ASHAs and MAS should be trained to create awareness in the community about factors including but not limited to nearest public health facility, services being provided, frequency, days of outreach services, information on referral transports and information on other social determinants like cleanliness and hygiene, nutrition, disease prevention and health promotion.
- ▶ All the urban health nodal officers in states and districts should be oriented and engaged in quality assurance committee. States should further expedite the process of baseline assessment of UPHCs.
- ▶ Where necessary, States should expedite the MoU process for operationalizing UPHCs in PPP mode. Under the PPP arrangements, the MoU must clearly define the responsibility of private partner and develop a framework to monitor performance of PPPs in terms of defined time bound deliverables and measurable outcomes.

TOR 7: COMMUNITY PROCESSES, GENDER AND CONVERGENCE

The Community Processes element of the National Health Mission, as previous CRMs have shown, has lived upto its potential in enabling increased community awareness in relation to entitlements, building a bridge between community and the health facilities, and serving as a platform from which to launch newer interventions. The community level collectives such as Village Health, Sanitation and Nutrition Committees, (VHSNC) who have not progressed as fast as the ASHA programme can now be re-invigorated with the interventions for health promotion and multi-sectoral convergence.

KEY OBSERVATIONS

- ▶ Reports from all states acknowledge the pivotal role played by ASHAs in linking public

health systems with the community, validating previous CRM findings. In addition, reports also highlight the role of CP in successfully building a strong community rapport, and lay a strong foundation to enable the community and outreach component of CPHC.

- ▶ Findings from all nineteen CRM states suggest that ASHAs are motivated and committed to their work. Overall, ASHA functionality is seen to be better where- ASHAs have been appropriately trained, ASHA programme staff/ ASHA facilitators are proactive and are providing on the job-mentoring and necessary supportive supervision.
- ▶ CRM findings, however, highlight the need to streamline training and mentoring processes and enhance the functioning of support systems to ensure equitable coverage, improve performance and programme management for ASHAs, Village Health Sanitation and Nutrition Committees (VHSNCs), Mahila Arogya Samities (MAS) across all states.
- ▶ While all states (except Bihar, Uttar Pradesh and Tamil Nadu) report over 95% ASHAs in position in rural areas, high population coverage was noticed for ASHAs in Bihar, Uttar Pradesh, Jammu and Kashmir and Rajasthan, affecting reach to marginalized and remote households. Shortfalls in selection of urban ASHAs have been specifically reported as challenge in Jammu and Kashmir and Bihar.
- ▶ ASHA drop-out rates are reported to be between 2-5% across the states. Assam, Tripura and Andhra Pradesh have done remarkable work in retaining ASHAs, while Arunachal Pradesh has reported a very high drop-out rate of around 20%. Low incentives, family pressure, migration, enrolment in ANM training courses and non-performance emerged as issues affecting ASHA retention.
- ▶ ASHA training systems in terms of state and district trainers are fairly robust in most states, but Bihar, Madhya Pradesh and Uttrakhand, all states with a significant need for outreach and frontline services, are faced with trainer attrition.

- ▶ Training of ASHAs in rural areas has progressed and states are at varying stages of completion of ASHA training in four rounds of Module 6 and 7, initiated in 2012. Most states have trained over 90% of rural ASHAs up to Round 2, while about 40% of ASHAs in Arunachal Pradesh, Andhra Pradesh, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh still need to be trained in Rounds 3 and 4 of Module 6 and 7.
- ▶ Bihar and Uttrakhand which had demonstrated progress in training and support through NGO involvement, have stopped using NGOs, resulting in delays in training and loss of mentoring support
- ▶ Overall, training delays, non-residential training, inadequate duration and lack of structured monitoring mechanisms seem to be affecting quality of ASHA trainings. Chhattisgarh, Punjab, Karnataka and Gujarat, all other states indicate knowledge and skill attrition and highlight a need of refresher training for ASHAs
- ▶ ASHA training in NCD was initiated in most states, but only Madhya Pradesh and Jharkhand has adhered to the five-days training with Himachal Pradesh, Rajasthan, Andhra Pradesh and Tripura conducted just one- day training and Rajasthan completed this training in two days. . In Bihar, ASHAs were asked to complete the tasks of population enumeration and filling up Community Based Assessment Checklist (CBAC) forms without undergoing any formal training in NCDs.
- ▶ States have commenced training of ASHAs in Non-Communicable Diseases (NCDs) but the persistent backlog of trainings related to RMNCH+A hampers progress in these areas. Poor training quality resulting in limited knowledge and skills among ASHA was highlighted in several state reports.
- ▶ The process of ASHA Certification in association with National Institute of Open Schooling (NIOS) has been initiated in thirteen of the nineteen CRM states, with 2015 ASHAs being certified by NIOS.
- ▶ Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Uttar Pradesh, Uttrakhand, and Tripura have dedicated ASHA programme staff at all four levels, with others using existing programme staff. Major vacancies in the support structure for ASHA are observed in Bihar. Even where they exist, the supportive supervision function of the support structures is yet to be completely realized in improving performance and functionality of ASHAs
- ▶ While these support structures serve ASHA and other CP interventions, Chhattisgarh is the only state that has an additional Block level coordinator for strengthening PRI action through Swasthya Panchayat Yojana and VHSNC.
- ▶ The role of ASHA Facilitators in improving coverage, organizing cluster meetings, and mentoring for skill upgradation is reported from Madhya Pradesh, Jharkhand, Chhattisgarh and Uttar Pradesh.
- ▶ The availability of medicines with ASHAs has been highlighted as a persistent challenge in certain states, with Andhra Pradesh, Rajasthan, Madhya Pradesh and Jharkhand being notable exceptions.
- ▶ Average reported monthly ASHA incentive was about Rs. 3500, ranging from Rs.1500 in Tripura to Rs. 7500 in Telangana.
- ▶ Aided by online bank transfers, PFMS, IT- based Incentive Tracking systems, payment of ASHA incentives have been streamlined in many states. No or minimal delays in payment of incentives was observed in Assam, Chhattisgarh, Madhya Pradesh, Rajasthan, Himachal Pradesh, Uttar Pradesh, Punjab, Bihar and Maharashtra. Assam, Madhya Pradesh and Rajasthan are using ASHA payment software which has helped them create a database of all ASHA's up to the block/village level and has facilitated auto-computation of incentives based on entry of online reports and vouchers. Payments with respect to individual programmes such as disease control continue to be delayed in a few states.
- ▶ The introduction of non-monetary incentives a few years ago, has served as an important motivational tool, and encompassed social

- welfare measures, building career opportunities, supporting educational equivalence, and higher education, Chhattisgarh is a leader in this regard.
- ▶ Tripura, Jharkhand and Bihar have built 'ASHA Ghar' / 'ASHA Rest rooms' in the referral high case load facilities. However, these rooms were largely dysfunctional or of sub-quality standards in Jharkhand (except for the DH Bokaro) and Bihar.
 - ▶ Some form of grievance redressal mechanism has been established in all states except Rajasthan, Tripura, Telangana and Bihar.
 - ▶ On an average, ASHAs reported spending about 3.5 hours a day on ASHA related activities, ranging from 2-3 hours in Tripura to 7-8 hours in Jharkhand (not including the time spent in accompanying patients to referral hospitals). Adding tasks related to other packages of comprehensive primary health care will need a carefully calibrated understanding of the allocation of tasks and support required to ensure that the time spent does not exceed five hours a day.
 - ▶ There is wide variation in the performance of VHSNCs across the country and in many states; VHSNCs are yet to emerge as institutional platforms for multi-sectoral action. Despite the constitution of VHSNC as per guidelines in most states, functionality was poor with wide intra state variation. Capacity building of members, including PRI, support and monitoring to enable monthly meetings and adequate fund utilization were major challenges. Madhya Pradesh and Uttrakhand have started training ASHA Facilitators in PLA-linked activities to revive participation of VHSNC members through these meetings.
 - ▶ In Rajasthan and Jharkhand, regular monthly MAS meetings are being conducted. MAS groups in Rajasthan are connected to National Urban Livelihoods Mission (NULM). Linkages with Mission for Elimination of Poverty in Municipal Areas (MEPMA) in Andhra Pradesh have led to increased functionality of MAS but there is no involvement of ASHAs or ANMs in the activities of MAS.
 - ▶ Convergence was seen vis a vis Health and ICDS in Himachal Pradesh and Rajasthan's Rajsangam' initiative. Jharkhand too reported a fairly good level of convergence between ICDS (VHND, referral of SAM children to Malnutrition Treatment Centre (MTC) by AWW or Sahiya, etc.) and education department (National Deworming Day Programme, AnemiaMukt Bharat including WIFS, etc).
 - ▶ The 'VISHWAS' (Village based Initiative to Synergise Health, Water and Sanitation) campaign was launched in 2017, on the VHSNC platform to improve water, sanitation and hygiene and strengthen the convergent action under the various initiatives of Swachh Bharat Mission (SBM). Only Jharkhand and Uttar Pradesh reported rolling out the VISHWAS campaign.
 - ▶ Rogi Kalyan Samities have been formed, in all states except in Tripura. In Arunachal Pradesh and Punjab, although the RKS have been formed, they are not functional, while variability in their functioning was observed in Jharkhand.. Regular annual meetings of the RKS committee were reported from the states of Andhra Pradesh, J&K, Himachal Pradesh, Madhya Pradesh and Maharashtra.
 - ▶ The major source of funds for the RKS across the country is the user fees charged and the untied funds received through NHM. Himachal Pradesh was generating funds through renting of shops and premises within the facility campus, as well as through local donations. In J&K, the funds generated through the user charges (through OPD tickets and lab diagnostic tests) were being deposited into Hospital Development Fund (HDF), which was a separate account from RKS fund. Andhra Pradesh reported 100% utilization of the RKS allocated funds (including some funds which were left over from previous year) while states like Himachal Pradesh and J&K could only partially utilise the funds.
 - ▶ Andhra Pradesh has developed a portal for the RKS/HDS, linked to the CM Core Dashboard for monitoring and evaluation purposes.
 - ▶ Gender-related training of health service providers was noted in Jharkhand. Rajasthan

(District Baran) and Punjab (District Gurdaspur had operationalizing a one stop crisis centre. Andhra Pradesh too has roped in local NGOs to raise awareness against domestic violence

RECOMMENDATIONS

- ▶ Revision of targets and selection of ASHAs needs to be prioritized for uncovered populations and villages to ensure equitable coverage, reach to the beneficiaries, population enumeration and empanelment of beneficiaries to HWC-SHC by ASHAs. Population coverage of ASHAs should be rationalized using more updated data, and also looking at the topography, and range of tasks to be undertaken by the ASHA.
- ▶ States should ensure completion of ASHA trainings in Module 6 and 7, strengthen avenues for refresher trainings through PHC review meetings/cluster meeting to address the gaps in knowledge and skill attrition.
- ▶ Having developed the needed workforce for ASHA support system at state, district, block and sub-block level, an urgent focus is required to revitalize their performance, improve quality of supportive supervision and programme management. States may plan robust performance appraisal of DCMs, BCMs and ASHA Facilitators through field validation of Community Processes initiatives to support poor performers. Feedback mechanisms by state counterparts, annual trainings for supportive supervision as practised in Jharkhand, and performance linked monetary/non-monetary incentive mechanisms may be introduced to improve functionality of ASHA programme staff.
- ▶ Provision of Comprehensive Primary Health Care through HWCs- and Universal NCD screening would require extensive programme support for necessary change management and states with significant vacancies of DCMs/ BCMs should expedite filling of these positions to support this function.
- ▶ Reduction in duration of ASHA trainings for Module 6 and 7 or for new service packages needs to be avoided by states in any circumstance as it has direct implications on knowledge and skills of ASHAs and limit achievement of programme objectives.
- ▶ Unresolved challenges of refills for ASHA kits need to be addressed for improving outcomes related to HBNC.
- ▶ All states would need to expedite action on implementing training of VHSNC members in VISHWAS and other necessary functions of organizing community-based health promotion, monitoring and planning village level action to improve public services at the village level.
- ▶ Avenues to improve performance of VHSNC as institutions for collective action on health at the community level will need to expand through capacity building of PRIs and increasing coordination and capacities of Gram Panchayats to support and monitor VHSNCs, support and supervise delivery of community level health programmes such as- Village Health and Nutrition Day (VHND), Nutrition Rehabilitation Centres (NRCs) and functioning of HWCs-Sub Health Centres (SHCs).
- ▶ Implementation of community-based healthcare services are a key component of CPHC and would require roping in additional technical capacities/NGO partnerships that can enthuse, mentor and hand-hold programme managers, primary care providers, ASHAs and her support structures and VHSNCs/MAS to work in coordination. This would be useful in activities for screening, primary prevention and management of non-communicable diseases, addressing life style issues for substance abuse, addressing gender-based violence, control of endemic /communicable diseases, etc.
- ▶ Role of RKS needs to be better realized as institutional level platforms for community participation through constitutions as per RKS guidelines, planning regular meetings and greater involvement in assessing patient satisfaction, quality of care and resolving issues with respect to delivery of services in addition to present limited function of approving local hospital-based procurements.

TOR 8: HRH (HUMAN RESOURCE FOR HEALTH)

Health workforce is one of the key elements needed to achieve desirable outcomes and sustaining the progress of National Health Programmes. With an objective of ensuring quality of health care services to the community, National Health Mission has added approximately four lakhs of additional Human Resources over the period of last fourteen years. However, issues related to deployment, retention and performance of the workforce is commonly observed across the states.

KEY OBSERVATIONS

- ▶ A significant shortfall of skilled human resource was observed in most of the states. Shortage of Medical officers and Staff nurses were observed in many states, and also lack of specialist was reported in Andhra Pradesh, Arunachal Pradesh, Assam, Chhattisgarh, Jharkhand Madhya Pradesh, Punjab, Telangana, Tripura and Uttar Pradesh.
- ▶ Some states have adopted different measures to address the HR shortfall issues. Assam has constituted separate Health and Medical Recruitment board for recruiting Medical Officers, while Chhattisgarh has a decentralized hiring process and is conducting walk-in interviews. Jharkhand has taken up a competitive bidding strategy and also reaching out to other states for campus interviews.
- ▶ Irrational deployment of specialists was observed in states like Arunachal Pradesh, Himachal Pradesh, Madhya Pradesh, Telangana and Uttar Pradesh.
- ▶ Lack of integration between Health Directorate and National Health Mission Programme Management Unit was observed in few states.
- ▶ Telangana has started a nine-day induction program for orientation of newly joined programme management staff under NHM.
- ▶ Implementation of a systematic Human Resource Management Information System (HRIS) has been implemented in most of the

states; however, issues pertaining to information captured and its utilization were observed in few states.

RECOMMENDATIONS

- ▶ States need to develop a robust HR policy, and ensure rational deployment and equitable distribution of workforce.
- ▶ There is a need to revise the existing sanctioned positions in state with regards to latest norms under IPHS guidelines.
- ▶ States with no specialist cadre, need to create one and ensure that post graduate doctors gain entry at higher rank than under graduate medical officers.
- ▶ Multiskilling and orientation trainings should be conducted for equipping the workforce across the facilities, as per their roles and responsibilities.
- ▶ Skill based competency assessment should be an essential part of recruitment process.
- ▶ HRMIS implementation should be scaled up and strengthened across the states, and training management system should be added as its sub system.

TOR 9: QUALITY OF CARE

This section covers findings related to the National Quality Assurance Standards, accreditation of health care facilities under National Quality Assurance Program (NQAP), and Kayakalp initiative implementation across the health care facilities.

9.1: NATIONAL QUALITY ASSURANCE STANDARDS

National Health Mission strives to provide Quality Health Care to all citizens of the country in an equitable manner. National Health Policy (NHP) 2017 affirms the Government of India's commitment to provide equitable, affordable, patient centred and quality care through principles of professionalism, integrity, accountability and pluralism. The Policy stresses upon attainment of highest possible level of health and wellbeing for all age groups, through

preventive and promotive health care orientation in its policies and ensure universal access to good quality healthcare services without any financial hardship. To achieve the goals of NHP, it further reiterates upon the need to evolve and disseminate quality standards and guidelines for all levels of facilities and a system to ensure that the quality of healthcare is not compromised. National Quality Assurance Standards and its accompanying checklists are intended to support the states by addressing the requirements of standards and its credible measurements system ensuring quality system for all level of health care facilities.

National Quality Assurance Program (NQAP) aims to inculcate the component of “Quality” in every component of health care service. Under its ambit efforts are made to reach minimum of the set criteria, which covers the structural as well as the process and the *outcome*.

KEY OBSERVATIONS

- ▶ This CRM witnessed a remarkable progress in terms of efforts and outcomes related to quality standards and accreditations. In last one year, the number of National certifications has gone up to 185, which is three times of number reported last time i.e. 59.
- ▶ Also, there was a rise reported in state certified facilities as per NQAP standards, where 503 facilities were reported as certified which is almost double the number accredited in previous year i.e. 286.
- ▶ Andhra Pradesh and Telangana made a tremendous progress in last year, while Arunachal Pradesh, Himachal Pradesh and Jammu and Kashmir are yet to take concrete measures to ensure the Quality standards across all the facilities.
- ▶ State Quality Assurance Committees and District Quality Assurance Committees (DQAC) have been formulated in most of the states, while Uttarakhand and Jammu and Kashmir are yet to complete the District Quality Assurance Committees formation. In Arunachal Pradesh, Chhattisgarh and Jharkhand, DQACs are formed

but regular meetings are not being undertaken, thus highlighting the concern of functionality of these committees in the states. Quality teams below district level i.e. at CHC and PHC are yet to be constituted in most of the states.

- ▶ Human Resource availability under Quality of Care initiative is not a concern as most of the states have quality consultants at district and state level, and Hospital Managers in position under this programme. In addition, a pool of trained internal and external assessors is also available across the states; however, the utilization of HR is either not begun or not as per their potential in most of the states.
- ▶ Bio Medical Waste management practices were found satisfactory in Himachal Pradesh, while it still remains a concern in states of Tripura, Andhra Pradesh, Karnataka and Jammu and Kashmir. Sub optimal supply of the required consumables or knowledge, attitude and practices by the BMW management staff were the major bottlenecks.
- ▶ States also need to make concerted efforts for ensuring compliance to the fire safety and AERB guidelines.

9.2: KAYAKALP

With an objective of promoting cleanliness, hygiene and infection control practices in Public Health Care facilities and incentivizing Public Health Care facilities showing exemplary performance in maintaining standards of cleanliness and infection control, KAYAKALP initiative was launched by Ministry of Health and Family Welfare, Government of India in year 2015.

Started with District level Health Care facilities, this initiative has now scaled up to also include Sub divisional, and Primary health care facilities i.e. SDH/ CHC/PHC in both rural and urban areas. This CRM, there was a significant improvement observed in level of cleanliness, hygiene and infection control practices in Public Health Care Facilities and a culture has been initiated across the facilities for peer review of performance to promote hygiene, cleanliness and sanitation.

KEY OBSERVATIONS

- ▶ In last year, a total of 2,959 Health Care facilities were recognized and awarded the prize for demonstrating cleanliness and hygiene and adhering to the standard protocols in maintaining the quality standards and thus regaining trust and confidence of the community in public health care facilities.
- ▶ Out of 2,959 facilities awarded under Kayakalp, 289 are District Hospitals, 109 Sub Divisional Hospitals, 658 Community Health Centres, 1,729 Primary Health Centres and 181 Urban Health Care Facilities. Where most of the states have also initiated the scheme for their urban areas, Karnataka, Madhya Pradesh and Tripura are yet to implement Kayakalp in Urban areas.
- ▶ Although the states are participating in Kayakalp every year, it is observed that PHCs are still not actively participating and achieving the Kayakalp qualification scores.
- ▶ Gujarat has proactively included all State Medical Colleges under Kayakalp which have been assessed and also awarded for their good performance.

RECOMMENDATIONS (NQAS & KAYAKALP)

- ▶ Constitution of state and district level Quality Assurance Committees need to be expedited in order to ensure continuous mentoring and monitoring the Quality Assurance efforts at the district and sub district level. Quality teams at CHC and PHC level to be also constituted simultaneously to undertake internal facility level activities, thus ensuring a continual and comprehensive cyclic process of Quality assurance.
- ▶ States should regular mentor and monitor available Human Resources including internal and external assessors for Quality Improvement and accreditation of Health Care facilities.
- ▶ State should utilize their existing trained human resource to build the capacities of service

providers and conduct refresher trainings at their level.

- ▶ There is a remarkable progress seen in NQAP implementation, and to ensure the sustainability the state level committees for Quality Assurance should monitor and ensure closure of identified gaps within the set timeline.
- ▶ States should undertake and complete the process of formulating the Standard Operating Procedures to be modified at facility levels, and orient the teams at respective health care facilities.
- ▶ Patient Grievance Committee needs to be formulated across the facilities and periodic Patient Satisfaction Surveys should be undertaken and analysed to close gaps identified in the results.
- ▶ States should ensure training of the BMW staff on BMW management, infection control protocols on a priority basis. Proper supply of consumables to be ensured for BMW management at the facilities.
- ▶ Primary Health Centres (PHCs) should be encouraged and supported to actively participate in achieving Kayakalp qualification scores. States also should now include urban health care facilities for implementing Kayakalp scheme.

TOR 10: MEDICINE, DIAGNOSTICS & BMMP

10.1: FREE DRUG SERVICE INITIATIVE

Free Drug Service Initiative (FDSI) was initiated in 2014 with an aim to reduce Out of Pocket Expenditure on drugs and consumables by providing free of cost drugs to the patients who seek treatment in public healthcare facilities. The initiative envisages on establishing a demand driven and transparent mechanism of drug procurement and disbursement. It also emphasizes on a Centralized Procurement Body which will ensure timely procurement, quality, storage, disbursement and also includes feedback mechanism.

The National Health Policy 2017 specifically also emphasizes on provision of “Free Medicines and Diagnostics” at Public Health Facilities.

Key interventions under this initiative are IT backed supply chain management systems i.e Drugs and Vaccines Distribution Management Systems (DVDMS). It also emphasizes upon prescription of Generic medicines, which should be available as per Essential Medicine Lists (EML). To strengthen the system, it embarks upon prescription audit which addresses the issues of irrational use of medicines; grievance redressal, creating awareness through Information, Education and Communication (IEC); training; dissemination of Standard Treatment Guidelines (STG) etc.

KEY OBSERVATIONS

- ▶ Free Drug Service Initiative (FDSI) has been implemented formally in states like Andhra Pradesh, Arunachal Pradesh, Assam, Jharkhand, Gujarat, Karnataka, Madhya Pradesh, Punjab, Tamil Nadu and Telangana; however, Uttar Pradesh and Jammu and Kashmir are yet to initiate the scheme.
- ▶ Central Procurement Board is present in most of the states except Arunachal Pradesh, Tripura and Uttar Pradesh.
- ▶ Essential Medicine List was available in most of the states; while EDL was not displayed in facilities of Andhra Pradesh and Arunachal Pradesh. In states of Assam, Chhattisgarh, Gujarat and Jharkhand, medicines in the facilities were not available as per the Essential Medicine List. Tamil Nadu has issued the guidance note to prescribe medicines with generic names only.
- ▶ While IT enabled inventory and procurement system was available up to the facility level in most of the states; Arunachal Pradesh and Uttar Pradesh are yet to initiate the system at the facilities. In Assam, although the IT system is enabled, the stock maintenance and records were being maintained manually.
- ▶ In Himachal Pradesh, the distribution systems seem to var across the state and the DVDMS was restricted to few facilities only

- ▶ High Out of Pocket Expenditure on medicines and frequent stock outs were reported in Arunachal Pradesh, Jammu and Kashmir, Jharkhand, Punjab, Uttar Pradesh and Uttarakhand.
- ▶ Tamil Nadu reported availability of medicines at all level of Health Care facilities. In other states, non-availability of medicines at the primary level of health care facilities was forcing the patients to seek care at higher facilities and thus incurring high OOPE on transportation along with the medicines.
- ▶ Standard Treatment Guidelines (STG) were not available in most of the facilities and if present, the clinicians were not aware of it. Except Andhra Pradesh and Karnataka, no other state had a system in place for prescription audits and awareness regarding grievance redressal was missing at the facility.

RECOMMENDATIONS

- ▶ States where Free Drug Service Initiative (FDSI) is yet to be implemented, need to adopt the plan to ensure the availability of quality free medicines across the Health Care facilities.
- ▶ States to expedite the constitution of centralized procurement body to ensure transparency and uniform system of procurement of medicines.
- ▶ Essential Medicines Lists to be displayed at all Health Care facilities, and service providers to ensure the availability of medicines as per the displayed list. States should ensure the availability of medicines across the facilities to minimize the OOPE incurred on medicines.
- ▶ IT enabled inventory and procurement systems should be developed and strengthened up to the level of Health and Wellness Centre (SHC/ PHC/UHC) to maintain an uninterrupted supply of medicines across the facilities.
- ▶ Drug ware houses to be constituted at regional, district and facility level based on the state's requirement.
- ▶ Patient grievance redressal mechanism and prescription audits to be implemented across the states.

10.2: FREE DIAGNOSTIC SERVICE INITIATIVE

National Free Diagnostic Initiative guidelines were designed to ensure the availability of comprehensive healthcare in public health facilities by providing quality diagnostic and imaging services. There is a defined list of 53 diagnostic tests at District and Sub district level, 36 at Community Health Centres and 17 at Primary Health Centre level, as per the NHM guidelines. All the CRM state visited namely Tripura, A.P, Assam, Jharkhand, Arunachal Pradesh, Chhattisgarh, Uttar Pradesh, Uttrakhand, Karnataka, Himachal Pradesh, Rajasthan, Madhya Pradesh, J&K, Punjab, Bihar and Maharashtra have certain free diagnostic tests available in facility through RKS/NHM/State funds. Lack of uniformity of test menu was found at different facility in same State/UT or price at which tests are provided wherever observed across Nation.

KEY OBSERVATIONS

- ▶ Most of the States/UT where CRM team visited has free diagnostic service at certain level and most State/UT is of view to expand or align the currently services to the test menu with turnaround time in NHM free diagnostic service initiative.
- ▶ The following CRM States namely Tripura, Andhra Pradesh, Assam, Jharkhand, Arunachal Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Karnataka, Himachal Pradesh, Rajasthan and Maharashtra delivers free diagnostic service in mixed model i.e. combination of in-house and PPP resources.
- ▶ Madhya Pradesh, Jammu and Kashmir, Punjab, Bihar is delivering diagnostic services utilizing its in-house resources.

RECOMMENDATIONS

- ▶ Training for Lab technician were only provided under certain disease specific National programs, hence skilling on most other tests conducted in facility needs to be undertaken.
- ▶ States need to harmonize the availability of tests among facility of same level.

- ▶ At least diagnostic test (indicated in NHM Guideline) provided in PHC/CHC/DH needs to be free of cost to all patients.
- ▶ CT and Tele radiology service may be extended to facilities in State/UT on need basis.
- ▶ Underutilization of Lab technician skill or capability of medical diagnostic equipment needs to be monitored and appropriate action may be taken.
- ▶ State/UT providing diagnostic tests may depict the number of tests provided in each facility on real time basis on NHM/State Health Website for public information.
- ▶ Reagent/consumable shortage or logistic delay may be mitigated via forming rate contract for all frequently/repeatedly purchased Reagent/consumable in each facility.
- ▶ Ensure EQAS/Internal quality monitoring of diagnostic tests delivered in each facility (in-house/PPP)
- ▶ Monitoring and evaluation needs to be planned for performance, quality, adherence to agreement terms, penalty etc. of PPP service providers
- ▶ IEC/Turnaround information of diagnostic tests may be appropriately displayed at each facility. Additionally, grievance redressal on free diagnostic may be put in place in each State/UT.
- ▶ Diagnostic service may be delivered in Hub and spoke model wherever possible samples can be transferred from drawing to testing facility, in order to reduce unnecessary patient transportation or referral.

10.3: BIOMEDICAL EQUIPMENT MAINTENANCE AND MANAGEMENT PROGRAM (BMMP)

Biomedical Equipment Maintenance and Management program has been implemented in most of the CRM States. The following CRM states namely Chhattisgarh, Jharkhand, Madhya Pradesh, Uttar Pradesh, Rajasthan, Himachal Pradesh,

Karnataka, Telangana, Maharashtra, Punjab, Andhra Pradesh, Arunachal Pradesh, Assam and Tripura have implemented this programme in PPP model. State of Tamil Nadu is having in house system for biomedical equipment maintenance and management. There is no progress in Bihar, Uttarakhand on programme implementation. J&K is in the process of selecting suitable vendors for BMMP.

KEY OBSERVATIONS

- ▶ The programme addressed long pending dysfunctional equipment in State/UT, average dysfunctional equipment was found by NHSRC in 29 State/UT in initial stage mapping was at rate 13%-34%.
- ▶ Toll free number which is uniform across for raising complaint or failure of equipment reduced time to report failure of medical equipment. Earlier only high-end critical equipment where covered by State/UT under annual maintenance contract, BMMP covered all the Equipment from simple B.P apparatus in PHC to complex high end critical equipment like ventilator and defibrillators in DH/SDH.
- ▶ Inventory or asset in terms of medical equipment in each state were recorded only in store record of particular facility with the BMMP inventory where unified as equipment database of state/UT and access of information were given to general public.
- ▶ In-house BMMP was only observed in Tamil Nadu. Biomedical Engineers are placed at necessary level to render services. IPHS recommend biomedical engineers at district level.

RECOMMENDATIONS

- ▶ State to encourage use of medical devices generated data for decision making, and use it as the basis for PIP planning, review of National disease specific programs etc.
- ▶ States need to strengthen technical monitoring of programme, by ensuring existing staff at facility level, district level and state level, actively undertake necessary field visit,

increase awareness of programme (incl. Toll free number and dashboard/website) among staff and periodically evaluating adherence with RFP/agreement terms by with State-Service Provider.

- ▶ There is a need to ensure that preventive maintenance, calibration, user training on medical devices etc. is scheduled so as to align with requirement needs for tasks such as renewal of blood bank licenses, NQAS assessments etc.
- ▶ State needs to expedite the process of equipment condemnation, after evaluation of the evidence submitted by service provider.
- ▶ In-house BMMP was only observed in Tamil Nadu, Biomedical Engineers are placed at necessary level to render services. Calibration tools, workshop, SOP and other technical document library is very limited and needs to be expanded and aligned with quality of service mentioned in NHM guideline Biomedical Equipment Maintenance and Management program.

TOR 11: GOVERNANCE, ACCOUNTABILITY & HEALTHCARE FINANCING

11.1: GOVERNANCE & ACCOUNTABILITY

The section of the report covers governance issues with respect to a) programme management institutional mechanisms and decentralized planning to ensure that health systems and resources are geared towards meeting local and regional health priorities; b) inter and intra sectoral convergence for coordinated and concerted inter-sectoral action for achieving programme objectives; c) accountability measures such as grievance redress and accountability safeguards in public private partnerships; and d) implementation of certain key regulations, primarily the Clinical Establishment Act, 2010 (CEA) and Pre Conception and Pre Natal Diagnostics Techniques Act, 1994 (PCPNDT Act), which are crucial for meeting public health objectives.

KEY OBSERVATIONS

Program Management

- ▶ Institutional arrangements (State & District Health Missions, Programme Management Units and City Level Committees) are by and large in place in most states. However, in some states regular meeting of state and district health missions are not being held. The Block Level Programme Management Unit has not been strengthened in most of the states.
- ▶ Decentralized planning process has been initiated in a few states such as Bihar, Chhattisgarh, Nagaland, Odisha and Maharashtra. However, it was observed that most states have not developed or are not using the institutional mechanisms to ensure decentralized planning.
- ▶ States are not using HMIS data, supervisory feedback or grievance related data for preparation of District Health Action Plan.

Convergence

- ▶ Intra-sectoral convergence with WCD and Education department for RBSK and WIFS programme was observed in states like Assam, Bihar, Chhattisgarh, Karnataka, Odisha, Nagaland, Uttarakhand and Punjab. Some good practices were also observed in Andhra Pradesh and Maharashtra.
- ▶ In most States, NUHM-SBM-NULM convergence has been initiated and trainings have been planned for concerned stakeholders.

Accountability

- ▶ All states visited reported functional 104 health helplines, except the states of Meghalaya and Haryana. Services include - medical advice, counselling, health service information and grievance redress.
- ▶ PPP arrangements in the States exist for radiology, diagnostics, laundry, fair price shops etc. In a few States, UPHCs were also found to be running on PPP mode, for instance in Uttarakhand. MoUs do not clearly cover the responsibility of private partners, do not define

time bound deliverables and measurable outcomes, conditions for termination, etc.

- ▶ In most states, the facilities displayed 'Citizen Charter'. However, there is no uniformity in the Citizen Charters seen across facilities/states.
- ▶ Implementation of Maternal Death Surveillance and Response (MDSR), Maternal Near Miss (MNM), and Child Death Review (CDR) has progressed but is still quite uneven.

Regulation

- ▶ The CEA, 2010 continues to receive unsatisfactory response from the States. Out of the states visited, following have adopted the CEA – Arunachal Pradesh, Assam, Bihar, Himachal Pradesh, Jharkhand, Uttarakhand, Uttar Pradesh and Karnataka. Even in states where the Act has been adopted, the enforcement is rather weak.
- ▶ Some states have adopted the CEA with certain modifications that may dilute some of the provisions of the CEA and compromise nationwide uniformity and objectives of the act (Kerala, Tamil Nadu, Karnataka and Maharashtra).
- ▶ Some states have pre-existing legislation to regulate clinical establishments (Andhra Pradesh, Madhya Pradesh and Tamil Nadu)
- ▶ PCPNDT Act - The States visited this year, which are relatively better in terms of enforcement of the Act, are Maharashtra, Rajasthan, Punjab, Gujarat, Tamil Nadu and Telangana.
- ▶ The enforcement of PCPNDT Act is poor in most states, in terms of registration of facilities, inspections, filing cases, documentation etc.
- ▶ States identify lack of funds and HR as challenges to implementation.

RECOMMENDATIONS

- ▶ States need to ensure that the planning process follows the bottom-up approach with community engagement. HMIS data should be used for planning, programmatic review and mid-course correction

- ▶ District Health Action Plans should be based on disease burden and priorities of the respective districts. Subsequently these plans / priorities reflected in DHAPs must become part of State plan.
- ▶ State-specific comprehensive and transparent HR Policy needs to be developed with special attention to recruitment, selection, training, transfer, Incentives, appraisal and increment.
- ▶ Ensure timely transfer of NHM Funds from State Treasury to State Health Society.
- ▶ Focus on vertical expansion and convergence of departments for holistic implementation of health action plan.
- ▶ GB and EC meetings should also monitor programme performance and not be limited to financial transactions.
- ▶ PPP in any area should follow structured principles, processes, standards and KPIs for monitoring.
- ▶ Prescription, Medical, Death and Near Miss reviews and audits to be conducted and linked with systemic gaps.
- ▶ Enforce PCPNDT Act by removing gaps related to HR and budget allocation. Deploy a sustained and continuous IEC and awareness campaign on PCPNDT Act and gender equality. Changing societal norms and biases on gender issues requires continuous and concerted engagement with the community.
- ▶ Need for continuous engagement with states for adoption/adaption of CEA and implementation support to states that have already adopted it.

11.2: HEALTHCARE FINANCING

Health financing is an important part of the overall health system and to a great extent, it influences the ability of health system to reach desired health goals. The National Health Mission (NHM) is India's flagship health sector programme to revitalize rural and urban health sectors by providing flexible finances to State Governments. NHM is one of the most important centrally sponsored schemes in the

health ministry with a share of more than 50 percent of the overall health budgets over the years. Over the years CRM reports have examined the status of fund flow under the programme and how these funds are utilised, uptake of new system like Public Finance Management System (PFMS) in financing system, accountability of the financing system and measures adopted to reduce OOPE.

KEY OBSERVATIONS

- ▶ Most of the CRM states visited have successfully implemented Public Financial Management System (PFMS) leading to a better financial management system. States such as Andhra Pradesh, Gujarat, Madhya Pradesh, Punjab, Tamil Nadu and Telangana have reached full coverage under this system. Maharashtra and Uttar Pradesh have registered coverage of more than 90%. PFMS implementation across states has shown promising results but, in a few cases, some roadblock was observed. In north-eastern states internet connectivity is an issue. In Jammu and Kashmir the transfer of funds from Block Head Quarter to CHCs/PHCs is not being done through PFMS
- ▶ Innovations in financing system were initiated successfully in some of the states and it can be a good example for other states to follow. Initiatives such as e-vittapravaha in Madhya Pradesh—or use of ASHA Performing Monitoring System (APMS) and Inventory Management System (IMS) in Assam have increased efficiency in the system to a great extent.
- ▶ Delay in fund disbursal from State Treasury to State Health Societies (SHS) continues to be a major problem for most states visited. Delay was also reported from state health society to district level in Andhra Pradesh, Bihar, Himachal Pradesh and Telangana. This delay in disbursal had a direct effect on utilisation of these funds for different health programmes.
- ▶ Under utilisation of funds is still an issue as states are still struggling to spend money. Utilisation of untied funds under VHSCN remained an issue in states of Bihar, Assam, and Uttar Pradesh. Utilisation at the district level

also showed varied results across the states. In Bihar utilization ranged from 51 % to 57% for NHM funds whereas, in Karnataka, utilization ranged from 65% to 85%.

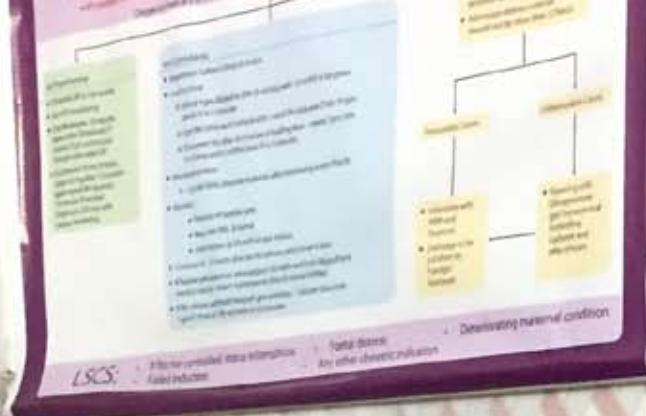
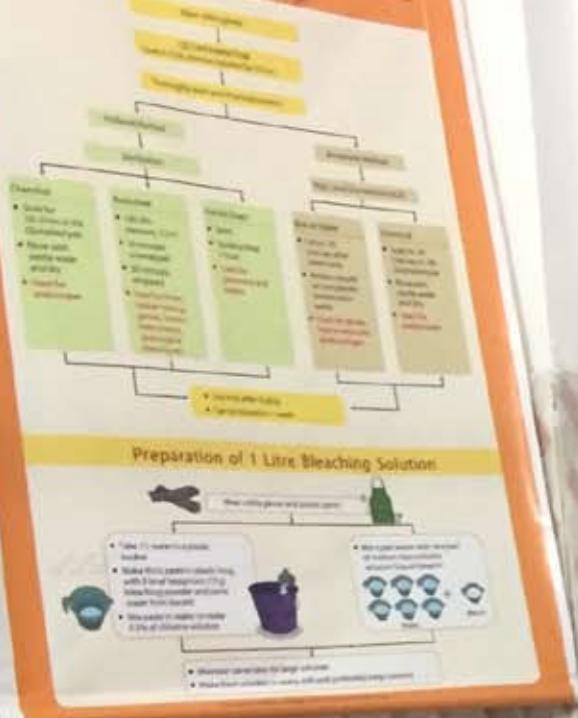
- ▶ Majority of the states reported of OOPE incurred by households due to the purchase of medicines and diagnostic services or utilization of services from private sources. In states such as Uttar Pradesh, Assam, Himachal Pradesh and Maharashtra cashpayment to mothers after institutional delivery under JSY was delayed.
- ▶ There is still room for improvement in accounting practices in terms of bookkeeping, accounts maintenance and better management of funds especially at the facility level. Even in case of auditing non-compliance were quite high in most of the states. Only Chhattisgarh and Maharashtra reported completing the statutory audits for 2017-18. Compliance with concurrent audit was found to be poor across all the states barring Maharashtra.

RECOMMENDATIONS

- ▶ There is an urgent need to reduce delays in fund disbursement from the State Treasury to the SHS. States should also ensure timely dissemination of RoPs and District Health Action Plans for better planning, rational allocation and timely release of funds.
- ▶ Steps must be taken for improvement in overall accounting practices especially at the facility level.
- ▶ The States facing problems in Internet connectivity should liaise with the concerned Government departments to have a smooth operation of PFMS.
- ▶ States should strengthen the implementation of programmes such as free Drugs and Diagnostic Schemes, JSY and the JSSK scheme which will help in the reduction of OOPE on health. States should also take steps in implementing the health insurance programme for the poor such as PMJAY.



Mandate & Methodology



MANDATE & METHODOLOGY of 12th COMMON REVIEW MISSION



Background

- ▶ The 12th Common Review Mission (CRM) was organized between 5th September and 12th September 2018 (in eighteen states), and between 8th and 14th October 2018 in Karnataka, to review the implementation progress of the National Health Mission.
- ▶ The Common Review Mission (CRM) is the most common cited source of information on National Health Mission. As an institution in its own right, CRM not only provides the evaluation information on the National Health Programmes, but also leads to incremental changes and corrective measures at the operational level of the National Health Mission.
- ▶ This report is the twelfth in the series, covers the findings from nineteen states visited during the CRM.

Introduction and Objectives

- ▶ The twelfth CRM was conceptualized with a community centric approach and focused on community interactions and assessment of service delivery at community and primary level of health care.
- ▶ Implementation of National Health Programmes was assessed from the community perspective, and thus the visits were planned at the level of the community and continued to examine the service delivery provisions from the primary health care facilities onwards up to the district level on the principle of continuum of care.

- ▶ Another focus of the CRM was to undertake an assessment of early roll out of Comprehensive Primary Health care through HWCs operationalisation and status of NHM and its key strategies and priority areas, analyse strengths and challenges with respect to strengthening health systems and assess interventions/strategies undertaken at state, district/ sub-district and community level to address equity, accessibility, affordability and quality of health care services.
- ▶ Focussing on patient-centric care approach, a community interaction tool was developed to be used during the “the community walk” designed as a part of the assessment in the village/slum areas to understand the health care seeking pattern of the community and to assess the health care needs and the awareness of the community on the national health programmes.
 - ◆ In order to assess the overall structure of village/urban areas and to assess social and environments determinants along with health care needs, a village/slum walk was designed to be undertaken during the community interaction.
 - ◆ A two pager tool was developed for the community interaction to cover the components of Village/ward/slum selection, activities to be undertaken during the community walk, group discussions and individual interaction with the identified beneficiaries under National Health Programmes. The tool was tested by two teams in urban and rural areas, and finalized based on the findings and the recommendations of the CRM team members.

Terms of Reference of the 12th CRM

The terms of reference were designed to reflect the approach taken by health systems to strengthen continuum of care. Information on demographic indicators, relevant Health Managements Information Systems (HMIS) data and district and state health profiles were made available to the CRM teams before the visit.

Geographical Coverage of 12th CRM

The 12th CRM covered nineteen states. Seven of these were High Focus States (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Uttarakhand and Uttar Pradesh), three were in the North East (Arunachal Pradesh, Assam and Tripura), and nine were Non-High Focus States (Andhra Pradesh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Karnataka, Maharashtra, Punjab, Tamil Nadu and Telangana).

Process and Methods of the twelfth CRM

The twelfth CRM covered nineteen states purposively chosen to be representatives of High Focus, Non-High focus, North Eastern States and Hilly states.

Of these states, Uttar Pradesh have been visited in all eleven CRMs earlier, while Chhattisgarh was visited in all except the seventh. Assam, Bihar, Madhya Pradesh and Rajasthan have been part of eight CRMs, and Jharkhand and Uttarakhand were included in seven. Andhra Pradesh, Maharashtra and Tamil Nadu were visited six times during CRMs and Gujarat, Karnataka and Punjab were visited five times. Himachal Pradesh and Jammu and Kashmir were visited in four CRMs, Arunachal Pradesh and Tripura were visited thrice while Telangana was included for the third time in twelfth CRM.

Team Composition

Each State was visited by a 8-10 member team comprising a mix of the following:

a. Government Officials

- ▶ Officials of the MoHFW, GoI
- ▶ Representatives of State Governments (Health Secretary/Mission Director/Director of Health)
- ▶ Regional Directors of Health & Family Welfare
- ▶ Officers from other Central Ministries and NITI Aayog

b. Public Health Experts

- ▶ Non-official member of Mission Steering Group of NHM
- ▶ Non-official member of Empowered Programme Committee of NHM
- ▶ Public Health Experts from the National Health Systems Resource Centre (NHSRC), National Institute of Health & Family Welfare (NIHFW), Public Health Foundation of India (PHFI), other credible institutions including Medical Colleges and Schools of Public Health and Non-Governmental Organizations

c. Representatives of Development Partners

d. Representatives of Civil Society (from amongst the following)

- ▶ Representatives of Advisory Group on Community Action
- ▶ Representatives of National ASHA Mentoring Group

e. Consultants from various divisions of the Ministry

vii. List of States and Districts visited for 12th Common Review Mission

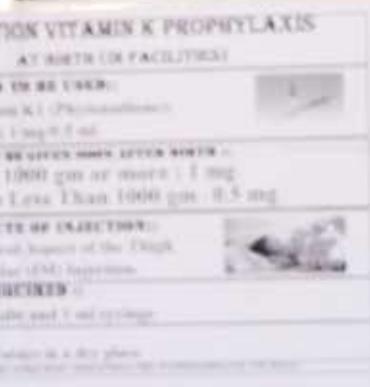
S No.	State	District 1	District 2
1	Andhra Pradesh	Ananthapuram	East Godavari
2	Arunachal Pradesh	East Siang	Papum Pore
3	Assam	Kamrup Rural	Barpeta
4	Bihar	Rohtas	Muzaffarpur
5	Chhattisgarh	Raipur	Korba
6	Gujarat	Narmada	Porbandar
7	Himachal Pradesh	Chamba	Bilaspur
8	Jammu and Kashmir	Kupwara	Doda
9	Jharkhand	Ranchi	Bokaro
10	Karnataka	Chikmagalur	Udupi
11	Madhya Pradesh	Rajgarh	Betul
12	Maharashtra	Satara	Gadchiroli
13	Punjab	Gurdaspur	Moga
14	Rajasthan	Baran	Jodhpur
15	Tamil Nadu	Ramanathapuram	Perambalur
16	Telangana	Jayshankar Bhupalpally	Karimnagar
17	Tripura	Unakoti	South Tripura
18	Uttarakhand	Haridwar	Uttarkashi
19	Uttar Pradesh	Varanasi	Farrukhabad

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STANLEY MEDICAL SERVICES LTD. TORONTO MEMPHIS					
MONTHLY SCHEDULE					
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	
1	See Committee	Reopened 10AM	At the Hospital 10:30AM		
2	See Patients	Reopened 10AM	10:30AM		
3	See Patients	Reopened	10:30AM		
4	See Patients	Reopened	10:30AM	10:30AM	
5	See Patients	Reopened	10:30AM	10:30AM	





Term of Reference



COMPREHENSIVE PRIMARY HEALTH CARE (CPHC)

NATIONAL OVERVIEW

Delivery of Comprehensive Primary Health Care (CPHC) Services through Health and Wellness Centres (HWCs) has emerged as one of the key priority areas under the National Health Mission. The Health and Wellness Centres are envisaged to provide a strong base for the Pradhan Mantri Jan Arogya Yojana (PM-JAY) and facilitate continuum of care with strong upward and downward referral linkages. Under the Ayushman Bharat initiative 1.5 Lakh HWCs would be operationalized by upgrading SHCs, PHCs and UPHCs by the year 2022. As part of this vision, over last two years, the main focus at central and state levels, has been on developing inputs such as operational guidelines, training modules for service providers and frontline workers, rolling out Certificate Programme in Community Health for training Mid-Level Health Providers and developing the IT application for CPHC.

The upgradation of existing SHCs and PHCs to deliver CPHC services require a paradigm shift in multiple areas such as – expanding the range of services being delivered at primary care level (moving beyond RCH and communicable diseases), reorganization of service delivery processes, building referral pathways and use of IT systems for ensuring continuum of care, health promotion for life style modifications, ensuring uninterrupted availability of medicines and diagnostics and providing performance linked payments. Currently, states are at varying stages in operationalizing HWCs. So far about 2913 HWCs have been made functional against the target of 15,000 for FY 2018-19.



This section summarizes findings from all states visited by CRM teams with reference to the roll out of CPHC through Health and Wellness Centres.

KEY OBSERVATIONS

Planning & Orientation of the program managers

All states visited have initiated roll out of Comprehensive Primary Health Care through operationalizing Health and Wellness Centres. However, several gaps were reported in terms of planning and selection of health facilities. The selection of facilities to be upgraded as HWCs in most states was not based on the principle of continuum of care, thus developing PHCs and all linked SHCs as a “primary care unit” with strong referral linkages to a well-functioning secondary level health facility. For instance, findings from Rajasthan indicate that

SHCs and PHCs under existing UHC pilot initiatives were prioritized for upgradation as HWCs and were reported to be scattered across districts/ blocks. This was reported as one of the biggest hurdles in service delivery as neither the service providers of the linked PHCs or SHCs were oriented to the principles of CPHC and their role in continuum of care nor the infrastructure of the linked centres was as per guidelines. Similarly, findings from states like Bihar and Telangana highlighted that even though the Additional PHCs (in case of Bihar) or PHCs are upgraded to HWCs, the outreach activities are yet to be rolled out due to lack of coordination between PHC and SHC.

The findings from all states reflect slow progress made against the targets for number of SHCs and PHCs/UHPCs to be operationalised as Health and Wellness Centres in FY 2018-19. Across all states, only 20% to 25% of the targeted HWCs have been operationalised so far. Of the HWCs operationalised, almost 70% were in aspirational districts under the Extended Gram Swaraj Abhiyan. As operationalisation of HWCs, is dependent on multiple factors (e.g.-HR, infrastructure, medicines, diagnostics etc), most states were in process of completing initial requirements.

One of the major concerns that emerge from most states is the limited understanding among programme officials especially at the district level about the overall concept of CPHC and HWCs. Even though the states have initiated the process of operationalizing Health and Wellness Centres, understanding about nuances of the programme were lacking. This was specifically documented as a major challenge from states of Arunachal Pradesh, Jammu Kashmir, Rajasthan, Telangana, Tripura and Uttarakhand.

Human Resource

Primary Health Centers (PHCs)

Availability of adequate HR as per the guidelines was identified as one of the major challenges in some states. At the level of PHC- HWCs, states of Rajasthan, Bihar and Jharkhand did not

fulfil the functionality criteria due to paucity of necessary staff. Eg- HWCs-PHCs visited in Bihar and Rajasthan did not have pharmacists while in Jharkhand staff nurses were not available.

Sub Health Centers(SHCs)

Mid-Level Health Providerand Certificate Programme in Community health

The main addition to the primary care team at HWC-SHC is Mid-Level Health Provider trained through the six-month Certificate Programme in Community Health (CPCH). The certificate programme is operational in all the states visited by the CRM team, however mixed findings have been reported. Currently, candidates enrolled in third academic cycle (July 2018-December 2018) are underway training and will be posted at the HWC-SHCs by January 2019. Discrepancies have been observed on review of target set by states for operationalizing SHCs as HWCs vis-à-vis the number of MLHP candidates who have been posted and candidates who will be posted in January 2019. However, only few states like Rajasthan have initiated the process of identification of more PHC- HWC in place of SHCs to meet the targets.

In most states, MLHPs have been posted at SHC-HWCs after completion of training in Certificate Programme in Community Health. However, in Jammu and Kashmir, candidates have refused to join as MLHPs despite being allocated SHC-HWCs. Similarly, in Madhya Pradesh, MLHPs have been posted at PHC- HWCs after training instead of SHC- HWCs. Another variation was reported from state of Tamil Nadu where, VHNs (MPW-F) have been trained through a state specific CPCH undertaken by MGR Medical University, to be posted as MLHPs. Similarly, Maharashtra has now planned to train the Ayurveda practitioners who were already posted as MLHPs through a state specific six-month CPHC by MUHS. Chhattisgarh and Assam present the oldest model of MLHPs, where candidates were trained in BSc Community Health and posted as Assistant Medical Officers (AMOs) or Rural Health Practitioners. These MLHPs were posted at PHC in Chhattisgarh and at SHCs

in Assam and had been filling the gap of critical HR shortage in these states especially in remote areas. Chhattisgarh has continued posting their AMOs at PHCs but have added a bi-weekly OPD visit at SHCs-HWCs. In HP, training of MLHPs in CPHC course has recently begun but there was lack of clarity noted among state officials about eligibility criteria of candidates. Jharkhand has also enrolled 146 candidates in BSc. Community Health in 2016 and additional 100 will be enrolled for 2018-21 batch.

Performance Linked Payment has not been initiated in any of the state. In states where the MLHPs are posted, they are currently being paid their basic fixed remuneration. In Rajasthan, amount of 10,000 pm is provided to all MLHPs with Rs. 2,500 as mobility support and Rs. 7,500 as rural posting allowance.

MPW- F and ASHAs

A positive finding highlighted in almost all states visited was that there was no shortage Frontline Workers (ASHAs and MPWs). In none of the states, FLWs have been oriented about CPHC and their critical role in delivery of CPHC services. However varied findings were observed with regards to training of ASHAs and MPW- F in Universal Screening of NCDs. Training of MPW- F and ASHAs have been conducted in Assam, Chhattisgarh, Jharkhand, Maharashtra, Telangana and one district of MP. Training of ASHAs is yet to be conducted in Bihar and Punjab, while in states of AP, J &K and Rajasthan duration of training was reduced to one – two days (from suggested 5 days) affecting the quality of training. This has majorly affected the activity of population enumeration and health promotion. These findings raise concerns about streamlining training of FLW which is pertinent to initiate service delivery for screening and management of NCDs at HWCs. State of Tamil Nadu has selected Women Health Volunteer (in place of ASHAs) from TN Women's Development Corporation to support the process of population-based screening during their household visits. WHVs have been selected for every 5000 population and paid Rs. 3100 pm for specific activities.

Community Outreach and Service delivery

An integral element of CPHC is expanded range of services which included universal screening, prevention and management of common NCDs in addition to RMNCH+A activities. Population enumeration and community-based risk assessment (CBAC) are the first tasks to be commenced at HWCs. AP, J&K, Rajasthan, Assam, Jharkhand, Rajasthan, UK and UP have initiated these activities however, quality of data was found to be poor in Jharkhand, Rajasthan, UK and UP owing to reasons like in-adequate availability of updated CBAC forms, appropriate training of ASHAs etc. The enumeration has not been initiated in Bihar (since ASHAs have not been trained), HP and Chhattisgarh. In Tamil Nadu population enumeration and screening is done by WHVs.

Roll out of universal screening of NCDs has been reported only from states of Maharashtra, AP, Chhattisgarh, Tamil Nadu, Rajasthan and Assam. The services were limited to screening of Hypertension and Diabetes in Rajasthan while in Maharashtra, Assam and Chhattisgarh screening was done for Hypertension, Diabetes, Oral and Breast Cancer. Screening for cervical cancer at PHCs was only reported in Tamil Nadu, Chhattisgarh and AP (as part of Mahila Master Health check-up). In Tamil Nadu high drop-out from screening at home to reporting to PHC for diagnostic confirmation was reported (over 70%) Reports from Jharkhand and Rajasthan indicate lack of clarity among the MLHPs about concept of CPHC and their roles with more focus on OPD curative services. Wellness activities are not reported to be undertaken at most of the facilities except display of IEC material and counselling services being provided by the service providers. Only Jharkhand has initiated yoga classes. Though rooms for yoga have been established in Bihar, Madhya Pradesh and Uttar Pradesh, but the activities have not commenced.

Essential Medicines and Diagnostics

Another critical component of HWCs, is ensuring uninterrupted availability of medicines and

diagnostics. As anticipated, availability of medicines and diagnostics at PHC- HWCs was reported to be satisfactory in most states except for Bihar and UP. In UK, diagnostics at PHC- HWCs were available but shortfall in medicines was noted while in states of J&K and HP, medicines were being made available but diagnostic services were deficient.

At SHC-HWCs, availability of medicines and diagnostics as per guidelines was scarce in states of Jharkhand, UP, Chhattisgarh and J &K. On the other hand, despite availability of medicines (including antihypertensives and antidiabetics) in Rajasthan, the medicines were not being used due to lack of clarity in the state about dispensing rights of MLHPs. Reports also mention that MLHPs with Ayurvedic background were inclined to prescribe Ayurvedic medicines (supplied to only SHC- HWCs where Ayurvedic Practitioners have been posted). The most common diagnostic tests available at the HWCs-SHCs included urine pregnancy rapid test, malaria smear, rapid diagnostic test (RDT) kit, blood pressure, random blood glucose via glucometer, haemoglobin test. Additionally, some facilities were the collection points for sputum under RNTCP. In case of HWC-PHCs, all the 19 tests as per the IPHS guidelines for PHCs were being conducted.

IT Systems

Use of IT system was reported to be poor in all states. This was on account of various reasons such as procurement and supply of IT equipment like tablets (Chhattisgarh, MP and Rajasthan) and installation of IT application in Bihar, non-availability of user IDs and passwords, internet connectivity in Jharkhand. IT system (Tablets with /NCD module) was reported to be operational in one district of UP and J&K. Tablets with ANMOL app and desktop for the PHC-HWC have been provided in AP and Telangana

Infrastructure

In order to expedite the process of upgradation of existing PHCs and SHCs as HWCs, availability of good infrastructure was taken as one of main criterion followed in selection of health facilities

across most states. Hence, in almost all PHC - HWCs visited during CRM, infrastructure with basic amenities like drinking water, toilet, power supply and back up was adequate except in Jharkhand and Rajasthan. In some states like Bihar, Chhattisgarh, Jammu & Kashmir and Jharkhand, the HWCs have provision for a “Wellness Room” for conducting Yoga sessions. Branding of HWCs in most of the states except states like Tamil Nadu was in accordance with the guidelines laid by MoHFW. States of Andhra Pradesh, Arunachal Pradesh, Punjab, and Uttarakhand were yet to complete the gap analysis.

RECOMMENDATIONS

Overall the findings reflect the slow pace of roll out of CPHC services and indicate the challenges faced by states during this initial phase of implementation. This emphasizes need for strengthening Programme Management Units at state and district levels to enable effective planning for operationalisation of HWCs.

As states move towards meeting the targets for operationalizing HWCs, it is essential that the quality of care is ensured through regular skill building, improving supply chain logistics and building strong referral linkages. A common finding from the states highlight urgent need to prioritize orientation on CPHC at all levels including-

- ▶ Orientation of district officials and block officials on principles of CPHC and all functional criteria and nuances of HWC.
- ▶ Training of service providers of the linked health facilities (SHC/PHC/ CHC and DH) on CPHC and their role in providing continuum of care.
- ▶ Refresher Training of ASHAs (by ASHA trainers) and MPW (F) on universal screening of NCDs as per the guidelines laid by MoHFW.

Limited focus towards roll out of CPHC IT application needs to be addressed since the IT application can act as an important tool for service providers and frontline workers to ensure continuity of treatment, life style modification and identify “loss to follow up”. In addition to the screening and curative

services being provided at HWCs, health promotion activities including wellness activities like yoga needs to be prioritized. Extensive IEC campaigns are also required to create awareness among community about the expanded range of services being provided at HWCs.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ State has commenced to operationalize UPHCs as Health and Wellness Centres. Branding has been done as per guidelines, however gap analysis for infrastructure and strengthening is under process.
- ▶ Block saturation has been envisaged in Anantapur district with District Hospital, Hindupur serving as First Referral Unit. Six PHCs in Hindupur Division of Anantapur district have been selected to be upgraded to Health and Wellness Centres.
- ▶ 19 investigations are currently being offered at the PHC-HWC of which around 7 are available through a PPP model. Adequate availability of medicines with three months stock was noted.
- ▶ Certificate Programme in Community Health has been rolled out from July 2018 with 78 candidates under training. Currently, there are three Programme Study Centres functional in the state. During the visit, counsellors were found to be well oriented.
- ▶ Among the HR posted at the HWCs, three-day training for screening of Common NCDs has been completed for Medical Officers. Additionally, MPW-Females and ASHAs have been trained however, training duration has been reduced which is not in congruence with the guidelines. Shortage of staff nurses was reported due to which the PHCs are not providing services 24*7.
- ▶ Population enumeration has been initiated in the operational HWCs, but the updated version of CBAC is not yet provided to the frontline functionaries.

▶ State had initiated screening of non-communicable diseases for women two years ago in their state specific programme called Master Mahila Health Check-up. After the roll out of CPHC, these services have been extended for males as well.

▶ Tablets have been provided to all MPW-F with ANMOL application along with a desktop at PHC-HWC, however, the CPHC-NCD- IT application has not been uploaded yet. The infrastructure for tele-consultation and wellness activities is not in place yet.

Arunachal Pradesh

- ▶ State has proposed to convert 200 Sub-Centres to Health and Wellness Centres. However, lack of robust action plan to operationalize the HWCs was observed at all levels.
- ▶ Gap analysis of the selected facilities (to be transformed as HWC) in terms of infrastructure, equipment and human resources is yet to be undertaken.
- ▶ The criteria for selection of SCs to be upgraded to HWC is not defined with no defined referral linkages with PHCs.
- ▶ Even though capacity building of the state, district and block programme officers has been done but the interaction reveals that their orientation towards the concept of Health and Wellness Centres and its nuances like health promotion and wellness component is low.



Assam

- ▶ About 16 HWCs are currently operational against the target of 691 in the state.
- ▶ The Sub- Health Centres-HWCs in Futuri, Bilasipara and Hazipara villages have Mid-Level Health Providers along with Multipurpose Worker-females and males. These HWCs are delivery points with labour rooms equipped with oxygen cylinders, ambu bag etc. However, there is need for building skills of the staff for its correct use.
- ▶ Population enumeration and screening for non-communicable diseases has been initiated in the catchment area and fixed day approach is followed for screening services.
- ▶ Tablets have been provided for data entry, however, issues were reported regarding the functionality of software.
- ▶ Though the community interaction revealed that people in the catchment area resort to these HWCs as first port of call and are happy with the services being provided. However, there is a need to strengthen the outreach services in order to raise awareness about the expanded range of services being provided at HWCs.
- ▶ Apart from HWCs, the state has a strong network of MMUs and boat Clinics to reach the last mile. The range of services being offered in these MMUs and Boat Clinics includes ANCs, PNCs, Family Planning services, eye examinations, routine blood and urine tests and referral services.

Bihar

- ▶ State has planned 543 Health and Wellness Centres for the financial year 2018-19, of which 334 centres are Additional PHCs, 176 Sub Health Centres and 24 are UPHCs. As of now, 43 HWCs-APHCs are functional across aspirational districts of the states as part of EGSA. Among the districts visited, 27 HWCs are planned to be upgraded in Muzaffarpur, and four in Rohtas.
- ▶ The facilities visited were recently renovated and branded as per GoI guidelines. However,

considering the principal of continuum of care, the infrastructure of the SHCs under these A-PHCs/UPHCs are in dilapidated condition and needs to be upgraded.

- ▶ As the state has only operationalised A-PHCs, the training of the frontline workers (ASHAs and MPW-F) at the SHC is pending. Hence, new services envisaged under CPHC haven't been initiated at any HWCs visited.
- ▶ Community interaction revealed that Sub-Health Centres largely remain locked and the MPW-Fs and ASHAs function as "immunization/vaccine providers". Thus, even basic services for ANC, growth monitoring, IFA distribution, family planning counseling are missing at the sub-centres and the APHC.
- ▶ The APHC-HWC was well staffed as per the standard. However, in one of the centre, the MBBS-MO was posted a day before the visit, hence the patient turn-out was very less. Availability of medicine was observed as an issue with even basic medicines for common NCDs not in stock. Though the state has e-Aushadhi in place, but it is only up to the level of CHC (block-PHC) and should be brought down to PHCs and SCs. Of the nineteen point of care diagnostics, only routine blood and urine examination were conducted.
- ▶ Orientation of Programme Management Unit at district and block level is still pending.

Chhattisgarh

Chhattisgarh was the first state to operationalize concept of Health and Wellness Centres with its first HWC known as "Hamaar Gaon Hamaar Haspatal", launched in 2016 in Korba district. The HWCs in Chhattisgarh are manned by Mid-Level Health Providers known as Assistant Medical Officers. AMOs are trained in the 3½ years BSc Community Health course. They are posted at PHCs-HWC and visit SHCs on rotational basis, twice a week.

- ▶ The infrastructure of the facilities visited was in good condition and they are branded as per the guidelines by MoHFW.

- ▶ The HWC-PHC are providing expanded range of services however, at the HWC-SHC, the service provision is limited due rotational posting of AMOs.
- ▶ Population enumeration, filling of CBAC forms and screening for NCDs has not started. Use of CPHC-NCD IT application is yet to begin, Health promotion activities are yet to take off in a major way, but yoga sessions have started in a no. of HWCS visited.
- ▶ Basic Diagnostic tests are being conducted at facilities however, there is a need to expand the diagnostics services as per the guidelines. Stock of NCD drugs was found to be adequate at these facilities.
- ▶ The awareness about NCDs was good among the community however, awareness about NCD services available at the HWCS was low.
- ▶ The proportion of OPD patients screened for NCDs at facilities (UPHC, CHC, HWC) was good, but the system of referrals from HWCS to higher levels of facilities was observed to be weak.
- ▶ MOs, AMOs, Staff Nurses and MPW-F have received 3 days training on NCD. In district Raipur in one model HWC the staff nurse was trained on 6 days VIA training on CA cervix screening.

Gujarat

- ▶ The infrastructure, human resources and medicines are available in the newly developed Health and Wellness Centres. Providing the comprehensive set of 12 package of services must now be the focus. The advantage seen is that these centres are located in spacious plots where even yoga centres, parks and walking paths can be built.

Himachal Pradesh

- ▶ For the current financial year, the target set by the state is to upgrade 104 Sub-Health Centres, 18 Rural Primary Health centres and 15 Urban-Primary Health Centres.
- ▶ However, the progress to operationalize the same has been very slow. So far two Rural-

PHCs, both in Chamba District, have been upgraded to HWCS against the target of 18 and state is yet to initiate the upgradation of SHCs and UPHCs.

- ▶ The branding has been completed in both the centres except some minor civil works which are under process. In term of diagnostics, some ad-hoc arrangements were made for some of the lab services, but there is need of a more permanent solution to ensure continued laboratory services.
- ▶ Training of MLHPs has just started as there was lack of clarity in State regarding the eligibility criteria of Mid-Level Health Providers.
- ▶ Increased caseload at the HWCS operationalised was noted. However, the expanded range of services (Health promotion/yoga, Essential medicines and 19 Lab services) to be offered through HWCS is yet to be initiated at the facilities.

Jammu & Kashmir

- ▶ State has planned 275 Health and Wellness Centres to be operationalised in year 2018-19 (approved in RoP). So far six HWC-SHC centres are fully functional with MLHPs positioned. Additionally, branding is completed 40 facilities.
- ▶ Among the three HWCS visited in Block Sogam of Kupwara district, gap analysis and branding were completed. One facility visited in Kralpora block where the panchayat building was being renovated as HWC. Though approval for the centre is pending, but the branding and renovation is complete owing to the proactive Programme Management Team at the block.
- ▶ Space for yoga and physical activities has been identified and set up either within the facility, or near to the centre, however, activities are yet to begin.
- ▶ The Programme officers at the district and block level were oriented to the concept of HWCS, but lack clarity on the functionality criteria and essential elements of CPHC. However, none of the service providers were given orientation on Comprehensive Primary Health Care.

- ▶ State has 38 candidates who have been trained as MLHPs in the Certificate Programme in Community Health in Baramulla, however, none has joined the facility leading to major concerns in service provision.
- ▶ ASHAs and MPW-F have been given a two-day training on Universal screening of common NCDs with no joint training. The training duration was insufficient for the FLWs, as only introduction to NCDs and risk factors could be covered during these two days.
- ▶ At present, none of the HWC/SC have medicines available as per essential medicine list including antihypertensives, antidiabetics and antiepileptics. Medicines were being distributed from the SDH/CHC to the respective centres i.e. HWC/SC/PHCs. Not all diagnostics were available at the time of visit. At the PHCs visited, the diagnostics tests were available and also the user charges were defined.
- ▶ All HWCs had functional tablets available with NCD-CPHC IT application uploaded, however the use of application was not started yet. An orientation-cum-training has been given to MPW-F as well.
- ▶ Population enumeration and Community Based Assessment Checklist (CBAC) has been initiated at all the facilities, however this activity is being done by MPW-F. However, due to lack of clarity, follow up for high risk and records are not maintained yet by MPW-F.
- ▶ Service providers are not yet sensitized and trained to roll out the health promotion and wellness activities in the field.

Jharkhand

- ▶ State has planned to convert 776 health facilities (HSC, PHC and UPHC) into Health and Wellness Centres in FY-2018-19 of these 502 HWCs are proposed in Aspirational Districts. As of now, 47 HWCs which includes 38 Sub Centres, 8 PHCs and 1 UPHC are functional.
 - ▶ State has created a dedicated CPHC cell in State Health Society with State steering committee, working committee and executive
- body constituted to monitor the progress of the programme.
- ▶ The gap analysis for infrastructure upgrade is in process. The branding is being done as per the guidelines, however some facilities had issues related to electricity, water supply and essential medicines supply.
 - ▶ For the PHC-HWC, HR as per IPHS is being followed by the state however, shortage of staff nurses was observed. The HWC-SHCs has complete Primary Care Team with MLHPs, MPWs and ASHAs.
 - ▶ Training of Sahiyas, MPW-F and MOs has been completed in universal screening of NCDs as per the guidelines and were well oriented to the concepts of CPHC and NCD. However, training of staff nurses on VIA was not completed. Only one GNM in DH Bokaro was trained in VIA for 3-5 days.
 - ▶ The population enumeration has started by Sahiyas and screening of people 30 years and above along with referral of high-risk population has been started by MPWs. Yoga sessions have begun in Pindrajora, Chas Block, Bokaro by a trained yoga practitioner.
 - ▶ Non-availability of most essential medicines for NCDs at HWCs was highlighted as an issue. All major diagnostic tests are being provided at HWCs-PHC in Bokaro, however, the HWC-PHC, in Ranchi had a non-functional lab.
 - ▶ The MOs and MPW-F & M have been trained in CPHC-NCD IT software. However, training of district programme officer is still pending. Tablets and laptops have been provided at 47 functional HWCs. However, as they have not started using the application, the knowledge regarding the same is very low.
 - ▶ Sahiyas in rural and urban areas are engaged in raising public awareness of universal screening of NCDs within the community. However, community interactions indicate that the community (rural and urban areas) still at large are unaware about universal screening of NCDs. It was found that they usually visit the nearby HSC-HWC only to avail ANC services.

Community members usually resort to private doctors for blood pressure and blood sugar testing incurring OOPEx.

- ▶ State has two programmes running to augmenting MLHP workforce for viz. BSc. Community Health, a three-year course and six-month Certificate Programme in Community Health (CPCH). Currently 146 candidates are enrolled for BSc Community Health followed by 100 students for 2018-21 batch. Three batches of Community Health Officers (CHOs) are undertaken in
- ▶ Jharkhand- 12, 38 and 149 candidates in first, second and third batch, respectively. Currently, 149 candidates are enrolled in 5 Programme Study Centres (PSCs) against the approved 210.
- ▶ Interaction with 40 candidates of current batch highlighted issues like lack of clarity about roles and responsibilities as MLHPs, delay receipt of hard copies of study material, delay in commencement of classes etc.
- ▶ State is working with NGOs like Project HOPE and Vikas Jila Bharti for capacity building of frontline workers and developing IEC material related to NCDs.

Madhya Pradesh

- ▶ State has initiated the roll out of CPHC, however, only PHCs are being upgraded to HWCs currently, known as Arogyam-PHC. Two PHCs (Machalpur and Kurawar) out of 27 have been strengthened into H&WC in Rajgarh district. Remaining 25 PHCs and 1 UPHC will be strengthened into HWC in current financial year.
- ▶ While in district Betul the operationalisation is in an early phase, all the essential elements like branding, positioning of HR medicines and diagnostics are available as per guidelines. Building of HWCs are in good condition and the existing infrastructure has been strengthened.
- ▶ Population enumeration and screening for NCDs has not been started uniformly across all state.

- ▶ The facilities have a well functional lab with almost all tests being conducted as per the guideline. The current state EDL has a list of 151 drugs which were available at the facilities at the time of visits including medicines for hypertension and diabetes.
- ▶ The IT infrastructure was missing at the HWCs visited. Procurement of tablets surfaced as a major issue where the state has asked the MPW-Females to procure tablets from their pockets which will be reimbursed later. The platform for Tele-Consultation at the HWCs has to be planned at the state level.
- ▶ Orientation of district teams and service delivery staff to the concept of CPHC is required. The training of MPW-F/M and ASHAs (in Machalpur Block) on Universal Screening of NCDs and VIA for staff nurses is yet to be planned at State level. Therefore, the HWC-PHC continues to offer basic services.
- ▶ Health promotion and wellness activities like Yoga sessions are yet to be started due to lack of infrastructure.

Maharashtra

- ▶ Among the districts visited, Satara has 50 Sub Centres chosen to be upgraded to HWCs whereas, in Gadchiroli, 5 PHCs have been proposed to be upgraded to HWCs. As the programme is in early stage of implementation, infrastructure repair and branding are under process. However, the selection of facilities is not done on the concept of block saturation.
- ▶ The training of the Primary Health Care Team (ASHAs, MPW-F and MLHPs) is still under process. Even though the staff has been oriented, but the awareness about the expanded range of services was very low among the team. Thus, basic services are being provided at the HWCs (HSC & PHCs) by the team and provision of expanded range of services is yet to be initiated.
- ▶ However, Population enumeration has been initiated with the revised CBAC forms being used. The screening has also started for all common



NCDs except for cervical cancer as the VIA training of staff nurse is under process. Drugs & diagnostics for Diabetes and Hypertension were available at all HWCs.

- ▶ The state has made the decision to train Ayurveda Practitioners as Mid-Level Health Providers who will be certified by MUHS in a state specific programme which is in line with the CPHC.
- ▶ Community interaction in Satara reflected that the community was happy with the services provided by Mid-Level Service Providers (MLHPs).

Punjab

- ▶ For the current financial year, 240 Sub-Centers are planned to be upgraded to HWCs. Additionally, 600 Sub Health Centers which including all Sub-Centers of Aspirational District Ferozepur & Moga have been planned. The state has also selected mini PHCs/PHCs to be upgraded as HWC but they are yet to be operationalised.
- ▶ Gap analysis, infrastructure planning, branding, is under process.
- ▶ As of now 197 Staff Nurses have been trained as MLHPs in CPCH and State has enrolled 300 more staff nurses for the current batch. However, results are pending for 90 Staff Nurses, enrolled in the first batch, who have already completed the training.

▶ Training of ASHAs on universal screening of NCDs has not been started. Orientation of staff at HWCs to the concept of CPHC and expanded range of services is awaited.

▶ Population enumeration is yet to be initiated. Recruitment of essential human resource, availability of drugs and diagnostics is pending.

Rajasthan

- ▶ Prior to the launch of CPHC the state had implemented Universal Health Coverage Pilot in districts of Churu and Baran since 2016. As part of this initiative, 150 SHCs (75 SHCs in each district) were selected to strengthen service delivery by weekly AYUSH OPD and lab services at SHCs. This was followed by an effort to create 870 Adarsh PHCs in 2016-17 across all districts in the state.
- ▶ After the launch of CPHC, the state has planned to operationalize 679 Health and Wellness Centres in FY 2018-19 which includes 529 SHCs, 100 PHCs and 50 UPHC. So far 225 HWCs (100 SHCs, 100 PHCs and 50 UPHCs) have already been operationalised. However, the state has not followed the principle of block saturation while selecting the facilities, which may hamper continuum of care once the HWCs are functional.

- ▶ Gap analysis and infrastructure repair/up gradation of proposed Health and Wellness Centres is yet to be completed at the visited HWCs though branding exercise has been completed.
- ▶ SHC- HWCs selected have a complete Primary Care Team Positioned with one MLHP, one MPW (F) and ASHAs (as per AWC), however, the rural PHC selected to be converted into HWC in Jodhpur did not meet the criteria of HR.
- ▶ Field observations highlight that though the services like population enumeration, screening of NCDs (HT and DM) have been initiated at the HWCs-HSCs, the orientation of the service providers at the linked PHCs towards the concept of Comprehensive Primary Health Services were inadequate.

- ▶ During community interactions it was reported that CBAC forms were filled by taking information from women members of the household in absence of the male members to meet the short time lines. Thus, men were largely unaware about the initiative.
- ▶ Among the services that are being currently provided at the facilities visited includes daily OPD service, ANC and PNC, Family planning counselling and immunization. The average OPD was reported to be 10-15/day at PHC and 80-100/day at UPHC-HWC.
- ▶ State has 130 trained MLHPs (60 -Ayurvedic Practitioners and 70 Nurses) in place posted at the HWC-HSC. In addition to the six months training, MLHPs at visited SHC have received one day CPHC orientation in Jaipur. Despite this there is a lack of clarity among MLHPs about their roles and understanding of the CPHC with more focus on curative care than on preventive and promotive health. Their understanding about public health functions of SHC- HWCs was limited.
- ▶ MPW (F) and ASHAs at the visited centres have received only one day orientation on Universal Screening of NCDs. At UPHC – HWC, one day orientation was done for all services providers - ASHAs, MPW (F) and MOs in Universal Screening of NCDs by District NCD Nodal officer and NUHM. PMU at the district and block level have received brief orientation on CPHC which is reflected by their lack of knowledge about the nuances of the programme.
- ▶ Medicines as per state EDL including those for Hypertension and DM and essential diagnostics services at HWC SHC and UPHC – HWC were available at the time of visit. However due to lack of clarity in the state about rights to dispense allopathic medicines by the MLHPs based on treatment plan by PHC-MO, most medicines (anti hypertensives and antidiabetics) were under-utilized at SHC-HWC.
- ▶ The NCD- CPHC application has not been implemented across the state due to non-availability of Tablets at the SHC-HWCs. NCD-CPHC MO portal has been installed at the UPHC



- HWC but the portal was not being used due to non-availability of login ID and password.
- ▶ Payment of additional Rs. 10000 pm to MLHPs was being done as rural posting allowance and was not linked with performance.
- ▶ State has initiated training candidates in the Certificate Programme in Community Health with MLHPs recruited from three categories i.e., Contractual Ayurvedic practitioners, Regular Nurses and Contractual Nurses. Currently state has six accredited Programme Study Centres (PSCs) with about 237 GNMIs enrolled for the current batch.
- ▶ Challenges in running the CPCH programme surfaced which included delay in supply of printed training material and notification of PSCs.
- ▶ Another issue highlighted was the high disparity in salary of three categories of candidates enrolled viz. fixed sum of Rs. 16,800 pm for Contractual Ayurvedic Practitioner, Rs. 10,000 pm for Contractual Nurses and Rs. 40,000 pm for Regular Nurses.

Tamil Nadu

- ▶ Tamil Nadu had launched UNIVERSAL HEALTH CARE MODEL in early 2017. The HSCs were made “building blocks” for UHC.
- ▶ After the launch of CPHC, the state has identified 1915 centres for up-gradation to Health and Wellness Centre (HWCs) of which there are 985

SHC, 510 PHCs and 420 UPHCs. State has already initiated a UHC model as a pilot in 3 blocks.

- ▶ Two VHNs are placed at the HWCs in 7 districts, where there are no ASHAs, of which one will be trained as MLHPs through the state specific six-month training programme adopted from the IGNOU module, certified by MGR Medical University. The second VHN would undertake facility-based activities like screening, diagnostics etc.
- ▶ A group of Women Health Volunteer, engaged through a non-health department-Tamil Nadu Women's Development Corporation (TNCDW) have been oriented in a three-day programme on CPHC. The function of these WHVs includes screening and follow up activities for which they are paid an honorarium of Rs. 3100/- linked with activities. The incentive pattern as per guidelines by MoHFW is followed in those HSCs where ASHAs are placed. The monitoring of WHVs is strengthened through TNCDW which includes supervision and regular field visits.
- ▶ However, issues have been reported in this model of screening by WHVs, where the drop-out rates of the patients are high owing to weak follow up mechanism. Follow up and compliance is an issue owing to the fact that there is no incentive linked with follow up for WHVs catering to a population of 5000 as compared to an ASHA covering 1000.
- ▶ Population based screening for common NCDs has been initiated with older version of CBAC. The suspect cases are referred to PHCs for all common NCDs except for VIA, where positive cases are confirmed by Colposcopy at the DH.
- ▶ NCD training for Staff Nurse posted at CHCs and above has been scheduled for 1 month. UHC-SHCs have limited blood testing facilities and the state is planning to create a hub and spoke system involving PHCs. Under UHC, these designated HWC has been provided with NCD drugs in addition to Kit A and Kit B. Lab investigations are limited to urine sugar and albumin, PTK, RBS. No haemoglobin estimation is done at SC level.

Telangana

- ▶ State has initiated implementation of CPHC and aims to follow the principle of Block / Mandal-wise saturation.
- ▶ Gap analysis for infrastructure planning has been completed. The training of MLHP is ongoing, with 26 MLHPs from first batch posted successfully in the newly established HWCs across the State. The 2nd batch (July 2018) has a mix of contractual / regular BSC Nursing / GNM students with a batch strength of 230.
- ▶ State is planning to develop a performance appraisal system of its own and is also planning to name the cadre as "Community Health Manager"
- ▶ Training of other health workers such as Medical officer, Staff Nurse, and MPW-Fs have been completed in 12 out of 31 districts in the state. Tablets have been procured and distributed for the MPW-Fs and MPW(M) in all HWCs.
- ▶ In one of the districts visited, Jayshankar Bhupapally, two HWCs have been made functional (under Extended Gram Swaraj Abhiyan), however, no services beyond RMNCHA+ and NCD are being offered. In Karimnagar, none of the SHCs are upgraded as HWC currently and the District officials were not aware about the plan to upgrade six HWCs in their district. As a result, there have been no preparatory activities at the peripheral level for the establishment of HWCs.

Tripura

- ▶ State has planned to operationalize 1113 Health and Wellness Centre (HWCs) till December 2022. In the current financial year, the focus is on operationalizing 71 HWCs including 40 SCs, 26 PHCs and 5 UPHCs in West, South, Dhalai and Unakoti districts. Till date only 2 HWC-PHCs have been upgraded in Dhalai as a part of EGSA.
- ▶ State level orientation workshop has been completed but the orientation of the district

officials and service providers on the concept of CPHC and HWC is yet to be completed.

- ▶ The state has one accredited Programme Study Centre, IGM state hospital located in Agartala, to conduct training of MLHPs. Currently, 40 candidates have been enrolled in the current session.
- ▶ High referral due to unavailability of assured services in both the districts is a major concern leading to high referral and overcrowding in the state hospitals, Medical Colleges and in adjacent districts/ states.

Uttarakhand

- ▶ State has planned to operationalize 376 HSCs and 50 PHCs as HWC which includes 46 HSCs which were approved in FY 2017-18 and remaining have been proposed for FY 2018-19. Currently 4 PHC-HWCs are operational in Aspirational Districts (two in each district) under EGSA. Upgradation of facilities is underway in 46 HSCs.
- ▶ In Uttarkashi district, 13 SHCs have been proposed to be upgraded to HWCs. Infrastructure strengthening and gap assessment is yet to be undertaken.
- ▶ No training/orientation on CPHC yet been conducted in the district and training under universal screening of NCDs also not yet started. ASHAs were not well aware about CPHC. The staff of the aspirational district has not been trained on NCDs yet.
- ▶ State has initiated the training of MLHPs, with 30 candidates already posted at HWC-SHC after completing the course. State has four Programme Study Centres with 207 candidates currently enrolled in July 2018 session and result is awaited for 30 candidates enrolled in January 2018 session.
- ▶ During interaction with MLHPs posted at HSCs, it was observed that, they had satisfactory skills and understanding about their role. However, the HSCs were not equipped in terms of space, thereby limiting the role of MLHPs.

▶ Community based Assessment for NCDs was being done by ASHAs using CBAC forms, however, the forms were not filled properly. The services provided at the HWCs visited in Haridwar included services related to RCH, NPCB, communicable disease and some NCDs. Screening of Hypertension and Diabetes was being conducted at the facility, however proper stock and disbursal of medicines was not seen. All 19 diagnostics were being conducted at the HWC.

- ▶ Lack of awareness and little evidence of follow up was found in the community.
- ▶ Cancer screening was not being conducted at the facility and awareness was also lacking in the community.
- ▶ IEC on various national health programmes was not found at the facilities or at community level.

Uttar Pradesh

- ▶ State has approval of 2329 HSC and 724 PHCs to be developed as HWC. Of which 147 HSC, 59 PHCs and 5 UPHCs in 18 districts were operationalised by 31st Aug 2018. In Farrukhabad 30 SCs, 6 PHCs and in Varanasi 30 SCs 1 PHC and 1 UPHC have been selected to be developed as HWC.
- ▶ Branding of HWCs has been done as per the norms. Family folder are being filled in both the districts however, the quality of data is poor. Although, MLHPs have tablets but due to lack of training in the software, they are not able to digitalize the information.
- ▶ Implementation of all expanded range of services was found to be a challenge.
- ▶ State has selected candidates with GNM/ BSc Nursing to be trained as MLHPs. Language was reported as one of the issues at Farrukhabad, where MLHPs cited proficiency in English as a major challenge in qualifying for the course.
- ▶ Rational deployment of HR, especially at PHCs, is needed at the facilities.

- ▶ Gaps were observed in the supply of essential medicines for diabetes at the visited HWC and the pharmacists were unclear about stock management and indent process.
- ▶ Similarly, issues were identified in the diagnostic services being provided especially at the PHC with co-located HSC. It was reported that despite having a Lab Technician, only two tests per day (mostly RNTCP and malaria test) were being conducted while rest of the diagnostic tests like Hb and Urine Albumin were being done by MPW-F of SHC.
- ▶ Gaps were observed in supply chain management of drugs and the pharmacists were unclear about the stock management and indent process.
- ▶ IT system (Tablets with ANMOL app/CPHC-NCD IT application) was operational in Farrukhabad whereas in Varanasi it is yet to be implemented.
- ▶ Community awareness about the health and wellness centres was low. ASHA/AWW of the corresponding area shared that HWC facilities have been inaugurated recently (in August 2018), therefore the information has not percolated down.



ACCESS TO CARE

(Ambulances, Mobile Medical Unit & Emergency Services)



NATIONAL OVERVIEW

One of the key achievements of NHM is the patient transport ambulances operating under Dial 102/108 ambulance services. Currently, 33 States/UTs have the facility where people can dial 102 or 108 telephone number for calling an ambulance. 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims etc. 102 services essentially consist of (but not limited to) basic patient transport aimed to cater to the needs of pregnant women and children. JSSK entitlements e.g. free transfer from home to facility, inter facility transfer in case of referral and drop back for mother and children are the key focus of 102 service. Currently, 9305 ambulances are being supported under 108 emergency transport system. 9985 ambulances are operating as 102 patient transport.

Support to Mobile Medical Units (MMUs) under NHM, is a key strategy to facilitate access to public health care to the doorstep of populations particularly to people living in remote, difficult, under-served and hard to reach areas. MMU services are envisaged to meet the technical and service quality standards for a Primary Health Centre through provision of a suggested package of services under 12 thematic areas.

Deployment of MMUs is based on a population norm with 1 MMU per 10 lakh population subject to a cap of 5 MMUs per district. However, further relaxation of norms is available on a case to case basis, where patients served through existing MMUs exceeds 60 patients per day in plain areas and 30 patients per day in hilly areas.



Medical Emergency is a situation, which requires urgent medical or surgical interventions to restore normal health, failing which it can result in loss of life or limb and/or permanent disability. The first 60 minutes of an emergency have been termed the “Golden Hour” as evidence show that the survival/success rate of emergencies managed within this Golden Hour is substantial. Therefore, it is necessary to ensure availability of comprehensive emergency services on a 24x7 basis.

Currently in India, most of the emergency services are confined to tertiary level only with limited access to secondary care and assured advanced referral transport systems. The absence of organized emergency care at primary and secondary health care level has a significant adverse effect on health outcomes. Therefore, to ensure timely intervention and better survival, comprehensive emergency services should be made available at primary, secondary and tertiary level with robust referral and transport network

2.1: AMBULANCES AND REFERRAL SERVICES

KEY OBSERVATIONS

In Community

- ▶ Ambulance services have shown growth amongst the community. Majority of the community had knowledge of 108 and 102 Ambulance services. The availability of ambulance services were found excellent in states like Madhya Pradesh, Maharashtra, Punjab, Gujarat, Tamil Nadu and Chhattisgarh.
- ▶ Community was aware of 108 & 102 ambulance service and reported that the responsiveness of the ambulance service was good. States like Himachal Pradesh, Arunachal Pradesh, Jharkhand and Karnataka reported instances of call drop in emergency.

In Service

- ▶ An overall improvement in ambulance service was observed. Availability and accessibility was seen in all the states. However, the timeliness of service, quality of training of EMTs, equipment maintenance varied across states.
- ▶ The service is reportedly better as observed in states like Madhya Pradesh, Maharashtra, Punjab, Tamil Nadu and Chhattisgarh, with availability of both BLS and ALS supported vehicles with functional equipment.
- ▶ In Maharashtra and Tamil Nadu, ambulances were covering 120 km with 4-5 trips per day. A good response time of 30 minutes was reported in all the cases. All the requisite drugs and equipment were found available/functional in BLS supported ambulances in Maharashtra.
- ▶ Gujarat had boat ambulance service also. In Jharkhand, the drop back service was provided by the local vehicle owners through a district level engagement.
- ▶ States like Chhattisgarh and Arunachal Pradesh reported delay in services and thus need improvement. None of the visited states were getting ambulances checked in month by a

designated technical official / specialist in the district.

RECOMMENDATIONS

- ▶ There is an immediate need to ensure quality emergency care in Advanced Life Support ambulances and building the capacities of emergency medical technicians.
- ▶ There is a need for ensuring uniformity in trainings of providers, scaling up emergency response teams, and solving the last-mile concerns in hilly and difficult regions especially in states like Uttrakhand, Himachal Pradesh and Arunachal Pradesh.

2.2: MOBILE MEDICAL UNITS

KEY OBSERVATIONS

In Community

- ▶ The community reach of Mobile Medical Units and its utilization is gradually increasing in all states. MMUs are primarily being used for ANC, PNC, Neonatal Care.
- ▶ MMUs are also being utilized for Health Education and generating awareness on communicable diseases and NCDs screening.
- ▶ Basic laboratory tests like MP slide, Hb estimation etc. are being done, apart from general treatment of the catered population.
- ▶ In district Annathapuramu in Andhra Pradesh, screening for hypertension and diabetes in community was done through Mobile Medical Units on a regular basis.

In Service

- ▶ The OPD load of Mobile Medical Unit has improved but the inconsistent follow-ups were seen as a key challenge in most of the states.
- ▶ The consultation services by the MMU in all states were reported to be 70+ per day with an average number of 20-25 trips per month. Better range of services were provided through MMUs in states like Chhattisgarh, Tamil Nadu and

Maharashtra. Monthly micro plan is prepared in consultation with CMO and is shared with area ASHA/ANM prior to the visit. In Tamil Nadu, MMU was also conducting screening of ICDS children as a mandate.

- ▶ States like Andhra Pradesh, Arunachal Pradesh, MP and Punjab were observed with improved MMU services in terms of increased number of vehicles, OPD & investigations.
- ▶ In Uttarakhand, 10 districts catering to a population in the range of 25-30% have severe problem of access to the health facilities due to geographical conditions. This makes operationalisation of Mobile Medical Unit a critical area for improvement.

RECOMMENDATIONS

States must ensure that MMU routes are planned to cover areas where service delivery is unreachable, either through health centres or outreach sessions. Further, there is a need for robust monitoring mechanisms for review of range of services provided through MMUs.

2.3: EMERGENCY SERVICES

KEY OBSERVATIONS

- ▶ The emergency services were found suboptimal in all the states visited. The services available were confined to the basic first aid care at most of the states visited.
- ▶ The quality of service was suboptimal due to unavailability or non-functionality of necessary equipment. Several activities 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.
- ▶ In states like Maharashtra, Chhattisgarh and Himachal Pradesh, basic first aid, stabilization, management of common medical emergencies - chest pain, MI, shortness of breath, poisonings, animal bites (dog and snakes), convulsions, suturing of wounds and fracture management - were in place and functional. Anti-rabies vaccine

and anti-snake venom were available and being administered at these facilities. Records of Medico Legal cases were also maintained well.

- ▶ A good practice of use of **Smart Card** facility by community people was observed in Chhattisgarh. However Assured Emergency Services were seen as an area of improvement at all facilities since the reports lack the element of Assured Emergency care services in all states.

RECOMMENDATIONS

- ▶ The number and adequacy of current Trauma Centres needs to be re-assessed. Current centers could be converted to Emergency Departments to cater to both medical and surgical conditions.
- ▶ These should have close collaboration and referral links with District Hospitals and Medical Colleges. The recent GoI Emergency Services guidelines should be used to adequately resource these departments with the requisite HR, drugs, equipment and protocols.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ The MMUs are functional under the name of 'Chandranna Sanchara Chikitsa' in the state. 23 vehicles have been earmarked for MMUs and are being run in a PPP mode with Piramal Swasthya.

Arunachal Pradesh

- ▶ The time lag between calling an ambulance and its arrival is about 3 hours (in east Siang). Therefore, communities are not availing ambulance services.
- ▶ The ambulance at the PHC Bilat is being used for vaccine delivery and transportation of staff from one facility to another.

Bihar

- ▶ The functioning of referral transport is being monitored and as per the records, recently the number of trips, per day per ambulance has

increased to 6.1 (from 3 in the financial year 2017-18). The average transportation of patients is around 4000 per day.

- ▶ There is a need of refresher training of EMTs and drivers.
- ▶ The IEC for generating community awareness for provision of transport services was found to be lacking and can be improved.

Chhattisgarh

- ▶ There were 239 Ambulances, of which 229 were BLS & 10 were ALS. Additional 100 BLS have been sanctioned in the current year.
- ▶ The average OPD observed is 1000-1200 per month. Each MMU plans 25 trips in a month.
- ▶ In case of emergency people usually seek health care in nearby health facility using the **SMART CARD** issued by the Chhattisgarh Government. Each card provides coverage for 5 family members and a cumulative coverage of five lakh that includes coverage for minor illnesses and injuries, for major surgeries/operations and for normal/ LSCS delivery. Community can avail the services in all the government facilities and empanelled private health care facilities.

Gujarat

- ▶ In Gujarat, boat ambulance service for the fishermen was seen in place.

Himachal Pradesh

- ▶ Response time for the 108 Ambulance service was satisfactory (considering the difficult terrain) at an average of about 30 minutes.
- ▶ MoU related issues were reported which were affecting the functionality.
- ▶ There is an absence of MMUs in the state currently.

Jharkhand

- ▶ The Mamta Vahan services are partially running in some districts and are closing down in many districts as vehicle owners feel the renumeration is very low for the services.

- ▶ Mamta Vahans are not functional in the urban areas. Urban community either uses their own transport or public transport to visit the health facilities. No travel reimbursement is given by the government.

- ▶ In Bokaro, no government ambulance is available in the slum. They were unaware of the 108-ambulance facility.

Karnataka

- ▶ Referral transport is available and monitored centrally.
- ▶ 108 and Nagu Magu ambulances are available on call, but sometimes private vehicles need to be arranged.

Madhya Pradesh

- ▶ 606 ambulances (108) and 735 Janani Express (102) was running in the State through integrated model.
- ▶ Average OPD per MMU/ month is approximately 1440 and 372 Lab test per MMU/ month was done in July 2018 in the state.

Maharashtra

- ▶ Good & clean infrastructure with patient friendly ambience seen across. However, available infrastructure in DH & SDHs are not meeting the space required for expansion and provision of assured services. Also Most of the higher facilities lacked assured critical care beds in Satara. In contrast, the other district which is an Aspirational District had good emergency and trauma services available at DH (with Triage, central oxygen supply, anti-venom, anti-rabies etc. in place and functional) and functional Modular OTs
- ▶ 108 services well functional with trained Ayurveda doctor. 102 provide drop backs. Community satisfied with emergency transport services in both districts, but concerned about lack of assured emergency care at Satara.
- ▶ Telemedicine: Functional patient nodes available at SDHs in both districts with 35-40 Specialist consultations per month in one district.

- ▶ An AYUSH wing with Ayurveda, Homeopathy, UNANI and Naturopathy & Yoga streams of service was functional at DH Satara. Good integration of the services with allopathy care was seen at this facility with common OPD number and cross-referrals from AYUSH stream to allopathy and vice versa. There is also an established system for reporting and monitoring the integrated service delivery.
- ▶ 1 MMU was functional in Satara, catering to a difficult area covering 60 villages with high footfall (OPD- 204/day, tests- 87/day). In Gadchiroli district, OPD- 84/day, tests-58/day.

Punjab

- ▶ There are no Advanced Life Support ambulances in the district to cater to high emergency cases

Tamil Nadu

- ▶ Regular cadre Medical Officer is posted in MMU, thereby improving the quality and accountability of the services in outreach areas.

- ▶ 104 is being used for counseling for mental health with a special focus on suicidal tendency and to the survivors, against an undertaking signed by the client.
- ▶ 936 ambulances are in operation which is mapped and of which 62 are ALS and 862 are BLS. Average number of trips is about 4 per day. The response time is 12 minutes in urban area and 16 minutes in rural area. On spot response time in a rural set up was 15 minutes. About 25% calls are to pick up the pregnant mothers to the facility. Patient satisfaction rate is high on verbal interview.

Uttarakhand

- ▶ 15 MMUs are sanctioned on OPEX Model with one MMU per district. Tehri and Chamoli have 2 MMUs each.
- ▶ 5 MMUs are also sanctioned on CAPEX+OPEX model for Pithoragarh, Almora, Champawat, Pauri and Uttarkashi district since FY 2017-18.





MATERNAL, NEWBORN & CHILD HEALTH

Reproductive Health/Family Planning and Adolescent Health



3.1: MATERNAL HEALTH

NATIONAL OVERVIEW

Since the launch of NHM in 2005-06, there has been a remarkable reduction in maternal and infant mortality in India. The country achieved the MDG target related to MMR in 2015 by reducing maternal deaths from 556 per 100000 live births in 1990 to 130 maternal deaths per 100000 live births in 2015. Similarly, IMR has also reduced from 86 in 1990 to 34 in 2017. The pace of reduction of MMR in India has been 59% higher than the global pace of reduction.

Despite a one-third reduction in MMR, India still accounts for 15% of the global maternal deaths. Moreover, for every death that takes place, there are many more with varying degrees of morbid conditions. Pregnancy-related mortality and morbidity continue to have huge impact on the lives of Indian women and their newborns. Multiple factors intersect and contribute to maternal morbidity and mortality –a) clinical causes; b) the three delays (delay in decision making, delay in transport/lack of assured referral and, delay in receiving appropriate emergency care on time) and; c) social determinants that make women vulnerable to poor health and negatively impact their access to health care services (gender discrimination, low socio-economic status of women, illiteracy, early/child marriage, teenage pregnancy, lack of autonomy and financial security etc.)



KEY OBSERVATIONS

The percentage of pregnant women (PW), who received ANC in the first trimester, has increased considerably from NFHS-3 to NFHS-4 in all the CRM states, except Karnataka (70% in NFHS- 3 to 64 % in NFHS-4) and Tamil Nadu (76% to 68 %). The percentage of PW who received any ANC in the first trimester increased from 19 per cent in NFHS-3 to 35 per cent during NFHS-4 in Bihar, while it has declined from 71 per cent in NFHS-3 to 66 per cent in NFHS- 4 in Karnataka. In all the states visited, the community was found to be aware of the services and the existing health care facilities available in the public sector. However assured services and quality of services still remains an issue in most of the states. With the launch of PMSMA, there has been an increase in the identification and management of high-risk pregnancies and line listing but the PW are just



being referred and not being followed up, thereby failing to capitalize on the increased identification of HRP. Proper line listing and follow up treatment were found to be lacking in most of the states. Birth preparedness is an issue in some of the CRM states visited and complication readiness remains an issue in most of the CRM states visited.

The percentage of PW who had an institutional delivery in a public facility increased in all states from NFHS-3 to NFHS-4. The increase is particularly significant in Madhya Pradesh (from 18% to 70%), Uttarakhand (from 16% to 44%) and Bihar (4% to 48%). This is consistent with the CRM findings of high footfall in public health facilities for ANC and deliveries. This also bears testimony to the contribution of various initiatives taken under NHM - JSY, JSSK and centralized referral transport - in improving the coverage of ANC, PNC, and increasing institutional deliveries in states. Despite these efforts, the beneficiaries in certain pockets have reported increased out of pocket expenditure as reported from the findings of CRM teams in the states of Arunachal Pradesh, Punjab, Bihar, Uttar Pradesh, Chhattisgarh, and Rajasthan, although the quantum varies from state to state.

CRM findings also seem to indicate that with an increase in the number of deliveries there is an increase in unnecessary episiotomies (Andhra Pradesh and Assam) and C sections (Tripura,

Andhra Pradesh, Assam, Punjab, Karnataka, and Tamil Nadu), which is a matter of concern. Effective monitoring and clinical audits needs to be implemented and carried out, as a policy for improving the quality of services.

All the CRM visited states have shown a decline in maternal mortality and states like Maharashtra (61) and Tamil Nadu (66) have even achieved SDG targets on MMR. However, states like Bihar, MP, Rajasthan, UP and Assam are far behind and contribute to approximately 65-75% of the total estimated maternal deaths in the country. These are the states where access and operationalizing maternal health care services remains a challenge largely because of non-availability of critical human resources, particularly the specialist obstetricians. Hence, despite availability of blood banks, blood storage centres, enabling infrastructure, and network of ambulances, etc. most of the high focus states have not yet been able to operationalize the designated First Referral Units.

Irrational deployment of specialists remains a major issue in most of the states (except states like Tamil Nadu and Karnataka). Lack of specialists negatively impacts assured services, sending out a negative message to the community and compelling them to avail services of private health providers, leading to increased out of pocket expenditure.

Assured and safe abortion services provided with dignity and respect remains an issue in most of the facilities visited. There is a need for sensitization of doctors and nurses for rendering quality abortion services with respect and care.

Health facilities need to be strengthened in terms of infrastructure, trained manpower, drugs and consumables. Wide awareness among the community is also a gap in most of the CRM states visited.

Overall the situation of maternal health in the CRM states has improved markedly. Although maternal care services need to be specially strengthened in rural areas, more accessible maternal health care services are needed to improve the health conditions of PW, mothers and their newborn babies throughout the country.

Community awareness

Women were found aware about the importance of the ANC in states like J&K, Andhra Pradesh, Telengana, Uttrakhand, Punjab, Chhattisgarh, Maharashtra, Gujarat, and Madhya Pradesh as the ASHAs were actively mobilizing pregnant women and maintaining records of it. However in other states antenatal care awareness, particularly at the level of sub center level, was deficient in terms of range of services (Tripura, Arunachal Pradesh, Rajasthan), identification and awareness regarding danger signs (Tripura, Assam, Arunachal Pradesh, Jharkhand and Rajasthan) and orientation on newer initiative under the maternal health like calcium supplementation, screening of PW for gestational diabetes and syphilis, deworming during pregnancy (Bihar, Arunachal Pradesh). In most of the states the pregnant women were registered within the first trimester. Quality filling of MCP card and full ANC visits still remains an issue in most of the states. The main reason being lack of knowledge and training of ANMs. On the contrary in states like J&K, Telengana and Tamil Nadu filled MCP cards were found. In most of the states adequate number of IFA tablets are available and provided to pregnant women, but due to poor counseling by the frontline workers on how to consume them the uptake is very less especially in states like Bihar, Uttar Pradesh, Tripura, Jharkhand, Rajasthan, Madhya Pradesh.

Birth preparedness plan was found to be adequate in states like J&K, Andhra Pradesh, Telengana, Punjab, Chattisgarh and Uttar Pradesh. In states like Tripura, Assam, Himachal Pradesh, Uttrakhand, Arunachal Pradesh, Bihar, Maharashtra, Jharkhand, Rajasthan, Madhya Pradesh, and Gujarat, awareness regarding birth seeking behavior, high-risk pregnancies and complication readiness was low, due to ineffective awareness generation by the ASHAs and ANMs. Identification of high-risk pregnancies and line listing remains low in most of the states and is limited mainly to anemia detection.

Home-based distribution of misoprostol is yet to be effectively implemented in the states where the home delivery rates are high, such as Assam, Tripura,

Maharashtra, Uttrakhand, Himachal Pradesh, Arunachal Pradesh, and Jharkhand. Reasons for the same were lack of proper awareness and training amongst the staff.

VHND sessions are mainly limited to immunization services. For antenatal services, pregnant women have to visit the nearest SC or PHCs. This is mainly attributed to the lack of privacy during VHND sessions, untrained and unskilled ANM, availability of sub-standard kits and equipment, etc. However, in some states, Uttar Pradesh, Telengana, Chhattisgarh, Maharashtra, and Madhya Pradesh, the ANMs were aware of signs and symptoms of high-risk pregnancies and also had adequate skills for basic investigations in ANC like Hemoglobin, blood pressure, abdominal examination, and urine test.

Facility based services

The institutional delivery rate showed an increasing trend in most of the CRM states. However, the number of home deliveries were higher in some states like Assam, Tripura, Uttrakhand, Himachal Pradesh, Arunachal Pradesh, and Jharkhand. Higher rate of cesarean sections was observed in states like Tripura, Andhra Pradesh, Assam, Punjab and Tamil Nadu which is a matter of concern.

Labor rooms were found well equipped, well maintained and organized with 24*7 water supplies, power backup, separate toilets mainly at the level of District Hospital in states of Telengana, Andhra Pradesh, Himachal Pradesh, Punjab, Chhattisgarh, Uttar Pradesh, and Madhya Pradesh.

In some of the states, the knowledge, attitude, and skills of nurses and midwives were satisfactory in the use of partograph, oxytocin usage, case sheets, AMTSL, essential newborn care, etc. States like Rajasthan, Jharkhand, Gujarat, Bihar, Arunachal Pradesh, Uttrakhand, Assam, Tripura and J&K did not have adequate number of labor tables and delivery trays in relation to the delivery load. Skills for neonatal resuscitation, complication identification and management, and IMEP were also predominately lacking. States of Bihar, Uttrakhand,

Maharashtra, Jharkhand, and TamilNadu reported that most of their labor room staff is not SBA/ DAKSHTA trained.

State reports indicate, that birth waiting area/room initiative has been implemented and unique initiatives like “Maher Gher” is being practiced by a few states like Andhra Pradesh and Maharashtra, especially for women coming from hard to reach areas. Emergency management protocols like PPH and eclampsia management were limited to secondary and tertiary care settings. Below DH level, emergency management was lacking in most of the CRM states. Privacy in maternity care was found to be grossly missing in most of the facilities visited as per CRM reports.

Gross under-reporting of maternal deaths was found in the visited districts of States like Uttar Pradesh, Bihar, and Chhattisgarh. The reporting and review of maternal death still remain an issue. States reporting maternal deaths like Maharashtra and Tamil Nadu are not reporting in the prescribed GOI format. Maternal near-miss review still remains unexplored in most of the states.

In almost all states beneficiaries were aware of the JSY schemes and most of the beneficiaries had bank accounts. Free diet and free drugs were available in most of the places. However, free diagnostics and drop back facility to beneficiaries was not assured and remains an issue in states like Uttrakhand, Arunachal Pradesh, and Bihar. States like Gujarat have started new initiatives like providing ‘Sari’ and ‘ghee’ to all post-partum mothers during discharge and provide drop back facility by refurbished ambulances after their complete stay at the hospital. Andhra Pradesh is giving drop back through dedicated vehicles.

PMSMA is implemented in all the states but the quality of service provision remains an issue. In states of Uttar Pradesh, Madhya Pradesh and Jharkhand, diagnostics, and drugs are mostly limited to Hemoglobin, urine, blood sugar and USG along with IFA and calcium supplementation at district hospital during PMSMA. USG services are mostly provided at the DH level only in almost all CRM states. This is leading to overcrowding at District

Hospitals and high out of pocket expenditure, as the patients are bound to go to private hospitals for availing services. The participation of private doctors/hospital volunteers remains low in most of the states. There should be enough IEC/BCC activities to generate awareness regarding PMSMA along with the provision of service delivery at the facility level.

RECOMMENDATIONS

- ▶ Districts should analyze block-wise data of delivery points and develop specific plans for strengthening and utilization of peripheral public health facilities.
- ▶ There is a need to develop a definite plan for integrated IEC and communication activities to create awareness on the importance of early registration of pregnancy and ANC and also generate demand for institutional deliveries at the community level.
- ▶ Rational deployment of HR in delivery points for effective service delivery is required.
- ▶ The ANMs conducting home deliveries need to be trained as SBA and should be given a safe delivery kit including Misoprostol tablets.
- ▶ Accelerating NSSK training of SNs, ANMs. Refresher training for ANMs and ASHAs on essential newborn care/ home-based newborn care.
- ▶ Strengthen Line listing and follow-up of High-Risk Pregnant women including severely anemic women for providing special attention and care at referred centre.
- ▶ Optimization of USG for ANC needs to be ensured at DH and expanded USG facilities at FRUs. Private facilities could be empaneled under JSSK to ensure access of USG during ANC for women.
- ▶ Conduct referral audits to identify corrective action at referring and referred facilities.
- ▶ Capacity building of service providers for regular reporting and review of MDSR/CDR. Sensitizing District Collectors for conducting

the review and improving interdepartmental coordination and convergence.

- ▶ States to develop/implement a comprehensive Supportive Supervision plan resulting in robust feedback mechanism and action planning including regular periodic visits from state and district and follows up on the action suggested.
- ▶ More advocacy and recognition is required to involve private practitioners in the PMSMA.
- ▶ Prioritizing certification of labor room and maternity wing as per LaQshya guidelines and MNH toolkit.
- ▶ Time-bound action for operationalizing FRU for assured EmOC services.
- ▶ Capacity building of healthcare staff needs to be prioritized and Skills labs need to be established across the state.
- ▶ Hand holding support and training of the block level officials for effective percolation of health programme and to get quality feedback and reports from the ground level.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Through dedicated vehicles (Talli Bidda Express) programme provides transportation services (from hospital to home) to new mothers who deliver at government hospitals. The transportation service is provided free of cost to the beneficiaries and to date 633 thousand mothers have utilized these services.
- ▶ Birth waiting home has been made available in remote facilities of east Godavari district.
- ▶ Basavatarakam Mother's Kit is being distributed to all pregnant women who deliver in a government hospital.
- ▶ The High Dependency Unit in DH, Hindupur, Ananthapuramu is fully functional
- ▶ Free scan under JSSK was initiated from April 2018 in Ananthapuramu district and MoU has



been signed with 33 private scan centers. A total of 6195 beneficiaries have been benefited.

Arunachal Pradesh

- ▶ The community isn't aware of the assured services such as free ante-natal and intra-natal services being provided at the facilities. Also, they were not aware of the ill effects of Anaemia and the treatment available.
- ▶ There is no line listing of high-risk pregnancies with ASHA/ANM, or at any facility. As the district has not streamlined the drug procurement systems, the stock out of IFA was also observed at the facility/community for the last two years.
- ▶ At the facility level, the instruments and consumables in labor rooms are not in line with the delivery load. The instruments are not being autoclaved for safe delivery. The LR protocols are not being followed.

Assam

- ▶ ANC check-up services were found to be universally available, including the boat clinics and all health providers were generally aware of PMSMA days. However, ultra-sonography is not universally included in ANC care.
- ▶ There is a very high rate of caesarean sections (CS) at the facilities visited, which is a matter of concern, as in those facilities only elective CSs are being performed (Kamrup R), in spite of multiple OBG specialists and anaesthetist deployed. There is urgent need to review the increasing trend of CS at major delivery points including DH in Kamrup R district.
- ▶ JSSK services are delivered well in delivery point HF. However, free transport for pick up facility for pregnant women is variable. Drop backs, though, are ensured by State initiative of Adarini vehicles.
- ▶ In all locations, it was observed that the ASHAs are accompanying the pregnant mothers to the hospitals for delivery.

Bihar

- ▶ Partograph, AMTSL were well adhered to. Availability of MgSO₄ & Oxytocin and Misoprostol was found to be adequate across all the facilities.
- ▶ Certain gaping lacunae in reproductive and child health activities, like unavailability of Line listing of High-Risk Pregnancies at most of the health facilities; no MCTS due list generated or used during ANC sessions.
- ▶ Lack of availability of basic investigations in ANC (Hb, Blood Sugar, Urine test) especially below PHC level.
- ▶ Arrangement of Labour rooms was not as per standards at most of the delivery points though most of them were well-equipped to ensure privacy.
- ▶ Free Diet, Free Drugs were available at most places but Free Diagnostics and drop-back of beneficiaries requires urgent attention

Chhattisgarh

- ▶ Staff posted at labour room at all delivery points were as per delivery load in both the districts and were also trained. Knowledge of staff nurses in intra-partum care was average and they require refresher training on MH protocols.
- ▶ Labor rooms were arranged as per MNH tool kit at DH and CHC level in both the districts and NBCC corners were functional.
- ▶ Biomedical waste management practice was found satisfactory at a level in both the districts.
- ▶ Utilization of JSSK services during PMSMA day was sub-optimal and most of the pregnant women were coming by their own vehicle. Some of the drugs prescribed by Gynaecologist for HRP cases during PMSMA were not part of EDL and contributed to Out Of Pocket Expenditure.
- ▶ Maternal death review: Observed gross underreporting of maternal deaths. MDSR committees not yet formed.

Gujarat

- ▶ Sub-committee on health under the panchayat was active and prepared plan and budget.
- ▶ Mahila Arogya Samiti (MAS) was acting as a driver of change and a role model for good health practices in urban areas.
- ▶ The procurement of medicines & equipment had been streamlined by Gujarat Medical Services Corporation Limited (GMSCL). All procurements were found to be following tender procedure.
- ▶ Nearly universal institutional delivery and drop-back service (Khil-khilat) was available.
- ▶ Proper line list of high-risk pregnancies maintained and monitored at all levels.
- ▶ Skills lab found to be established and functional as per Daksh guidelines.

Himachal Pradesh

- ▶ Rates of ANC registration in the first trimester, four ANCs and rates of institutional deliveries are high.
- ▶ Labour rooms of the facilities visited had adequate supplies and space and were providing respectful maternity care. Hence, they were able to ensure privacy to pregnant women. DH Chamba has been recently LaQshya certified and CH Dalhousie was Kayakalp Award winner.
- ▶ Postnatal wards at District hospital and at the delivery points visited were clean and adequately equipped. Privacy was being ensured with provision of movable curtains in between beds. Case sheets were being maintained in delivery points visited.
- ▶ Maternal and Child Death Review Committee has been constituted, forms were being filled up and review meetings were being held.

Jammu & Kashmir

- ▶ Adequate birth preparedness was found in the community among pregnant women (PWs) and families have identified the institutions for delivery and also identified the blood donors for an emergency.
- ▶ Most of the pregnant women in the community are registered within the first trimester as verified with filled MCP card maintained at the facility.
- ▶ ASHA Ghar and DEIC have been established at District Hospital. Daily immunization services were being provided at District Hospital and cold chain is maintained. Birth dose Hepatitis B administration was observed to be timely with good maintenance of records.
- ▶ The state is yet to implement the 3Ds initiative - Free Drugs, Free Diagnostics, and Free Diet Services, comprehensively and up to PHCs & SC level. By ensuring this the out of pocket expenditure will be reduced.
- ▶ Dearth of specialists at secondary and tertiary levels was found in Kupwara district due to hard to reach and difficult areas.



Jharkhand

- ▶ Labour Rooms in the DH were found better organized, in PHC Pindrajora, labour room drugs were found contaminated but were still retained in the tray. Oxytocin was kept in the open and not in the refrigerator.
- ▶ Maternal death reporting is being conducted at the local level and there is no information of the same at the level of DM or Collector.
- ▶ Quality ANC care services in the districts need strengthening, right from check-ups to providing quality obstetric care to the pregnant mother. 4 ANC is a distant reality and very limited.
- ▶ USG is done on the 9th of every month, free of cost but the load is more on the 9th because of the PMSMA programme; rest of the days a cost of INR 350 is levied, which makes it impossible for poor pregnant women to get the USG done.
- ▶ JSY Scheme is operational in the State, but there is also a backlog of payments and the process is relatively slow. Payments are through PFMS and there is a due list which is also not being tracked.
- ▶ Home deliveries through the local elder women who are untrained in SBA are still rampant.

Karnataka

- ▶ MCH services which are pivot of NHM are being provided on PPP mode in district hospital, Udupi. The facilities being provided are good but need to be monitored closely. The IEC is



missing, government programmes are not being highlighted adequately, and protocols are not being followed. Trainings and their quality also need monitoring.

- ▶ The linkages with tertiary level institutes like Kasturba Medical College, Mangalore are commendable and they complement the public health institutions.
- ▶ The linkages with community processes are good and ASHAs and ANMs are well trained in the programme.
- ▶ The institutional deliveries are more than 99 percent but Caesarean (LSCS) rates Rate is very high (50-60%) which is an area of concern. The Government share in institutional deliveries is less
- ▶ The sub centres are well equipped to diagnose high risk pregnancies and all the facilities have sphygmomanometers, stethoscopes, glucometers to detect high risk pregnancies.
- ▶ IEC is good in public health facilities but leaves a lot to be desired in institutions running on PPP mode.
- ▶ The proportion of deliveries being conducted in PHCs is very low.
- ▶ LaQshya guidelines are not being adhered to for Labor Room up-gradation.
- ▶ Maternal Death Review (MDR) is taking place but they are not being documented well and are inconclusive. Community audits are also sub-optimal.

Madhya Pradesh

- ▶ Maternal and Child Health services occupy top priority in the state with many good initiatives being launched to increase outreach and address the high-risk pregnancies among vulnerable groups.
- ▶ Labour rooms were well equipped with the availability of trained and adequately skilled Staff Nurses but number in Betul was not adequate. Utilization at PHC/CHC level as low as 89% of deliveries in DH Betul were normal deliveries.
- ▶ All the protocols for care around delivery are being followed in both the districts.
- ▶ PMSMA is operational, however awareness and its importance regarding utilization of this facility based special additional ANC by voluntary specialists doctors needs to be disseminated in the community, as one of the key focus areas of PMSMA is to generate demand through IEC, IPC, and BCC activities.
- ▶ Importance of abdominal examination during pregnancy, identification of HRMs, danger signs during pregnancy, component of IEC about it, and referral of such women well in advance before their expected date of delivery to avert maternal and neonatal morbidity and mortality seems to be totally neglected.

Maharashtra

- ▶ Well-placed maternal health services like ANC check-up were seen. Health facilities had Hirkani Kaksh (Breastfeeding room) for ensuring exclusive breastfeeding.
- ▶ In Gadhchiroli, 'Maher Ghar' was being used by the beneficiaries from hard to reach areas, who come a few days prior to delivery and return home with a new born after delivery. Maher Ghar are functioning well as birth waiting homes and the occupancy rate was good. ASHA bring women as per EDD. The Incentives are being paid and food is being given.
- ▶ While HRP s are being identified, common obstetric complications like PIH, GDM, etc. are being

missed. Identification and assured management of HRP s need improvement. For management of severely anaemic PW, IV sucrose was being given at the higher health facilities.

- ▶ JSSK implementation in the facilities was appreciable. Delay in JSY payments (Up to 20 to 30 days) was seen in both districts owing to the difference in services point and payment points. The payment is only made from RH, irrespective of the place of delivery.
- ▶ Out Of Pocket Expenditure (OOPE) seen only for C-sections and Ultrasound done at private facilities in Satara district
- ▶ Routine diagnostics was mostly limited to the examination of BP, Hb%, random blood sugar. Tests for HIV, syphilis, sickle cell was done at higher facilities. Gestational diabetes screening was being done through random sugar instead of testing 2 hrs after consuming 75 gms of glucose.
- ▶ No assured complication management was existing because of lack of Obstetric HDU at DH/ DWH level. Delivery trays were not autoclaved during visit, Oxytocin was not pre-loaded as part of AMTS, delayed cord-cutting was not in regular practice

Punjab

- ▶ High OOPE on accounts of drugs, diagnosis, and transport is reported. Major components being drugs, diagnosis and transport (especially drop back facility).
- ▶ The state has made significant investments in terms of formulating essential drug list (EDL) for various levels of health facilities, centralized procurement system, rate contracting, three drug warehouses and online drug procurement and logistic system-e-Aushadhi. However, only 40% to 60% drugs are available at the facilities visited.
- ▶ Irrational deployment of human resources was observed. CHC Purana Shala at Gurdaspur has state of the art building and infrastructure, adequate HR but only 12 deliveries are conducted in a month and no LSCS are being done.

- ▶ Most of the deliveries conducted were institutional deliveries (both govt. and private). Utilization of 108 for referral transport was mentioned by the beneficiaries.
- ▶ Labour room at CHC, SDH, and DH were well equipped. All seven trays were available, protocols were displayed, partograph were maintained and drugs and consumables are available. Color-coded bins were available in the labor room.

Rajasthan

- ▶ “Kaushal Mangal Karyakaram” for detecting and tracking of high-risk pregnancies is well in place at all levels in the state.
- ▶ Packed nutritious food is provided to all pregnant women on PMSMA day. It includes jaggery, groundnut, fruits, amla, and biscuits.
- ▶ In most instances, full and quality ANC care was not provided to pregnant women due to late registration (primarily due to cultural practices) and poor follow-up of missed ANCs.
- ▶ Labour room protocols not followed. MDR and CDR are yet to be implemented adequately in both districts.
- ▶ In Jodhpur, C- section services not available after 2 pm in DH while blood availability and Ultrasound facility were limited only to Medical College, leading to care seeking in private sector with high OOPE. Irrational referral in case on maternal complication from DH to MC in Jodhpur.
- ▶ The MCP card was available with all the pregnant woman interviewed in the community and observed in the facility, but cards had poor record maintenance (including lack of records for Hb, BP and urine albumin).

Tamil Nadu

- ▶ The VHNDs are primarily used for immunization in Perambalur district, in Ramanathapuram, some ANC check-ups are also being done along with the Immunization schedule.

- ▶ The C-Section Rates in both the districts are quite high-about 60%, the commonest cause being Previous CS.

Telangana

- ▶ A state-specific initiative “KCR Kit” has been introduced in public health facilities since June 2017 for promoting safe motherhood and healthy child-caring practices, which has resulted in an increase in intuitional deliveries in the public health facilities.
- ▶ The State has a dedicated and motivated workforce of ANMs and ASHA workers, which has led to a high level of awareness about the ANC services in the community.
- ▶ The SC, PHC, CHC & DH were well equipped with all essential equipment (like weighing scales, sphygmomanometers, glucometers, etc), drugs (like IFA, Calcium) and infrastructure (ANC/PNC ward, standardized labour room, newly born corner, etc). However, apart from the MCH wing, there is hardly any uptake of services at the public health facilities.
- ▶ The PMSMA footfall at the PHC, Gangadhara was about 80-100 ANCs on 9th of every month. However, the routine ANC and deliveries at PHCs were low, and most pregnant women preferred to go to MCH Hospital at DH for C-Section.
- ▶ District Hospitals provide free food to all IPD cases whereas in peripheral institutes without kitchens, the mothers are provided Rs. 100/ day.

Tripura

- ▶ Most of the ASHAs are not aware of the criteria to identify high-risk pregnancies among pregnant women, nor had they received any information or training on the same. Further, no ASHA, ANM, and AWW are aware of the Pradhan Mantri Matru Vandana Yojana (PMMVY).
- ▶ Home deliveries are common among tribal pockets of Ramdhalaipara (Unakoti district) and mostly conducted by non-SBAs, who are mostly relatives.

- ▶ Referral transport services for delivery is not available in the state and found to be managed by the community themselves.
- ▶ None of the labor rooms visited were following protocols. Asepsis management in the labor rooms, ANC waiting areas, PNC wards were all found to be poor. Instruments are being sterilized in the sterilizers while autoclaves are lying unused. Necessary five/seven trays in facilities were missing.
- ▶ The ANMTC in the district is also non-functional. HRP line listing was not found in most of the visited facilities in Varanasi.
- ▶ Beneficiaries were aware of the PMSMA and are availing services (Free antenatal care) on 9th of each month at public health facilities. It was verified during facility visit that all the ANC services: Haemoglobin, urine and blood sugar are checked, IFA and calcium supplement is given and Injection TT. Round the clock lab facility was not available in DWH Farrukhabad.

Uttar Pradesh

- ▶ Beneficiaries were aware of the PMSMA, importance of antenatal care, postnatal checkups and institutional deliveries, JSY entitlement, JSSK and 108 services.
- ▶ The community is and are availing services under PMSMA and the same (Free care) on 9th of each month at public health facilities. It was verified during facility visit. That all the ANC services: Haemoglobin, urine and bloodsugar are checked, IFA and calcium supplement is given and Injection TT. Round the clock lab facility was not available in DWH Farrukhabad.
- ▶ Community members however preferred private health facilities for intranatal services as they are accessible and perceived safer in both districts.
- ▶ Both districts had well organized and maintained labor room, in line with the MNH toolkit, was seen in both districts. Partographs, essential and emergency drug tray were prepared and maintained. Zoning and triaging were however absent.
- ▶ The nurses in CHCs are undergoing mentoring on a continuous basis, maternal & new born care processes and outcomes are being tracked.
- ▶ In DWH Farrukhabad there was a severe dearth of staff nurses²⁴ by 7 lab services and ultrasonography was unavailable resulting in high out of pocket expenditure. To add on the C-section rate is abysmally low (3%).

- ▶ Beneficiaries were aware of the PMSMA and are availing services (Free antenatal care) on 9th of each month at public health facilities. It was verified during facility visit that all the ANC services: Haemoglobin, urine and blood sugar are checked, IFA and calcium supplement is given and Injection TT. Round the clock lab facility was not available in DWH Farrukhabad.

Uttarakhand

- ▶ Good awareness amongst the community about JSY and JSSK schemes.
- ▶ ASHAs are routinely accompanying pregnant women for their deliveries.
- ▶ The numbers of home deliveries are high. Moreover, the proportion of deliveries conducted by skilled health personnel was less. ASHA was not aware of the use of misoprostol.
- ▶ Community awareness about JSY and Immunization was found satisfactory. All cases delivered in public health facilities received incentives through DBT.
- ▶ None of the facilities visited had the pregnancy test kits. ASHA did not have them either. ANMs in HSC had some kits which were supplied by the government but they were reportedly faulty. ANM had to buy PTKs from the market from untied funds.
- ▶ Birth companion were not allowed during delivery.

3.2: NEWBORN AND CHILD HEALTH

NATIONAL OVERVIEW: NEW BORN HEALTH

As per NFHS IV, early initiation of breastfeeding, within 1 hour of birth, is reported to be 41.5%.

and varied from 25.4% (lowest) in Uttar Pradesh to 75.4% (highest) in Goa. The national average of exclusive breastfeeding among children till six months, has increased from 46% in 2005-06 to 55% in 2015-16. However, as reported, many children under 6 months are given other liquids, such as plain water (18%), other milk (11%), or complementary foods (10%), in addition to breast milk. The community awareness on importance of early breastfeeding and exclusive breastfeeding has been steadily increasing and found to be satisfactory, but the practices of the same varied across states. Some cultural factors, myths and taboos are still prevalent and impede optimum breastfeeding practices, for instance, The taboo / myths of not giving the first expressed milk (colostrum) to the child were still prevalent amongst the tribal communities of Bihar. The acceptance of optimum breastfeeding practices amongst the women opting for institutional deliveries was seen to be higher.

The community awareness about danger signs of various childhood illnesses was found inadequate in all the states. Awareness and practice of Kangaroo Mother Care (KMC) in case of preterm babies, was also found lacking in majority of the states, in both the community as well as facility level.



Acknowledging the fact that critical care for sick new borns can reduce neonatal mortality, 794 SNCUs, 2329 NBSUs and 18570 NBCCs have been established in the country, to provide services for newborns [MIS report]. Such initiatives have helped in reduction of NMR from 39% in NFHS III to 29.5% in NFHS IV. SNCU online reporting system has been introduced in 28 states and almost 90% of the facilities are reporting SNCU services online. However, the functionality and service delivery need further improvement. Essential newborn care need to be mandatorily practiced at all facilities across the country. The NICU and PICU services have been established at states but the quality service delivery needs to be built upon.

KEY OBSERVATIONS

COMMUNITY

Breastfeeding

Community awareness about early and exclusive breastfeeding was found satisfactory in all states but translation of that awareness into actual practice requires more concerted effort. In almost all the communities, VHND was the most common platform utilized for counselling on feeding practices, immunization and healthy lifestyle. Exclusive breastfeeding was observed as a challenge in states like Jammu & Kashmir, Rajasthan, Tripura, Assam, Bihar and Jharkhand, where use of ghutti, honey, boiled water and bottle feeding are seen in practice. Telangana and Tripura had delayed breastfeeding for newborns due to high number of caesarean section deliveries in the state.

Home Based New Born Care

In majority of the states visited, ASHA are not getting adequate mentoring & supervisory support by ASHA facilitator / block or district community mobilizer. Community awareness of kangaroo mother care in cases of LBW and pre-term babies was found inadequate in most of the states. While, states like Maharashtra, Telangana and Andhra Pradesh had regular ASHA visits, HBNC services

were rather irregular in other states. In states of J&K, Assam, Bihar, Jharkhand, Uttarakhand, Tripura almost all the mothers reported less than six visits made by ASHA in the community.

State of Jharkhand, with the support of UNICEF, has established an online management information system (**Sahiya Sangi Portal**) for strengthening HBNC.

Intensified Diarrhoea Control Fortnight Programme

Awareness amongst community on management of diarrhoea and preparation of ORS was satisfactory in all the states except amongst the Kamrup community in Assam. ORS & Zinc were distributed by ASHA and mothers knew how to prepare ORS. However, in Assam, instances are noted where dry ORS powder or small amounts of ORS solutions prepared as soft drinks (sharbat) were being administered. Suboptimal awareness of childhood illnesses amongst community in states like Bihar, UP, Maharashtra, Arunachal Pradesh and Andhra Pradesh was seen. Inadequate IEC activities, shortfalls in Zinc & ORS stock and fewer number of home visits by FLW was seen.

In Satara district in Maharashtra, a very good practice in institutional deliveries and assisted home deliveries was seen. A woman plants a tree sapling at home at birth of a child and every year birthdays of both the child and tree is celebrated together. Around **12,000 such trees** have been planted in the PHC area.

FACILITY

Essential new born care

The concept of Essential Newborn Care varied amongst states. In Gujarat & Maharashtra, Essential Newborn Care protocols were followed including drying of newborn, skin to skin contact, early initiation of breast feeding, delayed cord clamping etc. However, states like J&K, MP, Uttarakhand and Bihar need to strengthen the services by focussing on the factors of: lack of skill development trainings for ENC, NSSK, SBA & IYCF & KMC. Refresher trainings as a regular activity need to be carried out in all the states.

Kangaroo Mother Care

KMC services varied across states. States like Punjab, Gujarat, UP, Telangana and MP, KMC was practiced as an essential component of care of LBWs in health facilities, whereas inadequate practices at DH Uttarkashi in Uttarakhand, J&K, Tripura and Jharkhand were observed. However, KMC advocacy at community and its services at facility need further strengthening throughout the country.

New Born Care Corner

New born corners were present in all the facilities visited. However, utilization is one of the major concerns. A number of states, such as Tripura, Bihar, UP and Jharkhand reported non-functional NBCC at some of the facilities due to non-availability of equipment maintenance protocols in place.

New Born Stabilization Unit

Most of the states have established NBSU services at the facilities but the utilization rate varied across the country. States like Telangana & Tamil Nadu reported high admission rates. 50 NBSU units were found functional at Telangana. Other states such as J&K, Assam, Uttarakhand, Bihar, UP, Chhattisgarh and Tripura exhibited underutilization or non-functional NBSUs, reason being untrained staff or inadequate manpower to manage the facility.

Sick New born Care Unit

A total of 14 states reported availability of SNCU services at the facilities. The states are Chhattisgarh, TN, MP, Himachal Pradesh, Punjab, Gujarat, Maharashtra, Telangana, Rajasthan, Bihar, UP, Tripura, J&K and Jharkhand. The functioning of SNCU varied from state to state. The major reason was lack of adequate human resource in states like UP, Jharkhand, J&K, Assam and Tripura. Trained manpower was found at almost all the facilities visited except at Bihar Medical college, where the Staff Nurses were not trained under FBNC, including observer ship. No protocols were maintained for infection control and antibiotic policy in most of the facilities visited. Community based follow up for sick newborns, once discharged from the facility was found inadequate at all the states. It was noted

that in Jharkhand, Tripura, Bihar & Tamil Nadu, the primary causes of death in most of the admitted cases were birth asphyxia and sepsis.

In Rajasthan, SNCUat Family Care Centre Baran is one of the good facilities observed. The mothers of the newborns admitted in SNCU are provided information and counselling on hand washing practices, feeding of low birth weight babies, KMC etc. State of the Art Human Milk Bank (Aanchal) is also operational at DH Baran where utilization of donated milk for the year 2017 was seen.

In Tamil Nadu, DH is equipped with Milk Banking programmes. This initiative has resulted in provision for milk and colostrum for the vulnerable newborns.

New born Intensive Care Unit

States like Jharkhand, Bihar, Tripura, Himachal Pradesh, Assam, UP, Gujarat have established the NICU services at their respective medical colleges. The facilities are being provided for sick new borns. However, it was observed that most of the facilities were managed by post graduate students and staff nurses and many of them lacked training for the FBNC & other NICU services.

In Jharkhand, Rajendra Prasad Institute of Medical Sciences has NICU unit managed by the resident doctors and hospital nurses. Approximately 2000 babies were admitted in the NICU of which 75% babies were out born; 570 died (30% mortality). Birth asphyxia contributed to 42% of the deaths and complications of prematurity 30%. 45% deaths were within 24 hours of admission. Assam, NICU (56 bedded) at Guwahati Medical college for the districts visited.

Gujarat, Balsakha Yojna – State has initiated partnership with private pediatricians in PPP mode to provide services to children up to one year of age. The latest addition in the scheme is Balsakha -3 which consist of admission of newborn in NICU.

NATIONAL OVERVIEW: CHILD HEALTH

As per NFHS IV, 54% of children under six years of age receive one or more services from the AWC. Out

of those receiving services, most likely, the provision of food supplements accounts for 48%, the services related to growth monitoring, immunization, health check-ups, and early childhood care or preschool services range from 38% - 43%. During the CRM visits, it was noted that complimentary feeding practices to children under 6 years of age continues to be a point of concern. Growth monitoring in the community by field level workers was also sub optimal and needs to be improved.

The immunization services have been improved from 43.5% (NFHS III) to 62% (NFHS IV) in the context of fully immunized children. During CRM visit it was observed that initiatives like Mission Indradhanush, have contributed to scaling up full immunization in the community.

The estimates from HMIS for 18-19 (till October'18) show that 19,41,245 newborns have been screened for defects after birth as compared to the previous years' number of 13,90,421. The total number of children identified with disease and developmental delay were 40,47,621 and the ones managed with medical intervention were 40% (16,23,246), by surgical intervention were 1.8% (73068) and under DEIC were 0.63% (258418). The RBSK screening and follow up mechanism has improved over time across all the states. However, the facility linkages need to be strengthened. The HR, infrastructure, referral transport, specialist, tie ups for critical surgical procedures were reported to be the major reasons for non-functioning DEIC, which are a system related issues that could be improved with time.

KEY OBSERVATIONS

COMMUNITY

Infant & Young Child Feeding & Mothers Absolute Affection

The IYCF programme has been initiated in all the states. However, awareness about complimentary infant & young feeding practices in the community was unsatisfactory across all the states. In most of the states, the FLW were not aware about the

growth milestones of a child nor could they explain the importance of complimentary feeding, IYCF & MAA programme benefits, which was reflected in the community. Follow up of NRC discharge children was found lacking at community level in all districts visited. None of the states had complete growth charts plotted in the MCP card as seen in the community. Appropriate BCC activities for nutrition enhancement could not be found anywhere across the states. In Assam, most of the counselling for feeding practices was seen during VHNDs instead of dedicated mothers' meeting as recommended by MAA programme guidelines. Use of formula food for children and bottle feeding was seen amongst Assam & Tripura community.

Growth Monitoring

Level of growth monitoring was negligible in all the states. In states like Bihar and Arunachal Pradesh, none of the ASHAs had any kit for home visits, weighing machine, MUAC tape, measuring tape etc. for growth monitoring. However, in district Satara, Maharashtra, there is good utilization of VHSNC funds for purchase of infant meter and additional nutritious food/therapeutic food for SAM/MAM children identified at Aanganwadi centre. In Bihar, growth monitoring was restricted only to AWC and not being done through the VHND. In Chhattisgarh, mitanin did not have growth measuring equipment, such as weighing scales, thermometer etc.

JSSK

Awareness about free drug and diagnostic services, free transport services under JSSK was lacking amongst all the communities visited. In Gujarat, although transport services for sick infants are available, information regarding the same is found poor in the community. None of the villagers interacted with shared any experience related to usage of transport services. In Andhra Pradesh & Bihar, the community is not aware of neonatal transport service.

Immunization

The awareness in community about the immunization and its importance was satisfactory at all the states except in Assam. The challenges for immunization services at Assam were: a) short supply of JE Vaccines,

b) access compromised areas e.g. Char areas where there are issues of shifting populations and c) densely populated minority communities where community mobilization is an issue. The immunization based micro plan at sub centres was not seen in Assam, J&K, Bihar, Jharkhand, Tamil Nadu, Punjab and Maharashtra. Follow up for immunization was found suboptimal due to inadequate planning and unused due list with ASHAs in these states. Inadequate micro-planning of vaccination sites in urban area was recorded across the states, especially in Maharashtra & Rajasthan.

FACILITY

Immunization

All states reported "Zero" dose administration of OPB, BCG & HepB as satisfactory except in Jharkhand. Cold chain management, Open Vial Policy and Alternate Vaccine Delivery were observed as being adequately followed in all the states except in states like Tripura, TN & J&K. However, in TN, the Public Health Nurse was making manual registers based due list. In Rajasthan, ASHA/ANM were carrying the vaccines to the immunization sites on the day of immunization. In J&K, ILR was used for the storage of other drugs along with vaccines. Moreover E-VIN was seen in practice in some states such as Chhattisgarh, UP, Jharkhand, Rajasthan and Himachal Pradesh. Records and documentation were in place at most of the facilities except at Assam, UP & Maharashtra where duplication/mismatch in the reports was present. Practice of new vaccinations in the field was seen across the states however stockouts for vaccines such as JE vaccine in J&K, Assam & Jharkhand, MR vaccine in Punjab was recorded.

In Bihar, a Model Immunization Center (MIC) has been established to provide 24X7 immunization service in the city. In Gujarat, staff nurses in urban areas used to visit private facilities empanelled under Chiranjeevi Yojna to vaccinate newborns for birth vaccines. Regular Immunization sessions held in each facility once per week. In Telangana, New District Vaccine Stores have been established in all the newly formed 31 districts of the state after reorganization into 31 districts. On a pilot basis,

10 vehicles have been provided to the districts to cover the immunization in Difficult / High-Risk Areas. Regular surveillance is conducted for VPDs like Measles - Rubella and AFP surveillance for Polio.

RBSK

Excellent RBSK team work was observed at three states of Tamil Nadu, Karnataka and Himachal Pradesh, where assessment, counselling, referral, school & community linkages, distribution of IFA, deworming tablets & other protocols were in place. However, states like J&K, UP, Chhattisgarh, Maharashtra, Telangana, Punjab, Andhra Pradesh, Rajasthan, Assam, Tripura and MP although have RBSK teams functioning in the community, but they need to strengthen the services. The teams are working in the field but do not carry the drugs and instruments, the linkages with AWC & ASHA are inconsistent, follow up and referral of cases are few in number, distribution of IFA & deworming tablets is suboptimal. TN is the only state where screening of birth defects was regularly in practice at facility and community both. Linkages of RBSK programme with facility based DEIC is a critical component.

DEIC

Telangana, Karnataka, Arunachal Pradesh, Gujarat, Tamil Nadu have functional DEIC in facilities visited. In states like Tripura, J&K, Assam, Uttarakhand, Bihar, Chhattisgarh, UP and Satna in Maharashtra, DEIC has been established but not yet functional in the districts visited. The reasons have been non availability of HR, equipment, training of the available staff members, lack of awareness in community and weak linkages of community to facility DEIC services. The cases even if identified are referred to other district facilities due to non-availability of services.

NRC

Good NRC practices was observed in states like Maharashtra, Chhattisgarh, Andhra Pradesh, Telangana and Jharkhand, where services of admission, discharge, management were found as per the protocols. 65-70% of bed occupancy was observed at Chhattisgarh & Andhra

Pradesh. Although Jharkhand has established 93 malnutrition treatment centres & also using an IT platform, in Ranchi these centres were found underutilized. One of the major reason could be the discontinuation of incentives for the Sahiyas for bringing malnourished children to the MTCs. Limited resources of workforce and infrastructure in states such as UP, Bihar, MP, Assam, Telangana and Andhra Pradesh were recorded. In Narmada, Gujarat NRC was functioning like a day care centre. This type of arrangement causes incomplete treatment to patients as once gone some patients do not come back. In Bihar, wage loss is given @ Rs 50/day to the mother accounting approximately Rs. 30,000/ month given through account payee cheque. Field linkages for referral and community follow up of discharge cases were found sparse in all the states. Record & documentation need to be strengthened at all the NRCs visited.

CDR

The review of child death was found inadequate in states like J&K, Maharashtra, Chhattisgarh, UP, Bihar, Jharkhand, Rajasthan, Bihar and Tripura. Some states like MP were reviewing 70% of child death cases but the process of analyses & action planning as per the reports was not seen in place, thereby losing an opportunity to plan to reduce deaths due to preventable causes. In Karnataka, child death reporting and its facility-based review were being conducted. But community level death audits were not taking place satisfactorily.

RECOMMENDATIONS

- ▶ Prioritizing community awareness regarding nutrition: complementary feeding along with early & exclusive breastfeeding upto 6 months of age, growth milestones and common childhood illnesses such as diarrhoea and pneumonia by increasing IEC activities, access to JSSK entitlements etc.
- ▶ Ensure all time availability of adequate stock supply of zinc, ORS, growth monitoring instrument to all FLW and monitoring of the same in the field for the practice to be strengthened.

- ▶ Community level High impact interventions like Gentamycin usage by ANM for Acute bacterial infections needs to be started.
- ▶ Monthly review of critical care units: SNCU, NBSU, NICU, PICU at district and facility level to identify critical factors, service quality by using SQCI (SNCU Quality of Care Index), action planning and ensure timely gap filling and corrective measures.
- ▶ All monitoring mechanism including SNCU review meeting, Child Death review meetings should be done for district hospital and medical college together to have a complete picture of the district and actions needed to be followed up.
- ▶ The district and state should monitor critical indicators for service delivery like percentage screened, percentage referred, percentage completed treatment at various levels and also the performance of the team.
- ▶ Strengthen MDSR/CDR by focusing on the District Collector review on activities relating to interdepartmental coordination and convergence.
- ▶ The FPC (Family Participatory Guidelines) of Government of India, if used properly can help in greater participation of the families in baby care in a structured manner. As the KMC Rooms already exist at many facilities, it should be taught & learnt by families in every institution.
- ▶ Conduct various trainings and periodic refresher training of FLW, ANM, Staff Nurses, Nutritionist, Counsellor, MO, Paediatricians and other on the programmes: Module 6 & 7, NSSK, MAA, HBNC, HBYC, NDD, IDCF, KMC, JSSK, IYCF, IMNCI, SAM, MAM and other.
- ▶ Training of frontline workers in routine immunization, cold chain handlers in basic knowledge logistics managements, MOs in Immunization & IDSP.
- ▶ There is a requirement to establish Skills lab at DH as per the state requirement for developing DH into a training hub.
- ▶ Intensify demand side interventions in Routine Immunization programme. Focus on micro-plan, due list, communication plan and social mobilization activities would address demand side issues.
- ▶ Records & documentation: quality data analysis of HMIS, consolidated & simplified reporting mechanism, Plan of Action and Work Plan of ANM, validation of data.
- ▶ Use of standard registers and reporting formats. ASHAs and registration system of RGI is to be utilized optimally for improving death reporting. State like Maharashtra should make roadmap for 100% registration of births and deaths.
- ▶ Implementation of RBSK programme needs to be strengthened. MHTs to have proper plan equipment for correct diagnosis, assured mobility support, availability of required drugs, school & community visits & with proper linkages with DEIC.
- ▶ To Functionalize DEIC: HR Positions including specialist for DEIC need to be filled, training of the staff, drug & equipment supply to be ensured.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Awareness of early initiation and exclusive breastfeeding, immunization services, diarrhoea, anaemia and use of IFA tablet etc. was present but Knowledge about complementary feeding was insufficient in the community.
- ▶ Micro-plan visit of RBSK team for 6 months was prepared and available but doesn't carry any medicine with them and for all ailments refer to nearby health facilities.
- ▶ However, ANMs & ASHAs were not aware of the RBSK team's visits plan in advance and mobilization of children at the AWCs was not taking place.
- ▶ There was no mechanism to follow-up about the status of children after referral by the RBSK mobile team3

- ▶ Parents at NRC, with children >1 year were unaware about the free transport facility under JSSK and used private vehicles.
- ▶ District Ananthapuram had no designated skill laboratory for training.
- ▶ In the urban areas, immunization services were not provided at the community level/ AWCs
- ▶ NRC functioning in Teaching Hospital, E. Godavari with a monthly footfall of 65-70 was doing well but facing shortage of manpower and also some medicines were procured by clients from the outside
- ▶ ASHAs in few areas don't have the due list for the immunization.

Arunachal Pradesh

- ▶ Community was not aware of the newborn danger signs and early childhood illnesses due to the negligible home visits by ASHA. The mothers of low birth weight babies had not been given any specific instructions regarding KMC.
- ▶ The MCP card was available with all mothers with details about immunization. However, none of the cards had details about the growth monitoring of children. Also, the lack of growth monitoring can be attributed to the fact that none of the ASHAs had weighing machine, MUAC tape, measuring tape etc for growth monitoring.
- ▶ The revised MCP cards were not available in the communities and PHCs/CHCs.
- ▶ Also, the screening at birth wasn't seen at any facilities visited.

Assam

- ▶ As per State report, Gaps found in deployment of Staff Nurse (34%) and MOs (29%) and paediatricians (50%) in the State as per the requirement.
- ▶ AEFI cases were reported in "Others" category but AEFI details were missing in registers.

- ▶ RBSK: More than 67% of target beneficiaries were screened under RBSK programme in Barpeta district during 2018-19.
- ▶ DEIC was yet to be established in Kamrup and Barpeta districts. Referral and free treatment component of RBSK services were hampered in the districts visited.
- ▶ NBSUs established in Kamrup were non-functional and referred to medical colleges because of this appropriate and timely care of sick newborn was a concern.
- ▶ SAM screening at community and referral for facility based management of sick SAM cases was to be prioritised as evident by very low bed occupancy (<30%) in NRC at Barpeta district.
- ▶ Health facilities had established ORS and zinc corners for diarrhoea management in Barpeta district. However, there was a lot of information gap on preparation and administration of ORS in the community.

Bihar

- ▶ Community awareness on feeding practices, complementary feeding and danger signs of illnesses in infant was found to be inadequate, especially amongst the vulnerable and hard to reach communities where many SAM children were seen.
- ▶ Anganwadis provide the supplementary feeding and egg for children but the concept of growth monitoring was lacking in the health workers. The MUAC tapes were not available with ASHA or ANM for community level screening of SAM.
- ▶ The knowledge of identification of infant or child with suspected bacterial infection was lacking and the practice of the high impact intervention of Inj. Gentamycin usage by ANMs for suspected sepsis had not yet started.
- ▶ KMC corners established at DH Sasaram and SDH Dehri but ASHA not informed to follow-up beneficiaries for KMC in respective villages.
- ▶ No DEIC sanctioned in Rohtas district. Curative and rehabilitative services are provided by

PMNCH Patna and the transportation cost borne by the parents. RBSK team at Kathra in was equipped with only BP apparatus, weighing scale and height measurement scale. No job aids were available with the RBSK team. Out of the recommended 32 drugs only 13 were available with the team.

- ▶ Muzaffarpur has a nonfunctional DEIC started 2 months back.
- ▶ The Medical college SNCU was very small and congested. At the Medical college, the Staff Nurses were not trained under FBNC including observership. No protocols maintained on infection control and antibiotic policy. female and male admissions were 35% and 63% respectively. Almost 70% of all admissions and 75% of all deaths were related to perinatal Asphyxia and death occurred within a day. LAMA rate is 22% for want of adequate critical care services and they went to private facilities.
- ▶ The community and facility follow-up of SNCU discharged babies are being conducted in 1/3 of cases and the quality of community follow up is inadequate at ASHA level.

Chhattisgarh

- ▶ Community awareness level was good on child health practices such as use of ORS, breastfeeding, immunization, complementary feeding and various community-based programme such as National Deworming Day, Rashtriya Bal Swasthya Karyakaram.
- ▶ Mitanin were aware of GOI recommendations for HBNC, Immunization, NDD and IDCF and are making household visits as per the activity schedule.
- ▶ SNCU discharges and NRC discharges follow up in the community was weak.
- ▶ SNCU at Medical College, Raipur were overcrowded and no admission protocols observed in the unit. It was also noted in medical college that several essential commodities were out of stock. Infection prevention protocols were compromised and

there was indiscriminate use of drugs, oxygen and antibiotics. The monitoring for the oxygen usage was also not being done strictly including the upkeep of ventilators. Human resource was managed through EKAM foundation (HR selection, appointment, and trainings).

- ▶ SNCU- Korba, regular microbiological samples and environmental samples were sent for culture and sensitivity at AIIMS Raipur, this has resulted in reduction of overuse of antibiotics in the SNCUs.
- ▶ KMC services needed strengthening as no patients were admitted. No records are maintained and no IEC for KMC was seen in either SNCUs.
- ▶ 10 bed NRCs were functional in both the districts (one at CHC level and one at DH level). All staff is trained with Bed Occupancy Rate (BoR) of around 60-65% in both the districts and major referrals were from AWW and RBSK teams. Record maintenance and follow up of discharged cases were the major challenge.
- ▶ No Child Death Review mechanism at community level and facility level.
- ▶ Both the districts had good coverage of immunization as per record, Korba district was also part of MI activities under eGSA programme. Birth dose were given to all babies delivered at facility level. Both the districts had implemented e-VIN system.
- ▶ The Mobile Health Team (MHT) faced difficulty in approval process for heart surgeries due to which surgeries got delayed.

Gujarat

- ▶ Information regarding free transport services was found poor in the community so, Private facilities were used even for general illness among children.
- ▶ Linkage with AWCs was good for young child care and weight monitoring.
- ▶ None of the CHCs visited in Porbandar district had functional NBSU.

- ▶ Essential Newborn Care protocols were followed. However, concept of delayed cord clamping varied among service providers in Porbandar district.
- ▶ Functionality of DEIC was suboptimal. In Porbandar, there was no audiologist and speech therapist. The dentist and dental technician were underutilized due to unavailability of dental chair. Field referral was poor. Strengthening physiotherapy services was desired by beneficiaries.
- ▶ ASHAs were not carrying out of Growth Monitoring of children.
- ▶ RBSK teams visit schools for screening of children for 4 Ds but the visits are irregular because of unavailability of vehicles.
- ▶ DEIC were established at District Hospital but non-functional due to unavailability of HR and equipment.
- ▶ Child Death Review is not in place.

Himachal Pradesh

- ▶ Childhood immunization services were good. State had taken a policy decision of making age appropriate vaccination essential for school admission. However, as reported, admissions would not be denied on grounds of incomplete immunization.
- ▶ Home based newborn care provision needed some attention as it was observed that the ASHA could not recall most of the danger signs. ASHA kits were replenished almost a year back and had non-functional thermometers.
- ▶ In terms of immunization, adequate arrangements for maintenance of the cold chain were in place, eVIN was operational and data records were present.
- ▶ The RBSK teams did not have the complete set of equipment's and had nil supplies with them.
- ▶ No nutrition rehabilitation centre in the districts visited
- ▶ Vehicles under RBSK had been hired on contract and the agency based in Chandigarh. Hence, challenges being faced in plying of these vehicles that resulted irregular movement and service provision.
- ▶ ASHAs were not carrying out of Growth Monitoring of children.
- ▶ RBSK teams visit schools for screening of children for 4 Ds but the visits are irregular because of unavailability of vehicles.
- ▶ DEIC were established at District Hospital but non-functional due to unavailability of HR and equipment.
- ▶ Child Death Review is not in place.
- ▶ Protocols of essential new born care were not being followed such as unavailable sterile towel for newborns and practice of immediate cord clamping & cutting in the labour room
- ▶ Staff nurses/ANM's posted in the labour room of District Hospital Handwara had not received the training of SBA, NSSK, Kangaroo Mother care and PPIUCD.
- ▶ SNCU at CHC Bhadarwahwas underutilized in -spite of Paediatrician and necessary infrastructure. Services catered mostly to the inborn cases (89%) and 32% cases were referred to the higher facilities. MPW-F at SNCU not trained in NSSK. Kangaroo Mother Care (KMC) corner for the care of Low birth weight babies was not found.
- ▶ Inappropriate vaccine stock management with frequent stock-outs were observed at the block level. Staff was aware of open vial policy under UIP but not practicing uniformly.
- ▶ NBSU was non-functional in the Sub-district Hospital Tanghdar and Kralpora.

Jharkhand

- ▶ The Rajendra Prasad Institute of Medical Sciences had a 16 bed SNCU sanctioned to the department of paediatrics under National Health Mission. It was managed by three doctors (Paediatricians) and 14 staff nurses while NICU was managed by resident doctors and hospital nurses.
- ▶ In 2017-18 - Six SNCUs were functional. Total 2721 babies were admitted in the six SNCUs in 2017-18. 21% cases were admitted for birth

Jammu & Kashmir

- ▶ At community, minimal knowledge of malnutrition and complementary feeding, Measles Rubella vaccination campaign was seen.

asphyxia, and the SNCU mortality was 12.4%. Referrals and LAMS were 13.6% and 11.2% respectively.

- ▶ Routine Immunization was being done, but not covered well in all the blocks. In Chas block of Bokaro district, it was observed that children who missed the Zero dose were given the dose after 4 months and therefore the further doses were mostly blocked. If there is a left-over dose, the Sahiya follow up was also not there and it was not observed in the due list of the Sahiya. Gap in home delivered babies for new-born care and also a gap in immunization. Around 30% of the cases didn't have zero dose in facilities below DH, Bokaro, even in Bokaro DH, there was a gap in zero dose.
- ▶ HBNC: In Bokaro, Sahiya visits to the newborn were limited to just once or twice in lieu of 6 visits, mostly visit happened when the child fell sick. Mothers in Sharu Beda Village of Nawadih block were not aware of the services of a Sahiya for the newborn. In case of home delivery, visit to the newborn happened rarely in some complication
- ▶ Pindrajora PHC, Bokaro, did not have a newborn corner. Some facilities were using a bulb over the bassinet as a warmer.
- ▶ All FRUs did not have NBSUs such as one of the best FRUs in Ranchi – Ratu did not have a NBSU. The NBSU in Sonahatu CHC was not being used. There were three radiant warmers and the hospital staff was not aware of the availability and functionality of the phototherapy unit. No record keeping being done in the NBSUs. The Hospital had one paediatrician but no staff nurse in the NBSU.
- ▶ RBSK: In Bokaro, the programme was not as per the guidelines because of less manpower and training. Screening was limited to information collection and basic anthropometry readings. Cases identified, had not been treated.
- ▶ Major gaps in the skills of ANMs posted in labour rooms on both obstetric as well as newborn

care were observed. The ANMs had been trained in SBA three to four years back and only some remembered Dakshata and NSSK training.

- ▶ In Bokaro, breastfeeding within one-hour services was poor. The use of rock sugar candy, honey and sugar water was prevalent.
- ▶ Child Death Review: Infant and child deaths were reported but not reviewed properly.
- ▶ Sahiyas did not have adequate knowledge of HBNC and RBSK.

Karnataka

- ▶ 40 Special New Born Care units (SNCU), 169 New Born Stabilization Units (NBSU), 1301 New Born Care Corners (NBCC) are established under NHM and are utilized. Pediatric ICU services are also available in higher centres.
- ▶ Functionality varies in different institutions.
- ▶ SNCUs in district hospitals have breast feeding corners and Kangaroo mother care cots but lack ventilators and provision of Surfactant therapy (Chikmagalur).
- ▶ Good Kangaroo Mother Care (KMC) facility, breastfeeding corners and step-down nursery were functional in district hospitals. Staff was well trained and motivated.
- ▶ Unlike the rest of the country, above 90% targets in routine immunization was achieved with reduced number of sessions in the State Outreach sessions were rarely conducted.
- ▶ NRCs visited have good infrastructure- clean toilets, clean kitchen with F75,
- ▶ F100 formulas and Menu of food items displayed and followed in Chikmagalur, although facility was under-utilized. Community screening of Severe Acute Malnutrition (SAM) children was not done. NRC was not functional in District Hospital Udupi.
- ▶ RBSK had good linkages with the community and ASHAs/ANMs. Real time GPS and biometric

- attendance on mobile with real time monitoring by RBSK app was witnessed in Chikmagalur.
- ▶ District Early Intervention Centre (DEIC) in district head-quarters was referring beneficiaries for various interventions to higher centers, including costly surgeries and implants. 6047 surgeries were done after screening 1.28 Crore children last year. 17 cases were operated from April to September, 2018 in Chikmagalur district alone.
 - ▶ Migration of MCTS to RCH Portal—ANMOL was in progress.
- ### **Madhya Pradesh**
- ▶ Anganwadi centre: importance of growth charts, its monitoring and proactive role of AWWs on focussed IEC activities was not observed. Moreover, as per estimation, not more than 50% of children were regularly attending AWCs.
 - ▶ CDR: Key observations, especially on preventable causes, their attributable and corrective actions were not shared regularly with medical officers and health staff, to prevent similar deaths in future. As against estimated maternal and infant deaths, not more than 70% deaths were recorded and reviewed.
 - ▶ NBCCs and well-functioning SNCUs with sufficient number of trained staff in the district. But late referral of neonates and considerable still births including macerated still births in district hospitals represents poor quality of antenatal services in the field as observed in Rajgarh.
 - ▶ Screening of children under RBSK was being carried out as per guidelines, but follow-up of the diagnosed and treated cases at tertiary level needed improvement.
- ### **Punjab**
- ▶ Identification and referral of sick new born after HBNC visits found lower than expected.
 - ▶ Focus on child care in urban area was found lacking.
 - ▶ Use of cotrimoxazole was not known to ASHAs and interaction with the state revealed that it was not being supplied in non-tribal districts.
 - ▶ Only 103 child deaths reported in Satara which is lower than estimation.
 - ▶ Village Health Nutrition Days(VHNDs) were mostly held at AWCs around twice a week (Tuesday and Friday), other than the SC villages. Moreover, it was mostly limited to Immunization services.
 - ▶ Rashtriya Bal Swasthya Karyakram (RBSK): RBSK Teams were available as per guidelines with one male and one female Ayurveda doctor; one pharmacist and one ANM/nurse. Micro-plans were available with the team. Visits were being made to AWCs and schools. Screening of children was being done and referrals being made. However, screening at birth was not taking place.
 - ▶ Incoordination noted between RBSK team & ASHA/ANM which resulted inadequate follow up in the community.
 - ▶ DEIC in Satara was not functioning as per guideline and neither providing full range of services and needed to be strengthened. In Gadhchiroli. DEIC was yet to be established.
 - ▶ Delay in referral care specially surgeries (delay ranging from 6 months to 2 years) was noticed.

Maharashtra

- ▶ ORS and Zinc corners at the PHCs and above, and NRCs were seen in the districts.
- ▶ Incomplete micro-plans for routine immunization and duplication of records were observed at the visited facilities.

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evident in the community as the awareness regarding malnourishment was found to be inadequate.

- ▶ There was no growth monitoring chart available at AWC visited at District Gurdaspur. Though CRM visit duration and POSHAN MAH were overlapping but food rations for beneficiaries of AWC visited in Gurdaspur, had not been available since June, 2018.
- ▶ The micro-plan for immunization was not available at any level (SC, PHC, CHC, District). MR vaccine was stock out in the district since last two immunization sessions though MR campaign had just finished only one week ago and state had got 3 lac doses of MR vaccine at state stores.
- ▶ SNCU was functional at DH, with average monthly load of 60 cases. There was scarcity of adequate human resource for SNCU (MO, sweeper, security guard); and equipment like pulse oximeter, oxygen conc., wash facility, centralized O2 system.
- ▶ District Early Intervention Centre (DEIC) was not available districts reviewed.

Rajasthan

- ▶ CDR was not being done properly. Deaths during the visits were recorded but not reviewed.
- ▶ SNCU at DH Jodhpur was underutilized.
- ▶ Family Care Centre at Baran SNCU was one of the good practices observed.
- ▶ Malnutrition Treatment Centre (MTC/NRC) was observed to be well functional at FRU and DH in Baran, while it was underutilized in Jodhpur with no referrals from community
- ▶ In many facilities, AEFI registers and reporting was not satisfactory at the PHC/Block level.
- ▶ HMIS data shows more than 90% full immunization, but with high drop outs found in the community particularly at vacant SCs, Mini AWC without ASHA, villages without AWCs.

- ▶ AVD plans were either not or irrationally available. The AVD funds were grossly underutilized because of long distance travel by ANM to get the vaccines

Tamil Nadu

- ▶ Alternate Vaccine Delivery policy was not in place at the state level. Village Health Nurse carries vaccine from centre to field and back to PHCs, for which they were given incentives by the state.
- ▶ Growth monitoring was not done regularly at the AWCs and records were not well maintained.
- ▶ PHCs were cold chain points and regularly undertaken facility-based Immunization. However, these were not mapped in E-vin software. The Open Vial policy was not being followed properly.
- ▶ In Perambalur, Newborn care areas were situated outside the Maternity OT. The Health Facilities were supplied with Vitamin K3 (Menadione) whereas recommended is Vitamin K1 (Phytonadione).
- ▶ NBSU in Ramanathapuram Taluka Hospitals showed newborn mortality primarily due to birth asphyxia and sepsis which were in many cases preventable. The NBSU admission rate was high, in the range of 35% and mostly intramural. Death rate was about 10% and 25% deliveries were low birth weight.
- ▶ In Perambalur, 27% of admissions to SNCU were due to neonatal physiological jaundice, which also increased load on the SNCUs. At Ramanathapuram, SNCU load was mostly intra-mural and admission rate is 35-40%. Most of the deaths were due to Birth Asphyxia and Sepsis

Telangana

- ▶ The essential new born care was seen suboptimal. Radiant warmer at 24X7 PHC Gangadhara was non-functional for the last 12 months and the resuscitation kit also did not have the bag with mask size '0'. It pointed

towards a systemic issue mandating an efficient alert and repair/replacement system through the biomedical equipment maintenance programme, which had currently reached only up to the district level.

- ▶ SNCU at Karimnagar was characterized by an unusually high LAMA (Leaving Against Medical Advice) rate of 19 percent in the year 2018-19 (till August), indicating that every fifth baby left against medical advice and these cases were not being followed up.
- ▶ There were 8 mobile health teams in Karimnagar, where the average referrals were around 300/month. They organized school health camps once in a year. Many of the laboratory tests like thyroid, EEG, MRI, and medicines were not part of the free diagnostics, therefore, the patients had to get these done in private laboratories and chemist by their own.

Tripura

- ▶ The new-borns were given honey or sugar syrup on birth after bringing the child back home from the facility. In Unakoti district, the practice of exclusive breastfeeding was found to be good and mothers' knowledge on EBF was also correct.
- ▶ Home Based New-born Care was given by ASHAs, but not all the visits (6/7) as per schedule were made. None of the ASHA had a complete ASHA kit.
- ▶ ASHAs had received training on modules 6 & 7. However, they were unaware of KMC of LBW and pre-term babies.
- ▶ The immunization schedule was filled in most of the MCP cards. However, none of the cards had growth monitoring plotted.
- ▶ In South Tripura, on VHND, the khichri was cooked with vegetables and was provided to the pregnant/ lactating mothers at the AWC. The vegetables were purchased using VHND fund.
- ▶ NRC was not available in either of the two districts visited.

- ▶ The SNCU was not yet functional.
- ▶ At Agartala Medical College level, Neonatal Intensive Care Unit (NICU) and Paediatric Intensive Care Unit (PICU) were functional. However, it was found that vitals (heart rate or oxygen saturation) were not being regularly monitored (leads were missing).
- ▶ Parents were roomed in with their sick children in PICU. More than one child was roomed in the same bed. Medicines were purchased by the clients only.

Uttar- Pradesh

- ▶ Inadequate community awareness on exclusive breast feeding practices, prevention and management of childhood diarrhoea and pneumonia was seen. Community was largely aware about the immunization services.
- ▶ Most of the ANMs & SNs in the visited health facilities were not trained on essential NSSK, SBA & IYCF.
- ▶ KMC was observed as an inherent component of care of LBWs in health facilities in both districts.
- ▶ NBSUs were well equipped with requisite HR. However, the staff nurses posted are not trained in F-IMNCI and no tracking mechanism is instituted for the referred outbabies.
- ▶ In Farrukhabad, Kayamganj NBSU was being used as a transit facility and 90% cases were discharged within 12 hours of admission with the reason being cited as "Discharged on Parents' Request" (DOPR).
- ▶ DWH Varanasi had a high Still Birth Rate (SBR) - around 20 per 1000 total births.
- ▶ There was no separate paediatric ward in DDU, Varanasi and children were found to be admitted in the general medicine ward, increasing their risk of contracting nosocomial infection.
- ▶ NRC in Varanasi, was located adjacent to the general ward and the passage was being used commonly for both NRC & other surgical

patients and also there was no exclusive toilet for children admitted to NRC, resulting increased risk of nosocomial infection.

- ▶ Rashtriya Bal Swasthya Karyakaram (RBSK): the coverage of screening at community in Farrukhabad was inadequate. Incoordination noticed between ASHAs and RBSK team.
- ▶ eVIN, was being effectively implemented in districts. Districts had rolled out all newer vaccines like Pentavalent and Rota Virus. However, Measles vaccine was in short supply.
- ▶ In Farrukhabad most of the cold chain points were at block level health facility, not at PHC as a norm; therefore, it took longer to distribute vaccines to all session sites. Regarding alternative vaccine delivery (AVD), vaccines were sent through couriers but one courier was taking vaccine for 16-18 immunization session sites by auto-rickshaw resulting in delay in vaccine delivery.
- ▶ Child death reviews were not being carried out in practice.

Uttarakhand

- ▶ Lack of IFA distribution to children at community was observed.
- ▶ MCP card was available with all interviewed mothers and immunization status duly filled but no growth charting of child (weight. Height) in MCP card were observed.
- ▶ ASHAs either not doing HBNC visits (Haridwar) or doing incomplete visit (Uttarkashi). No follow up of LBW babies seen. Screening at birth not done and documentation not prepared. Refresher training for ASHAs was lacking.
- ▶ DEIC established in both districts, but under-utilized in Haridwar. Developmental delays not screened at hospitals routinely unless referred to counsellor
- ▶ KMC being practiced in SNCU in Haridwar but not in DH Uttarkashi

- ▶ NBSUs not functional in PHCs and CHCs in Uttarkashi

3.3: REPRODUCTIVE HEALTH

NATIONAL OVERVIEW

Since the commitment under FP2020 in 2012, India has reinvigorated its efforts to expand the range and reach of contraceptive options by rolling out new contraceptives, and delivering a full range of family planning services at all levels. However even after the introduction of new methods (injectable like Antara and Chayya Pills) in the basket of choice, the contraceptive use prevalence rate still remains low in most of the CRM states, and the unmet need remains high in the community.

The demand for family planning among the states in India is highly diverse. The current use of any contraceptive method varies considerably among the states from 24.1 percent in Bihar to 69.5 percent in Andhra Pradesh. In terms of the method mix, female sterilization is the dominant modern method in all the states except in the northeastern states like Assam, Arunachal Pradesh and Tripura, where pills are used more than any other modern method.

Though the community is aware of the importance of small family size, they don't have enough knowledge regarding the wide range of contraceptives available in the government facilities. The most preferred method of contraception amongst community is female sterilization, condom and oral pills. Awareness regarding injectable contraceptives is lacking in most of the states.

A target-free approach based on unmet need for contraception; equal emphasis on spacing and limiting methods; and promoting 'children by choice' in the context of reproductive health are the key approaches to be adopted for the promotion of family planning and improving reproductive health. Improving male participation remains critical to increasing the coverage as does the monitoring of complications, failures and deaths following sterilization operation.

KEY OBSERVATIONS

COMMUNITY

- ▶ Early age of marriage leading to teenage pregnancy still remains a major cause of concern in some of the states like Jammu and Kashmir, Tripura, Andhra Pradesh and Bihar. Awareness within the community about the importance of family planning and methods was found unsatisfactory in states like Jammu and Kashmir, Tripura, Telangana, Uttrakhand, Rajasthan, Andhra Pradesh and Arunachal Pradesh.
- ▶ Condoms and Oral Contraceptive Pills are prevalent methods but awareness and usage of EC Pills appeared to be low in the community. There is a general lack of counseling services at the community level regarding available family planning contraceptive methods & choice.
- ▶ Pregnancy Testing Kits are available in ASHA Kit and are well utilized in most of the states. Awareness regarding safe abortion facility is lacking in most of the states like Jammu and

Kashmir, Tripura, Telangana, Uttrakhand, Andhra Pradesh, Arunachal Pradesh and Gujarat. Medical methods of abortion were found to be prevalent in most of the states and pills are taken over the counter from pharmacists.

FACILITY

- ▶ Most of the facilities are providing spacing methods of contraception like IUCD/PPIUCD. However, non-steroidal contraceptive pills and injectables still need to be rolled out in most of the states. More concerted efforts are required to ensure effective roll out of newly launched contraceptives Chhaya & Antara.
- ▶ Adequate resources to deliver the services of interval IUCD, PPIUCD and post-partum sterilisation were found at DH and CHC level in many states like Madhya Pradesh, Tamil Nadu, Maharashtra, Punjab and Uttar Pradesh. However, services were not functional at the level of sub centre and need strengthening in most of the states. In states like Assam and Himachal Pradesh, IUCD insertions were being done at the level of SC as well. In Tamil



Nadu, although the facility is providing PPIUCD services but the PPIUCD forceps could not be seen.

- ▶ Training gaps were observed for IUCD and PPIUCD insertions for most of the states.
 - ▶ Availability of contraceptive products including injectables in the community and facility is an issue in states, such as Tripura, Andhra Pradesh, Assam, Uttarakhand, Bihar and Punjab.
 - ▶ In most of the CRM states, beneficiaries have greater acceptance of female sterilization as compared to male sterilization. However, Fixed day static services were preferred more in winters season with higher male participation. Awareness and information, from a gendered perspective, to bust the myths and misconception regarding sterilization needs to be focused upon.
 - ▶ Family Planning Logistics Management Information System (FP-LMIS) has not been implemented in most of the states except for states like Uttar Pradesh and Karnataka, where the indenting process has reached till sub centre levels. In most of the states the beneficiaries are not aware of the drop back facilities provided after sterilization from the facilities. However, in some states like Uttar Pradesh the beneficiaries have reported zero out of pocket expenditure for the transport facility and 102 is usually utilized for the same.
- ▶ Strengthen counselling of the eligible couple and women in antenatal period
- ▶ To create more awareness amongst population, support of panchayats, religious gurus and elderly persons of the village or society can be taken. This can help in breaking the stereotypes in the community
- ▶ State should focus on capacity building of HR at all levels, especially RMNCH+A counsellors / FP counsellors. Need for more focussed training on newer contraceptives
- ▶ Rational deployment of trained specialist up to CHC level to prevent overcrowding at district hospitals. A district data base of the empaneled doctors to be maintained for regular updation
- ▶ Regular follow up and performance monitoring of trained Lap/Mini lap/ NSV trained doctors is required
- ▶ Requirement of refresher training for staff conducting IUCD and PPIUCD insertions
- ▶ Injectable MPA programme and Chayya to be implemented at all APHCs/SHC level. State to focus on follow-up of clients for subsequent doses
- ▶ Newer contraceptives, particularly injectables to be made available at various levels for widening the access and choice for contraceptives
- ▶ FP-LMIS to be operationalised at the earliest up to SC level to ensure quality and uninterrupted supply of contraceptives
- ▶ States need to ensure fixed day services for family planning at all facilities below district hospital level as well. FDS calendar to be displayed at facility levels so that the people are well aware about the fixed days
- ▶ High unmet need for spacing was visible in the community. Systemic preparedness- capacity building of service providers, supply chain management, recording, reporting has to be strengthened

RECOMMENDATIONS

- ▶ Ensure timely line listing and updation of the eligible couple register by the ANM and ASHAs
- ▶ Encourage and enhance IEC/ BCC activities significantly at all levels to address practices related to low family planning measures and other programmes. Activities like nukkad natak, FDGs, mothers meeting etc can be encouraged for better population awareness regarding family planning and encouraging men to shoulder the responsibility along with the women

- ▶ More condom boxes at the non-traditional outlets below APHC level can be installed by states for better coverage and accessibility
- ▶ Proper planning, monitoring and follow up is required while implementing the family planning services at the community level
- ▶ Good rapport with other departments needs to be established for dissemination of IEC on other family welfare spacing as well as terminal methods among community by discussing various newly launched family welfare schemes in the National family Planning Programme during DHS meeting

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Oral pills and condoms were the preferred choice of contraception.
- ▶ Counseling of the women on FP services for spacing is inadequate. Awareness on newer methods of FP was found to be lacking.
- ▶ Also there was lack of awareness about free transport facilities provided by the Government for MTP/Abortion/Family Planning Services.

Arunachal Pradesh

- ▶ Abortion services (MVA and DNC) are being provided at the FRU level.
- ▶ People had very limited knowledge of contraceptives and basket of choices. Few females were aware of only sterilization as a method of contraception. There has been a lack of counseling by front line workers in the community.
- ▶ The uptake of PPIUCD/IUCD and abortion services uptake is very low in CHC and below, due to poor knowledge and awareness among the beneficiaries and subsequent poor demand among the community.

Assam

- ▶ Family planning counselling service is available in all health facilities.
- ▶ OCP and IUCD are the most preferred methods of contraception.
- ▶ There is a need for strategies to increase uptake of the programme at community level, as the team observed gaps in community awareness on modern contraceptives and negative perceptions around them.

Bihar

- ▶ All the facilities had PPIUCD forceps available in the labor room. Most of the clients interacted with were being counseled during early labor.
- ▶ Clients have good acceptance for female sterilization but usage of service depicts a seasonal variation.
- ▶ DQAC and DISC is formed and active as per the Gol guidelines.
- ▶ At district hospital level, RMNCHA counselor was found to be actively counseling on the basket of interventions at the ANC clinics and for the post-natal mothers. The IEC materials on family planning were organized well.
- ▶ Early marriage and teenage pregnancy still remain an issue in the state.
- ▶ The pregnant women were not aware of newer contraceptives like DMPA in the community. Also the second follow up visit is negligible

Chhattisgarh

- ▶ Good Community awareness about appropriate age of marriage (after 18 years for girls and after 21 yrs. for boys) was observed.
- ▶ Mitanins demonstrated good level of knowledge about contraceptive methods and were able to counsel the community members for its utilization. Awareness about the newer contraceptives like Antara, found lacking among Mitanins. In some

regions Mitanins had inadequate supplies of most of the contraceptives.

- ▶ More focused efforts required to ensure effective roll out of newly launched contraceptives Chhaya & Antara. Tab. Poor follow up of Antara clients were observed which is leading to poor uptake for second dose.
- ▶ Training gaps were observed for IUCD and PPIUCD insertions. Irrational distributions of FP commodities in the facilities were observed in most of the facilities visited in both the districts

Gujarat

- ▶ Counseling and registration of eligible couple was found to be good in the community.
- ▶ Natural method of contraception is usually preferred in tribal areas.
- ▶ All contraceptives were available at almost all facilities. However, Antara and Chhaya was in short supply as the programme had been just initiated
- ▶ Skill labs with well-equipped staff and skill station were available. There is a need for continuous training.

Himachal Pradesh

- ▶ The state TFR is below replacement level (1.7) and the density of the population is low. FP services are not a key priority in terms of requirement.
- ▶ The sterilization rate is better than majority of other states of the country. A complete basket of choices for family planning was available.
- ▶ Camp based operative procedures were preferred in winters as it had higher male participation.

Jammu & Kashmir

- ▶ Community was aware of the importance of small family size

- ▶ ASHAs were aware about eligible couple, conducting EC survey, healthy timing and spacing of births, WPD etc.
- ▶ FPLMIS is not being implemented in the state except at the level of DH. Even service providers didn't have knowledge about it.
- ▶ Modern contraceptive methods (Antara) and Centchroman(Chaya) are yet to be implemented in the state. Hence unmet need high in the community for injectable contraceptives is high.
- ▶ RMNCHA counselor was not trained/skilled for counseling skills on modern contraceptives. Need for refresher training of the counsellor.

Jharkhand

- ▶ The state is doing quite well on PPIUCD, with majority of the facilities performing PPIUCD services. PPIUCD performance across facilities is satisfactory. However, interval IUCD and injectable contraceptives seem to have taken a back seat.
- ▶ Newer Initiatives like Mission Parivar Vikas (MPV), injectables and other methods of FP needs to be implemented in a better manner, along with strengthening the earlier initiatives for RMNCH+A for better Health outcomes.
- ▶ Knowledge on injectable contraceptive is very poor in the community and also amongst the facility staff and Sahiyas. The documentation of consent form for providing sterilization services in both the district, was found to be poor.

Karnataka

- ▶ Female sterilization is the most common limiting method practiced.
- ▶ Laparoscopic sterilization is the preferred method. Quality of sterilization services, record keeping and disbursal of incentives was good.
- ▶ Male sterilization performance is very low.
- ▶ Facilities had adequate equipment and supplies (both IUCD 380A and 375).

- ▶ Providers exhibited adequate knowledge and skills.
- ▶ Condoms and Combined Oral Contraceptive Pills (COCs) are well utilized methods, though awareness and usage of Emergency Contraceptive Pills appeared to be low.
- ▶ Injectable contraceptive ‘Antara’ has been launched up to sub-district levels.
- ▶ Trainings on Antara have been done, albeit roll-out is slow. Awareness in community as well as health workers about Antara is low. Antara cards are not available in many facilities.
- ▶ ASHA distributing contraceptives free of cost in the community under Home Delivery of Contraceptives Scheme. ASHA supply of condoms and COCs seen being used in Sub Centres instead of Facility supply.
- ▶ Family Planning Logistics Management Information System (FP-LMIS) has been implemented up to Taluk level.
- ▶ Facilities are providing safe abortion services with MVA and MMA methods. Post Abortion Family Planning Services have been initiated.

Madhya Pradesh

- ▶ The mean age of marriage is 23-24 years among the community visited in Betul, and most of them were aware about family planning methods.
- ▶ PPIUCD acceptance was rather low and women preferred interval IUCD to PPIUCD in both the districts. Component of proper counselling before PPIUCD and regular follow up is missing, resulting in high expulsion and removal rate.
- ▶ Ensuring spacing at birth scheme (ESB scheme) is implemented in the state. However, execution of the scheme, in terms of proper planning, implementation and monitoring needs to be relooked in to.
- ▶ Good rapport with other departments need to be established for dissemination of information and education about other family welfare spacing

as well as terminal methods among community by discussing various newly launched Family Welfare schemes in the National family Planning Programme during DHS meeting.

Maharashtra

- ▶ Good awareness & acceptance on various family planning methods including male sterilization was found.
- ▶ Awareness about newer contraceptives like hormonal and injectable is low.
- ▶ IEC was good as seen in the sub centres onwards on various family planning methods. ASHAs were involved in contraceptive distribution and promoting, including escorting clients for IUCD insertions and were getting incentives for both delaying and spacing of births. RCH registers were not being adequately used for tracking of Family Planning services and this needs to be used for all RCH services provided.

Punjab

- ▶ ASHA and ANM were aware about all contraceptive services. They are providing family planning counseling to women.
- ▶ ASHA is distributing the contraceptives available in the government supply in the community. Hence, private purchase is found to be minimal.
- ▶ However, information regarding the new contraceptives like ANTRA, CHHAYA and ECP was found to be limited.
- ▶ Family planning counseling was found to be of concern at district hospitals. Need for dedicated counselors was expressed by specialists working at the district hospital.

Rajasthan

- ▶ DQAC, Family Planning Indemnity scheme and DLC for Abortion care are in place.
- ▶ PPIUCD insertion rate is good in the state, but the follow up is negligible.

- ▶ Counseling services were found to be inadequate at community and facility level.
- ▶ Contraceptives and Nishchay Kit were available with ASHA and health facilities. E pill not available at most of the facilities or with ASHA
- ▶ Antra has been rolled out in both the districts. Antra software has been launched but updation is a concern.
- ▶ Number of female & male sterilization operations has progressively decreased over the years. Lack of awareness and assured quality service are the major reasons.

Tamil Nadu

- ▶ The health facilities are well maintained and provide facilities like sterilization, Interval IUCD etc.
- ▶ There was good uptake of interval IUCD, PPIUCD, sterilization services, Antara and Chayya
- ▶ Facilities providing FP services are of satisfactory standards. Reproductive and child health themed monthly meetings are chaired regularly by the Block MO at the Block PHCs

Telengana

- ▶ The choices available for family planning are many, but oral pills have been the most common contraceptive used in the community.
- ▶ Awareness generation required in the community, for instance on associated bleeding with IUCD insertion.
- ▶ Frequency of Family planning camps organized is once in 3 months. Tubectomy is more accepted in the community.

Tripura

- ▶ High number of teenage pregnancy seen in the state. Healthy spacing between children not being followed in the community.
- ▶ There was a lack in counseling services in the community. Objective behind identification of

eligible couple needs to be understood by the health workers.

- ▶ FPLMIS has not been rolled out in the state.

Uttar Pradesh

- ▶ Beneficiaries and field functionaries (AWW/ ANM/ANM) were aware about the rightage of marriage, delay of first pregnancy and spacing between pregnancies. However, the adequate spacing between births is not maintained with the usual norm of 4-5 births in rural areas of both districts (largely due to socio cultural practices)
- ▶ Beneficiaries displayed adequate knowledge of modern contraceptives, but displayed general concern on contraceptives side effects. Overall contraceptive counselling services is week in both districts with limited awareness generation activities.
- ▶ ASHA schemes like HDC and ESB were operational and ASHAs were aware about the schemes. ECP and Oral pill uptake was low.
- ▶ Antara Programme (Injectable MPA) has been rolled out in both districts. However, the role out of trainings is slow and limited facilities having actual service provision. Both districts grossly lag in its efforts to promote injectable MPA services.
- ▶ Providers displayed poor knowledge on Centchroman (Chhaya).
- ▶ Providers lacked correct knowledge on IUCD services and importance of IUCD card.
- ▶ ASHAs are aware of PPIUCD and are motivating clients for PPIUCD insertions. PPIUCD incentive scheme has been rolled out in the district.
- ▶ Male sterilization services are non-existent in both the districts with lack of concentrated efforts for promotion of male sterilization.
- ▶ Post-partum sterilization was generally not advocated by providers as a contraceptive option after normal delivery.

- ▶ Active follow up was not reported by the sterilization beneficiaries. District Varanasi have high number of reported cases of failures.
- ▶ Medical abortions were found to be prevalent and usually abortion pills are taken over the counter from pharmacies. Knowledge of PAFF options was poor among ASHAs and community. PAFF orientations are yet to be initiated in both the districts.
- ▶ FPLMIS has been initiated in the state and trainings have been completed.

Uttarakhand

- ▶ Community is aware about the preferred age of marriage
- ▶ Awareness generation by the front line workers in the community was found to be poor and inadequate
- ▶ Newer contraceptives were not available in the community.
- ▶ Not a single surgeon was trained on NSV. Urgent training is required.
- ▶ No information regarding fixed day approach, No IEC displayed in the facilities.
- ▶ Non availability of Nischay kits and OCPs/ condoms with ANMs/ASHAs all across the facilities visited.

3.4: ADOLESCENT HEALTH

NATIONAL OVERVIEW

Through adolescent friendly health clinics (AFHCs), counselling and curative services are provided at primary, secondary and tertiary levels of care on fixed days with due referral linkages.

Still there is lack of focus on adolescent health which has a significant impact on the maternal and child health and missing a crucial stage of life cycle.

Adolescent Health component at community level was found lacking in most of the states.

The role of the peer educators and ASHA in community mobilization for adolescent health has been negligible. The states must roll out the adolescent health components by establishing and strengthening linkages of adolescent health with Anganwadi centres, community, school and facility levels; plan and start the IEC / BCC strategies and activities; celebrate Adolescent Health Day at village level on a fixed day etc. In some of the states there are no separate clinics or dedicated counsellors for AFHCs and ICT counsellors are providing selective counselling services. Some states have established the AFHS clinics at the facility but the utilization of the services was found to be insignificant at most of the states.

KEY OBSERVATIONS

COMMUNITY

- ▶ Knowledge amongst adolescents about common health problems e.g. substance use, nutrition, healthy lifestyle, age of marriage, menstrual problems, acne, teenage pregnancy, emotional, psychological issues, was suboptimal. In some states like Andhra Pradesh, Karnataka, Chhattisgarh, Gujarat & Telangana and Uttar Pradesh awareness and knowledge among community was better than other states.
- ▶ In Telangana, while the community was aware of anaemia and had an understanding of its linkage with dietary habits but awareness of the benefits of use of sanitary napkins & its proper disposal was not found satisfactory. Similarly, awareness /knowledge of use of sanitary napkins was noted to be low in all states.
- ▶ Field level screening of anaemia in adolescents was seen in Tripura, Telangana, J&K, Himachal Pradesh and Punjab. It was noted that the outreach activities in the states were not being conducted on a regular basis. The linkage of RBSK with RKS was weak.
- ▶ Adolescent Health day was not being linked with VHNDs. J&K and Tripura were not conducting AHDs. In Arunachal Pradesh, a total of 1068/2171

(50%) peer educators were identified, out of which 896 were trained and delivering services in the field. Referral services to AFHC from community were found negligible in all states.

- ▶ WIFS implementation was seen in states like Telangana, Tripura, Assam, Himachal Pradesh, Uttarakhand, J&K and Andhra Pradesh. Uttarakhand, Himachal Pradesh & Punjab reported frequent stock outs of IFA tablet. J&K has had no stock of IFA tablet since the last 4-5 months and Telangana reported stock out of IFA syrups.
- ▶ The community level distribution of IFA for adolescents and school dropout was found insignificant in all the states.
- ▶ National deworming day was seen in practice across all states visited.
- ▶ Menstrual Hygiene Scheme and the provision of sanitary napkin is not well operationalised in visited CRM states. In most of the states girls are still using traditional cloth during menses.

FACILITY

- ▶ In states like Punjab AFHCs are called **Umang** Clinics, as **Yuva clinics** in Bihar and Andhra Pradesh, **Maitree** clinics in Maharashtra while in Karnataka they are termed as **Sneh** clinics.
- ▶ The Telangana state has started a pilot campaign in Hyderabad to counter anaemia in the name of Fight Anaemia Campaign. In Tripura a total of 34 AFHC has been established and operationalised. However, the outreach activities were found less in the field due to allocation of other work responsibilities to the counsellors or less trained manpower in facility. Similar reasons were also seen in states like Uttarakhand, Arunachal Pradesh and Punjab. Monitoring mechanism was found sub optimal at all levels for the programme across all states.
- ▶ AFHS were functioning well in Tripura, Telangana, Maharashtra, Jharkhand, Karnataka, Uttarakhand, Arunachal Pradesh, Jammu & Kashmir, Himachal Pradesh, and Punjab but not in Assam.

RECOMMENDATIONS

- ▶ States should strengthen the monitoring mechanism of the RKS K programme, its outreach activities and also its linkages with RBSK for diagnosis and treatment.
- ▶ States should take steps for training of manpower and delineate clear roles and responsibilities for the staff members for effective implementation of RKS K at facility level.
- ▶ Better ARSH training for counsellors which focuses on all aspects of Adolescent health care including SRH services
- ▶ Repeated trainings of peer educators to build their capacity to interact with other adolescents
- ▶ Regularize Adolescent health days in the community and monitoring of the same.
- ▶ Orientation Programme for adolescent issues particularly healthy lifestyle, nutrition, reproductive health, hygiene and sanitation needs to be organized.
- ▶ Intensive IEC campaign including digital campaigns in social media, to educate adolescents on menstrual hygiene and nutrition should be organized in the schools. A special plan should be in place for out of school youth and adolescents

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Free sanitary napkins are being provided to the adolescent girls and they were aware and informed about menstrual hygiene, sanitary napkins and appropriate age of marriage.
- ▶ Yuva clinics have been set up for adolescent.
- ▶ WIFS is being implemented but out of school adolescent are left out of coverage.
- ▶ Adolescent girls were aware and informed about menstrual hygiene, age at marriage, sanitary napkins distribution in the community through media and other mode of awareness.

Arunachal Pradesh

- ▶ Adolescent community was not aware about physical activities, balanced diet and importance of iron in diet.
- ▶ The AFHC were non-functional because of the transfer of the AFHS trained MOs to some other facility.
- ▶ No IEC material related to SRH, nutrition, mental health, NCD, injuries & violence and gender equity was displayed.
- ▶ State has selected only about 50% of the peer educators till now out of the target PEs to be selected (1068/2171) and is also lagging behind in the training of the selected peer educators (896/1068). MOs and counsellors have not been trained in providing counselling for adolescent friendly health services in 2017-18.

Assam

- ▶ WIFS programme is being implemented in the schools visited.
- ▶ Adolescent health counselling services are not available throughout the district.
- ▶ Sanitary napkins are sold to adolescents at Rs. 5. Hence, the usage is confined to a small group of adolescents who can afford it.

Bihar

- ▶ State has 205 Adolescent Friendly Health Clinics (YUVA Clinic) which has catered to 74448 clients in FY 2017- 18.
- ▶ WIFS is yet to kick-off in the state though the WIFs tablets have recently been received by the district.
- ▶ Menstrual hygiene scheme is not implemented by the department of health & Family welfare as the same has been done by department of Education.
- ▶ The counselling services are not available at SC level, APHC Level. AFHC Clinic is not functional in the DH of Muzaffarpur.

Chhattisgarh

- ▶ AFHC clinic was in place in both the districts however under-utilized.
- ▶ The counsellor was working in close coordination with ICTC and AFHC. Training of counsellor and MO was not carried out.
- ▶ Peer educator programme was not been rolled out in both the district.

Gujarat

- ▶ The main source of information on sexual and reproductive health for adolescents was still the friends and books/online sources.
- ▶ The peer educator's interaction is limited to WIFS and sanitary napkin.
- ▶ The ARSH clinics are established with limited functionality, which may also be taken up on priority.

Himachal Pradesh

- ▶ Distribution of sanitary napkins by ASHAs under the Menstrual Hygiene programme has been introduced, but community and health service provider feedback suggests less than optimum acceptance due to perceived sub-standard quality of the napkins being offered.
- ▶ AFHC services was being provided on fixed days i.e. on Fridays and Saturdays from 2.00 p.m. to 4.00 pm.
- ▶ Adequate stock of IFA and de-worming drugs were available.
- ▶ Systematic and regular AFHC services, counselling for adolescents and peer educator was absent.

Jammu & Kashmir

- ▶ WIFS programme is not being implemented as IFA tablets have been out of stock since last 4-5 months
- ▶ Outreach activities were being conducted twice a week by AH Counsellors.

- ▶ Sanitary napkins (either free or with cost) were not being distributed at any level.
- ▶ Average client load is low and between 50 to 100 per month. Staff has not received any training on ARSH.

Jharkhand

- ▶ Uptake of services for adolescents was very minimal.
- ▶ In Ranchi, distribution of IFA is not happening.
- ▶ Sanitary napkins distribution is not happened since 2016 in Bokaro and Ranchi. No procurement of sanitary napkins has been done at the state level.
- ▶ Perspective of counselling is amiss in the AFHC, focus has been on achieving targets.

Karnataka

- ▶ Adolescents exhibit good awareness about common adolescent health problems e.g. menstrual problems, acne, teenage pregnancy, and emotional and psychological issues.
- ▶ Good health seeking behaviour seen among adolescents & generally contact the ASHA or ANM or Medical Officer PHC in case of any health problems without hesitation.
- ▶ Weekly Iron Folic Acid Supplementation is being carried out on Mondays in schools. Sanitary napkins are being distributed
- ▶ 512 Adolescent Friendly Health Clinics running in 8 districts where the programme is being implemented. Medical Officers and Peer educators are being trained. In District Hospital psychiatrist, psychologist and counsellors providing services to adolescents.

Madhya Pradesh

- ▶ WIFS programme is being implemented in both the districts visited however other components under adolescent health programme require focus and strengthening.

- ▶ School going Adolescent boys and girls are getting weekly IFA tablets by their class teachers in their School.
- ▶ Adolescent health services among out of school going girls' needs to be focus.

Maharashtra

- ▶ Only one district visited was covered under RSKS and Maitree clinic as well as peer educators were in place in Gadhchiroli. Community awareness still is on lower side particularly among boys. Low utilization of ARSH clinics and counsellors.
- ▶ Peer educators were engaged (as per guideline) at village level in some blocks in Gadhchiroli as per guidelines. However, awareness on adolescent health issues was weak in Gadhchiroli particularly in tribal blocks.
- ▶ Record keeping pertaining to the programmes was poor at all visited facilities visited.

Punjab

- ▶ UMANG (AFHS) clinic for adolescent health was available at SDH and DH Gurdaspur with adequate arrangements for privacy and had a trained MO and ARSH counsellor.
- ▶ AFHC utilization is sub-optimal. IFA tablets under WIFS programme has not been procured at the state.
- ▶ Adolescents were not aware about the menstrual hygiene and deworming programmes.

Rajasthan

- ▶ Good awareness among adolescents on Anaemia and IFA in schools visited
- ▶ Non availability of IFA tablets at Schools and AWCs under WIFS programme
- ▶ Sanitary Napkins available and distributed at the schools visited

Tamil Nadu

- ▶ Free Sanitary Napkin to the adolescent girls through RSKS programme.

- There was no proper adolescent activity undertaken at the community level at the VHNDs.

Telangana

- The State has a high rate of anemia among adolescent and women in the reproductive age group.
- Sanitary pad was distributed to the school girls through the Department of Education; however, the utilization of sanitary pads by the adolescent girls was low as they were not counseled on its use and the potential benefits.
- The State has piloted a “Fight Anemia Campaign” in Hyderabad district. The campaign is under plans for being scaled up across the State
- IFA is not being distributed to adolescent girls despite the stock being available.

Tripura

- Total 34 AFHCs have been set for providing counselling and curative services in the state.
- The AH counsellor shares his monthly tour plan with the CMO, but the counsellor has not



conducted any outreach sessions for almost six months (Feb–July 2018).

Uttar Pradesh

- Adolescents were aware of the importance of nutrition, balanced diet, anaemia and iron supplementation. The awareness activities are conducted at VHND session through AWW/ ASHA.
- In Farrukhabad, the adolescents are aware about the availability of sanitary napkins with ASHA/ANM. However due to quality issues they prefer to buy it from the local pharmacy.
- The interaction with adolescents is only during adolescent health day, the frequency of which is erratic. Facilities had adequate IEC display related to anaemia and other nutrition disorders. The facilities had adequate stocks for blue IFA (except SC in Farrukhabad) and albendazole.
- District Varanasi has not implemented the peer educator programme.
- In Varanasi none of the facility visited had functional AFHC. In Farrukhabad well functioning AFHC was present.

Uttarakhand

- AFHS clinics were functional in Haridwar but not in Uttarkashi.
- Community awareness about physical activities, balanced diet and importance of iron in diet was seen mainly in Uttarkashi only.
- WIFS programme was not functional in the state.
- Under NDD programme, State received albendazole tablets for bi-annual rounds in a year for the schools.
- Adolescent girls were aware about use and disposal of sanitary napkins but not receiving supply from ANM and ASHA. Peer Educators were seen in AFHCs but the AFHCs did not have IFA tablets and sanitary napkins

COMMUNICABLE DISEASES

(IDSP + RNTCP + NVBDCP + NLEP)



National Overview

The recently released India State-level Disease Burden Initiative Report, states that India is transiting epidemiologically and infectious and associated diseases are reducing overall in India.

A declining trend of overall endemicity of malaria has been observed in the country. The trend shows that the malaria cases have consistently declined from 1.87 million to 0.49 million during 2003 to 2017 (till July). An aggressive scaling up of interventions and intensification of malaria control activities through innovative approaches supported by Global fund in IMCP-3 has led to substantial decrease in mortality and morbidity due to malaria in the 8 high endemic States of the country. Since 2012, there is continuing decline in Kala-azar cases and deaths too. Kala-azar is at present endemic in 54 districts of which 33 districts are in Bihar, 4 districts in Jharkhand, 11 districts in West Bengal and 6 districts in Uttar Pradesh.

However, the risk of dengue has shown an increase in recent years due to demographic and societal changes such as unplanned and uncontrolled urbanization and concurrent population growth, thereby increasing the breeding potential of the vector species. Currently, Dengue is endemic in 29 States and 6 UTs (except Lakshadweep). Recurring outbreaks of Dengue have been reported from Andhra Pradesh, Assam, Delhi, Goa, Haryana, Gujarat, Karnataka, Kerala, Maharashtra, Odisha, Puducherry, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal.

The year 2016-17 started with 0.86 lakh leprosy cases on record as on 1st April, 2016, with Prevalence Rate (PR) 0.66/10,000. Till then, 34 States/UTs had attained the level of leprosy elimination. 554 districts (81.23%) out of total 682 districts also achieved elimination by March, 2017.

As per WHO Global TB Report 2017, out of the estimated global annual incidence of 10.4 million new (incident) TB cases, 2.79 million were estimated to have occurred in India i.e. around one fourth of the global incident TB cases. However, the incidence of TB has reduced from 289 per lakh per year in 2000 to 211 per lakh per year in 2016 and the mortality due to TB has reduced from 56 per lakh per year in 2000 to 32 per lakh per year in 2016.

The declining trend of the communicable diseases in the country can be partly attributed to the newer and intensified actions under several National Health Programmes such as the National Vector Borne Disease Control Programme, National Leprosy Eradication Programme, Revised National TB Control Programme, under the umbrella of National Health Mission (NHM).

The observations of the XII CRM validated the implementation of programme activities on the field. However, overall, certain newer initiatives under the various diseases control programmes were reported to have not reached the beneficiaries. Need of intensification of activities to achieve and sustain the decreasing burden of most of the communicable diseases and concurrently be watchful of the emerging disease threats was a general finding of the CRM teams.

4.1 INTEGRATED DISEASE SURVEILLANCE PROGRAM (IDSP)

KEY OBSERVATIONS

- ▶ Reporting under IDSP through S, P, and L forms was found adequate in Korba district of Chhattisgarh, Madhya Pradesh, South Tripura District, Jharkhand, Arunachal Pradesh, Punjab, Telangana, Andhra Pradesh, Karnataka and Gujarat.
- ▶ In Raipur, Chhattisgarh, IDSP registers are not appropriately maintained. In Maharashtra, Rajasthan and Uttar Pradesh, even S forms were unavailable.
- ▶ One positive observation was that in Assam and Chhattisgarh, private labs have been engaged for reporting but this is not the case with many other states.
- ▶ Lack of human resource thereby affecting the functioning of the programme, was reported from Chhattisgarh, Betul district of MP, Maharashtra, Uttarakhand and Andhra Pradesh.
- ▶ Outbreak investigations along with constitution of Rapid Response Teams (RRTs) was found to be adequate in Korba district of Chhattisgarh, Jharkhand, Maharashtra, Punjab, Telangana, Uttarakhand, Andhra Pradesh, Gujarat, Tripura and Rajasthan
- ▶ To identify early warning signs of outbreak, data is analysed weekly in Punjab. However, such data analysis must be done in all the states/districts which is not the case presently.
- ▶ In Madhya Pradesh, all the Medical Officers except the newly posted at the facility have been trained in IDSP. However, in Assam and Uttarakhand, most of the MOs are not trained in IDSP. Also outbreak investigations are not done in these two states

RECOMMENDATIONS

- ▶ Positions lying vacant under IDSP need to be filled urgently to ensure proper implementation of IDSP activities.

- ▶ Updation of the existing software is needed to improve the performance and functioning of the programme.
- ▶ Appointment of professionally trained epidemiologists/public health specialists and mobility support is critical and needs to be in place.
- ▶ Training of the field staff for closing the knowledge gap and reinforcing the implementation of IDSP as per guidelines.
- ▶ Improvement on data reporting is required from private establishments and it needs to be ensured across all reportable diseases.
- ▶ IDSP data analysis should be done on a regular basis, especially in states and districts planning for control of locally endemic diseases and other communicable diseases.
- ▶ Implementation of Epidemic Diseases Act for improvement of notification from Private sector.
- ▶ Approved District Public Health Labs to be made functional.

4.2 REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

KEY OBSERVATIONS

Community Awareness & Primary Care Services

- ▶ Awareness about TB signs and symptoms and its testing centres was found good in Chhattisgarh, Jharkhand, Arunachal Pradesh, Punjab and Himachal Pradesh.
- ▶ Knowledge among ASHAs and MPWs regarding signs and symptoms of pulmonary tuberculosis was adequate in Chhattisgarh, Maharashtra, Rajasthan, Punjab and Himachal Pradesh. However, information regarding extrapulmonary tuberculosis needs to be imparted.
- ▶ The awareness about Nikshay Poshan Yojana (NPY) was good among the community

members in Andhra Pradesh, but inadequate in Bihar, Moga district of Punjab and Tripura. Even service providers and ASHAs had no knowledge about NPY in Bihar and Tripura.

- ▶ IEC/ BCC for TB was reported to be lacking or insufficient in Uttar Pradesh, Himachal Pradesh, Uttarakhand, Andhra Pradesh, Karnataka and Punjab.
- ▶ In Chhattisgarh and Maharashtra, the Mitanins act as the facilitator to get the presumptive TB cases tested in the nearby microscopy centre. However, in Tripura, Madhya Pradesh and Maharashtra, TB patients in the community complained facing financial hardships and difficulty in diagnosis and treatment.

Training & Knowledge Gap

- ▶ Bihar, Jammu & Kashmir, Uttarakhand and Tripura, are unaware of the new treatment guidelines for the management of TB and Drug-Resistant TB.
- ▶ Training and knowledge of General Health Staff (MO, MPH-W-Male, and Female) and ASHA was adequate in Gujarat, but inadequate in Punjab, Jharkhand and Andhra Pradesh.

Human Resource

- ▶ Inadequacy of HR was a major issue in most of the states visited.

TB Notification

- ▶ **Public:** Annualized TB Notification Rates are below the target in Bihar, Uttar Pradesh, and Karnataka.
- ▶ **Private:** The patients notified by private facilities are lower than the expected number in majority of the states.

Nikshay Poshan Yojana (NPY)-

- ▶ DBT Status of TB patients under Nikshay Poshan Yojana are less than adequate in Bihar, Jammu & Kashmir, Uttarakhand, Himachal Pradesh, Uttar Pradesh, Arunachal Pradesh and Madhya Pradesh.

- ▶ NIKSHAY data entry was regularly being done at Block level by the RNTCP staff in Assam and Andhra Pradesh. In Tripura and Arunachal Pradesh patient enrolment in Nikshay was satisfactory but treatment outcome registered in Nikshay was not complete.

Diagnostic Facilities

- ▶ Well established CBNAAT Centres with adequate utilization were available in Andhra Pradesh and Karnataka but same were found underutilized in Bihar, UP, Maharashtra, and Tripura.
- ▶ Patients are reported to be travelling to CBNAAT Lab from distant places for giving their sample for testing, resulting in out of the pocket expenditure. Lack of organized mechanism for sputum collection & transportation was reported from Jammu & Kashmir, Rajasthan, Madhya Pradesh, Andhra Pradesh, Punjab, Uttar Pradesh, Arunachal Pradesh, Tripura and Jharkhand.
- ▶ X-ray facilities were functional in visited districts of Maharashtra. However, they were inadequately functional in the districts of Bihar, Gujarat and Tamil Nadu.

Schedule H1 implementation

- ▶ H1 register was maintained and updated in the visited pharmacies in Haridwar, Uttarakhand and Perambalur district of Tamil Nadu.
- ▶ State of Himachal Pradesh has developed a good system of Schedule H1 data reporting from chemists. But very few TB patients have been notified through Schedule H1 implementation by chemists in Bihar, Telangana and Tripura.

RECOMMENDATIONS

- ▶ Strict enforcement of the Gazette Notification mandating TB notification from private health care providers and private chemists.
- ▶ More intensified ACSM activities needs to be conducted for mass awareness on the newer activities especially NIKSHAY POSHAN

YOJNA (Nutritional support) and all diagnostic and treatment facilities available under the programme.

- ▶ All district level vacancies should be filled up at the earliest.
- ▶ Real-time updation of records in NIKSHAY needs to be ensured in all the districts for quality data analysis and feedback.
- ▶ Districts to establish sputum collection and transportation mechanism from the periphery to the CBNAAT laboratories as it has been observed that patients themselves are travelling to the CBNAAT site.

4.3 NATIONAL VECTOR BORNE DISEASES CONTROL PROGRAMME (NVBDCP)

KEY OBSERVATIONS

Community Awareness

- ▶ Awareness about vector borne diseases prevalent in the area especially of malaria and Dengue was found to be adequate in Madhya Pradesh, Chhattisgarh, Andhra Pradesh, Maharashtra, Uttarakhand, Punjab, Arunachal Pradesh and Tamil Nadu.
- ▶ Private consultations with non-registered Practitioners, quacks were found quite prevalent in Madhya Pradesh, Uttarakhand.
- ▶ Long Lasting Insecticide Treated Nets (LLINs) were distributed to the community in Arunachal Pradesh, high API sub-centres of Betul, Madhya Pradesh, Chhattisgarh, Tripura (District South Tripura) and Jharkhand. The community was aware of the benefits of using LLINs and was using it correctly. However, in Maharashtra and Bihar community lacked knowledge on maintenance of LLINs.
- ▶ Core vector control interventions like Indoor Residual Spray (IRS) were in place in Chhattisgarh & Arunachal Pradesh.

▶ In Gujarat, MP has undertaken linking of control of vector borne diseases with 'Swachh Bharat Abhiyan' for source reduction and vector management. Fogging and spraying was conducted in concurrence of Gram Sanjeevani Samiti in Gujarat.

▶ In Bihar, Uttar Pradesh, Rajasthan and Uttarakhand, vector control activities were found to be inadequate.

Healthcare Services

- ▶ The knowledge and skills of ASHAs and ANMs for diagnosis e.g. preparing thick & thin smears and treatment of malaria were satisfactory in Rajasthan and Arunachal Pradesh but inadequate in Madhya Pradesh and Uttarakhand.
- ▶ A Functional microscope and trained laboratory technicians were available in all health facilities PHC and above in Uttarakhand, Bihar, Rajasthan & Arunachal Pradesh. In Punjab, such facilities are available at DH level.
- ▶ Active screening and testing of symptomatic cases are reportedly not being done as required, in Tripura. Even documentation for the malaria tests being conducted and positive cases detected was found to be very weak in Tripura and Bihar as well.
- ▶ Availability of RDTs and anti malarial medicines with ASHA/ANM and in health facilities was found to be adequate in Gujarat, Jharkhand, Madhya Pradesh and Arunachal Pradesh. However, in Arunachal Pradesh, available ACT/ Chloroquine/Primaquine drugs were of short expiry at few visited facilities.
- ▶ District hospital at Raipur, Chhattisgarh, high endemic blocks of Bihar, few centres in Gadchiroli, Maharashtra, Uttar Pradesh UPHC Farrukhabad and Unakoti district, Tripura had inadequate supply of anti-malarial drugs and RDTs.

RECOMMENDATIONS

- ▶ Recruitment of all vacant positions for effective supervision and monitoring

- ▶ Sub-centre wise mapping of high risk areas using epidemiological data for intensifying the control strategy.
- ▶ Awareness activities need to be strengthened and monitored so as to ensure higher utilization rates of interventions like LLINs.
- ▶ Monitoring the use of LLINs for optimal coverage, results and policy decisions regarding further IRS continuation/stoppage in future is recommended.
- ▶ Appropriate and timely interventions for source reduction and community awareness for dengue is needed.
- ▶ Assessment, training of ASHAs/ANMs for correct diagnosis and treatment is recommended, non-performing ASHAs/ANMs to be identified and appropriately retrained or replaced with appropriate frontline health workers for this purpose.
- ▶ Capacity building of all frontline workers, DMOs, MOs, etc. across all cadres of health staff to be considered on priority.
- ▶ Documentation including reporting and recording needs to be strengthened. Monitoring of the programme needs to be intensified. Updated formats for malaria reporting need to be provided to the districts.

4.4 NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

KEY OBSERVATIONS

- ▶ Community awareness of the signs and symptoms of Leprosy and its complications was adequate in Chhattisgarh, Madhya Pradesh, Jharkhand and Arunachal Pradesh but poor in Maharashtra, Rajasthan, Gujarat, Arunachal Pradesh, Andhra Pradesh and Uttarakhand.
- ▶ Peripheral health workers in Chhattisgarh, Jharkhand, Maharashtra and Andhra Pradesh were found aware of the signs and symptoms of

leprosy and are actively involved in passive as well as active case detection as well appropriate referral of leprosy cases.

- ▶ Follow-up visits of the leprosy patients by the supervisory staff were found lacking in Chhattisgarh and Bihar.
- ▶ Appropriate records such as master treatment register, individual patient treatment card and disability register were available at rural and urban PHCs in Arunachal Pradesh and Gujarat but found lacking in Chhattisgarh and Uttarakhand.
- ▶ IEC/BCC activities for Leprosy were found very weak in Madhya Pradesh, Maharashtra, Punjab, Arunachal Pradesh, Uttar Pradesh and in district Raipur of Chhattisgarh.
- ▶ Adequate supply of drugs was available in the health facilities in Andhra Pradesh and at CHC level in Jharkhand. However, there was stock out of Prednisolone for last 6 months in district Korba of Chhattisgarh.

RECOMMENDATIONS

- ▶ Sensitization of MOs/AMOs towards correct & timely diagnosis and treatment of leprosy cases is required.
- ▶ Micro-plan should be prepared at all the levels for LCDC.
- ▶ Implementation of contact investigation with proper recording mechanism is required.
- ▶ Cases with Grade II deformities need to be identified and services provided.
- ▶ Integration of screening services to avoid duplication and to improve efficiency (e.g. LCDC+ACF). TB screening may be included in upcoming LCDC campaign and vice versa.
- ▶ Involvement of private practitioners for strengthening surveillance and appropriate care of Leprosy in private sector is recommended.
- ▶ IEC for removal of stigma around Leprosy needs to be strengthened. Sensitization or awareness campaign for migrant communities to cover the unreachd communities is crucial.

- Mechanisms of regular follow up and adherence to treatment of detected cases of such diseases needs to be developed and strengthened.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- The general community was found to be aware of the communicable diseases and availability of health services under the communicable disease control programmes.
- Good multi-sectoral coordination observed in East Godavari district for NVBDCP & Malaria Control activities. Inter-sectoral coordination for corrective actions at field with the support of GPS camera map app was reported.
- Under RNTCP, daily regimen has been initiated across the state. Functional CBNAAT machines are present in the districts. Drug Resistant TB (DRTB) Services are available. In Tribal Area CBNAAT machine is under-utilized (90/month).
- Nutritional Support Incentives for TB patients were not paid timely. Only 13% (538/4322) have received money in Ananthapuramu district. Home visits by RNTCP field workers to TB patients are not being conducted regularly in few areas.
- IDSP - Private facilities are not mapped and reporting from private facility is poor. Epidemic monitoring & prediction need to be improved.
- In Andhra Pradesh, it was reported that the leprosy patients are aware of the incentives provided for patients suffering from leprosy. Social security measures like Monthly Disability pensions for life to both Multi and Pauci bacillary cases were found to be in place. Free Dry Ration supply on first of every month at the doorstep of patients is being organized by Dist. Administration, E. Godavari, Andhra Pradesh.

Arunachal Pradesh

- The interviewed community was found to be sufficiently aware and proactive about the VBDs and its control and preventive measures. The

message has been imparted through effective IEC/BCC in terms of IPC in villages and municipal council ward.

- LLINs were also distributed to the community after every 4 years and people were aware of the precautions to be taken while using it. IRS was also being done as per the interviewed individuals and there was no resistance from the community.
- ASHAs of both rural and urban areas were fully aware of the symptoms and confident in RDT testing and treating positive malaria cases. ACT was available with them. Further, ASHAs were imparted timely refresher training. The ASHAs are regularly getting payments since last 2 years.
- ACT\Chloroquine\Primaquine were available but all the drugs were of short expiry. The common issues reported across the facilities were that short expiry logistics/medicines are pushed from state and frequent change of stock.
- All the visited health facilities had functional microscope and lab technicians. There was regular cross checking of slides at the facilities.
- IPC has been carried out by DVBDCPO, DVBDC, MTS, MPW and other field staffs under NVBDCP in each and every field visit and house visit. In hotspot areas, source reduction/ Swatch Bharat Abhiyan is being conducted thrice in a month with the collaboration of MAS, students and general public.
- Community is well aware of the cause of tuberculosis. TB Case notification in the visited district is good and increasing over the period. But at the State level, case notification is unsatisfactory and an area of concern.
- The microplan for LCDC was available at DH and CHC but not at the visited PHCs and UPHCs. IEC material related to leprosy was also not seen. The lack of IEC display was due to non-release of funds or material from the state.
- IDSP is functioning well in the State and implemented in all 20 districts through DSUs. All HR are in place. Unit established at the district level are reporting at state level regularly.

Assam

- ▶ Malaria control programme is effective in both districts as no malaria related deaths are reported in Barpeta and the API has also come down.
- ▶ Status of Nikshay Poshan Yojna is 95% in EGSA districts and only 9% in the non-EGSA districts. Awareness about Nikshay Poshan Yojna is not encouraging among the community.
- ▶ FRUs and CHCs are referring the presumptive TB cases to the nearest DMCs. However, neither sputum cups are being provided, nor records are being maintained for follow ups.
- ▶ Number of snake bite cases has significantly increased from 2016 to 2017. FRUs are not equipped with ASV. As per State response, only few designated facilities have provision of treatment for snake bites. Measles has shown an increasing trend over last three years in Barpeta.

Bihar

- ▶ The state is progressing well for Kala-Azar elimination. Trend of Kala-azar is declining and no death has been reported in the year 2016 and 2017 due to Kala-azar. Development Partners like CARE India, Kala-CORE, WHO, BMGF are also providing good support for Kala-azar elimination programme.
- ▶ However, surveillance activities for malaria were found to be inadequate. Only passive surveillance is being done at the PHC level. No active surveillance in the villages of endemic blocks is being undertaken. RDT kits were not available with ASHAs and ANMs. Anti-malarial treatment- Primaquine and ACT were not available in the district (Rohtas) and even in the high endemic blocks.
- ▶ NVBDCP Gol, guidelines were not being followed for the distribution of LLINs. Very low usage was observed among the community.
- ▶ A-PHCs/UHCs visited across two districts were reported to be not providing adequate services for disease control programmes and acute simple illnesses.

- ▶ Although 16,100 kg DDT was available in stock at the district, IRS could not be done since sufficient funds for spray wages were not available.
- ▶ Blood smear examination by slides was being done by LT at DH, SDH and some PHCs. Supply of smear and slides was also adequate. However, the quality of blood slide was not adequate at most of the places and no mechanism for ensuring quality of slides was in place.
- ▶ Less than 20% of the notified TB patients have been tested for DST. Most of the RNTCP staff lacks complete knowledge of UDST and universal diagnostic algorithm. Patient travel support guideline implementation needs to be strengthened for improvement of UDST coverage.
- ▶ The achievement for Nikshay Poshan Yojana (NPY) is less than 4% in Rohtas and less than 40% in Muzaffarpur.
- ▶ Many interviewed people were unaware of the existing facilities under RNTCP. Their first preference was private facility leading to an increased out-of-pocket expenditure. The awareness about Nikshay Poshan Yojana (NPY) was poor in the community.
- ▶ None of the X-Ray facilities were functional in the districts of Rohtas and Muzaffarpur due to pending contract renewal under PPP scheme for the last 5 to 6 months.
- ▶ During community interactions in village of PHC Kochas, interactions were held with a woman with leprosy with bone deformities and ulnar nerve thickening. She was diagnosed with Leprosy in 2016 and since then she has been receiving irregular treatment from a private provider, which has cost her around Rs 500 per month (OOPE).

Chhattisgarh

- ▶ Awareness among the community on services available for Malaria and TB treatment was good. Community targeted interventions like LLINs were available with the people and being used. However, maintenance of LLINs was inadequate due to inadequate messaging.

- ▶ Under RNTCP, screening for symptoms of TB is a part of regular field activity for Mitanins, which is highly appreciable. However, role of ASHA as DOT provider showed certain gaps.
- ▶ Gaps were also seen in Nikshay Poshan Yojana, and both districts had only about 45% beneficiaries registered.
- ▶ Under NVBDCP, RD Kits for diagnosis of malaria was being used at CHC, DH and Medical College at Raipur district. It is not a recommended routine test for diagnosis at the secondary and tertiary hospitals.
- ▶ District hospital at Raipur, Chhattisgarh, had stock out of anti-malarial drugs and even antimalarial injectable required to manage severe form of the disease.
- ▶ Home based morbidity management for Lymphedema patients was found lacking in Chhattisgarh as the Mitanins were not aware about it.
- ▶ Gaps were seen in National Leprosy Eradication Programme (NLEP), as there was no plan for Leprosy Case Detection Campaign (LCDC) in place and drugs were out of stock.

Gujarat

- ▶ Training and knowledge of General Health Staff (MO, MPHW-Male and Female) and ASHA regarding Tuberculosis was adequate. Recording and reporting was as per RNTCP guidelines. NITI Ayog Indicators (Total TB Notification Rate and Success Rate of New Microbiological Confirmed Case) are being monitored in regular video conference. As a result of it, total TB notification rate (public and private sectors) and treatment success rate from public sector is good.
- ▶ Universal DST (testing of all TB cases for drug resistant) has been initiated in the state. CBNAAT machine utilization was good in Porbandar district and suboptimal in Narmada district.
- ▶ ACF in high risk group population started in the state since last 3 years. Qualitative implementation of Technical Operational

Guideline (2016) and PMDT Guideline (2017) observed at visited facilities as per directives of Central TB Division. Mono H regimen and shorter DR TB regimen initiated in state recently in addition to Bedaquiline access since 2016.

- ▶ For disease control programme (NVBDCP, Water borne and IDSP), Fogging and spraying were being regularly conducted in concurrence with Gram Sanjeevani Samiti. Preventive action in the form of survey, fogging and anti-larval activities are initiated under NVBDCP. Free diagnosis and treatment services, Anti-malarial drugs were available at PHC in adequate quantity.
- ▶ The state has a plan to train and utilize Urban-ASHAs for all disease control programmes, which is appreciable.
- ▶ For NLEP, the recording and reporting of treatment card and registers was found to be as per guideline. Disability Prevention and Medical Rehabilitation services (like Ulcer Care Kit, Microcellular Rubber Shoes etc) were provided to beneficiary as per disability register. Disability register were available and well maintained at visited health facility.
- ▶ The state was undertaking special activity plan (SAP) from state budget other than LCDC, which is appreciable.
- ▶ Under IDSP, disease surveillance feedback is instituted from the State & districts to periphery and private facilities are included for reporting.

Himachal Pradesh

- ▶ Under RNTCP, commendable effort has been made by the state in improving TB case detection (including active case finding), ensuring treatment compliance and improving notification. Notification rates among the highest in the country and well above the estimated national detection rate to ensure elimination by 2025.
- ▶ State has launched a special scheme called “Mukhya Mantri Kshay Rog Nivaran Yojna” from state funds to fast track the TB elimination.

- ▶ Formation of RRT along with leadership from the district administration and other inter-sectoral departments has resulted in a coordinated outbreak control response of Dengue.
- ▶ An innovative good practice has been the introduction of the ‘dry day’ initiative – led by the District Magistrate and related line departments, there has been a major campaign to raise public awareness for source reduction by abolition of breeding sites for the vector. This includes an initiative to introduce financial penalty and/or a court notice under the Epidemic Diseases Act, on households where a breeding site (e.g. stagnant water with larvae) is found. Photographic evidence is provided before the ‘challan’ is made; despite initial apprehensions this has been received well and accepted by the public.
- ▶ Convergence between different departments (e.g. IPH, WCD) was reported to be good during outbreaks. A Dengue Death Audit Committee has not been formed to investigate Dengue deaths in the state.
- ▶ Risk assessment for leprosy and TB has been introduced in the ‘Community Based Assessment Checklist’ (CBAC) form for ASHAs.

Jammu and Kashmir

- ▶ Drug Sensitive and Drug Resistant TB patients are being treated in district as per latest RNTCP Guidelines. All diagnosed TB Patients should undergo CBNAAT Testing to know Rifampicin Resistance status of TB patient (Universal DST), which at present is being done for Sputum Smear Positive TB Patients. Sputum Collection and Transport mechanism needs to be strengthened for U DST in district.
- ▶ Medical and Paramedical Staff of district was trained in Treatment Operational Guidelines for RNTCP in 2016. But, trainings in Revised PMDT Guidelines 2017 and e-Aushadhi are pending in the districts.
- ▶ District has no DRTB Centre in District Hospital Doda, which should be created at the earliest with constitution of D DRTB Committee.

- ▶ Although RNTCP Contractual Staff has been provided with tablets for real time Nikshay entries, real time Nikshay entries in district are sub-optimal and needs improvement.
- ▶ RNTCP Laboratory Data of 2017 and 2018 shows that only 2 DMCs (DMC DH Doda & DMC Bhaderwah) are performing well. Rest 5 DMC have sub-optimal work load with low laboratory positivity.

Jharkhand

- ▶ The state has successfully reduced the number of malaria, falciparum malaria cases and case fatality rate of malaria. However, there has been an increase in the number of dengue cases over the years.
- ▶ All required drugs and diagnostics for malaria are available in all facilities. LLIN distribution and IRS has been conducted in identified areas.
- ▶ In Jharkhand a decline in incidence of Filaria cases has been observed. MDA round was conducted and community was aware about it. However, as per records, many cases need Hydrocele operation.
- ▶ Under RNTCP, state has established 324 Designated Microscopy centers, 36 CBNAAT machines, 1 Intermediate reference laboratory, 5 Nodal DRTB centers and 10 District DRTB centers.
- ▶ An increasing trend of TB notification from private sector was reported for Jharkhand, though in Bokaro, notification from Private chemist was reported to be very less.
- ▶ For presumptive TB cases, X-ray facility is not free and very few private TB patients get CBNAAT test done.
- ▶ LCDC campaign and Sparsh leprosy awareness campaign was conducted in the state in high focus districts.
- ▶ Jharkhand reported an outbreak of Chikungunya and Dengue in Ranchi district. Timely response to outbreak was taken and necessary activities like house to house surveillance, community awareness and various IEC activities were conducted.

KARNATAKA

- ▶ Overall, the TB programme is in the right direction towards National targets set for TB elimination with high level politico-administrative support. The formation of state level programme review committee under the chairpersonship of Hon'ble Chief Minister, the State TB forum with stake holders and intra-departmental coordination are underway. The districts are following the formation of sub-committees at their level.
- ▶ The integration framework of NUHM RNTCP has been formulated to improve TB case finding and care and a comprehensive collaborative project JEET for private sector TB notification has been launched.
- ▶ The State has undertaken the newer initiatives as per latest guidelines and implementing U-DST since April 2018 and DST guided Drug Resistant TB (DRTB) management with newer drugs Bedaquiline and Delaminade.
- ▶ Govt. of India's newer initiative 'Nikshay Poshan Yojana' (NPY) needs further system strengthening and state monitoring to credit with 100% of NPY benefits through DBT.
- ▶ The efforts taken by the state health department in source reduction activities is laudable. One main initiative was "Sarvajanikarigondusavaal" (Question to the public) campaign in which households were visited by team of ASHA and ANM, Aedes breeding sites were identified, source reduction measures were taken up. Information was collected from households through a questionnaire & marks were awarded. Based on these marks a certificate of appreciation was given to the "best household, best village, best grama panchayat & best taluks".
- ▶ It has been noted that there is sustained decrease in malaria incidence in the state. Karnataka is one of the earliest states to prepare an action plan for elimination of malaria. The State Framework for Malaria Elimination is ready and has been approved by the Govt of Karnataka. However, multi-sectoral co-ordination and legal requirements need to be pursued.

- ▶ Though reported MDA coverage is quite high in various districts of Karnataka, the evaluation studies show significant gap between reported coverage and actual coverage. The compliance gap needs to be addressed. Lymphoedema survey is to be strengthened in the endemic areas.
- ▶ Detection and investigation of outbreaks is going on well. However, improvement is required in utilization of data reporting in picking up increasing trend of diseases, proper documentation of the investigation, and identification of particular pathogens. The team appreciates the external quality assurance activities of sentinel laboratories.
- ▶ During 2017-18, Leprosy Case Detection Campaign was carried out on a mission mode in the selected 5 districts with more than 92% of targeted population covered. 264 cases were detected. ASHA Based Surveillance for Leprosy Suspects (ABSULS) and Focused Leprosy Campaigns have also been carried out very well. Rifampicin prophylaxis for contacts of leprosy cases is also going on well.

Madhya Pradesh

- ▶ Awareness among community about diseases prevalent in the area especially malaria and dengue was found to be adequate.
- ▶ LLINs have been distributed in the high API sub-centres of Betul and are being used by people as observed during the house to house visit. Community reported usefulness of LLINs in protection from mosquito bites and malaria.
- ▶ ANM/ASHAs have received training for active malaria case finding at community level, but they are not focusing on the same due to low priority to Disease Control Programmes by ASHAs. They are involved in both passive and active surveillance of malaria but lack the skills for performing RDT for malaria as well as slide preparation. Knowledge regarding treatment of malaria was also found to be inadequate. Wrong diagnosis using RDTs by ASHAs/ANMs and administration of wrong treatment to the patients is a matter of concern which needs

urgent attention. Availability of RDTs and medicines with ASHAs/ANMs was reported to be adequate.

- ▶ Male Multipurpose Workers- MPW(M) are fully engaged in MCH and immunization activities but their role in active surveillance of communicable diseases like malaria, leprosy, TB, etc was very limited. This needs to be addressed on priority to improve disease surveillance.
- ▶ Sentinel Site Hospitals (SSHs) for Dengue have been reported to be functioning well with adequate availability of testing kits. However, NS1 utilization was reported to be low as compared to IgM, which indicates late referral/detection of cases.

Maharashtra

- ▶ Under RNTCP, adherence to treatment, follow-up, monitoring and supervision was reported to be good in both districts.
- ▶ However, 40% of estimated TB patients not being reported, more so in Satara where private sector is present in large numbers. JEET project has recently been launched in Satara, to sensitize private practitioners.
- ▶ District DR TB Centers are functional, free diagnostics and drugs are available. Newer drugs 'Bedaquiline' is accessible to patients. Nikshay-Poshan Yojana is being implemented in both districts.
- ▶ Service providers up to ASHA level are well aware about RNTCP. However, case detection and reporting is weak with less number than expected cases were detected. Though special drive has helped in improving TB case detection. Shortage of Falcun tube and pediatric TB drugs was seen in both districts
- ▶ Epidemic outbreaks are being identified and investigated by Rapid Response Team under IDSP.
- ▶ Good implementation of 1st phase of Leprosy Case Detection Campaign (LCDC) activity has been reported. In urban areas of visited district of Maharashtra, a community habitation for

the leprosy patients (Kustha Niwas) has been created through individual donations. Health department sends personnel for their check-ups and provides medicines regularly. Case management in terms of counseling, visits, linking patients with social welfare services is good. Clinical care services rendered at District Civil Hospital is good in Satara.

- ▶ Good awareness in community about vector borne diseases were found, however, awareness about maintenance of LLIN was poor.

Punjab

- ▶ The general community awareness about the disease control programmes was found to be adequate. The people are aware about preventive measures for vector borne diseases, provision of free diagnostics and free treatment services for Tuberculosis at the Government health facilities.
- ▶ The DOTS centre is easily accessible to the community. Daily treatment under DOTS regimen is being provided to the patients.
- ▶ However, the community in Moga was not well aware that any kind of nutritional support in the form of Direct Benefit Transfer that is being provided by the government for TB patients. There is no visible IEC material like wall paintings, in the village.
- ▶ The ASHAs interacted at the facility were aware of change in treatment regimen and provision of Rs 500 as nutritional support for TB patients.
- ▶ Medicine stock for TB was available and there was no shortage of drugs generally. in Gurdaspur, however, there was shortage of Inj. Streptomycin and pediatric TB drugs.
- ▶ The RNTCP staff was well trained and well aware of the newer diagnostic methods and the new guidelines. However, the RMOs and medical officer interacted were not trained in new technical and operational guidelines and new PMDT guidelines. The ANMs and ASHAs had received training about 1.5 years back. Hence some knowledge gaps are present.

- ▶ At the health facilities, lack of awareness among medical officers about Malaria drug policy at the PHC was observed.
- ▶ Surveillance system established from sub-district to district level and with functional rapid response team. S, P and L forms are duly filled and submitted regularly. Data is analysed weekly to identify signs of outbreaks.

Rajasthan

- ▶ Public sector notification for TB is nearly 100% but only 50% in private sector notification in both districts.
- ▶ Smear microscopy services are available in all PHCs under Mukhya Mantri Nishulk Jaanch Yojana (MNJY). However, quality of microscopy is sub-optimal at Peripheral Health Institutes (PHIs) other than Designated Microscopy centres (DMCs) in Jodhpur. Sputum microscopy being performed at most of PHIs in Baran but only in approx 50% in Jodhpur. No facility for sputum microscopy at UPHCs.
- ▶ Under Nikshay Poshan Yojana (NPY), 58% beneficiaries in Baran and 21% in Jodhpur received DBT.
- ▶ There is no special provision of training under RNTCP/ NVBDCP. They are being merged with sectoral meetings and other trainings, which is adversely affecting the quality.
- ▶ During visit to Sorshan village in Baran district water logging, mosquito breeding sites, larva colonies were observed. The community here was found to be unaware of the causes of fever, and vector borne diseases like Malaria and Dengue.
- ▶ Overall knowledge and involvement of ASHAs, SWACH (community) workers is found to be good in Baran but sub-optimal in Jodhpur.
- ▶ Sprash Leprosy Eradication Campaign has been initiated. State prevalence rate is below the National level at 0.15 per 10000 populations. Medical Officers, Health Workers and ASHAs are being regularly trained. The state has taken initiative for focused leprosy campaign, case

detection in hard to reach area and ASHA based surveillance for leprosy. However, community level awareness on leprosy found very low and no incentive is being given to ASHAs in either of the districts visited.

- ▶ The state has a good practice wherein students of medical college were involved in house to house survey for source reduction activity in the month of March 2018 when 50,000 household were examined.
- ▶ To combat incidence of diseases and prevent deaths, the state of Rajasthan has been undertaking campaigns through multi-sectoral coordination, intensification of routine activities (Dengue Mukt Rajasthan) etc.

Tamil Nadu

- ▶ Community level awareness about the epidemiology of spread of Dengue and Malaria among villagers was found to be adequate.
- ▶ National programmes for diseases control are mostly restricted to the district hospitals and in some places Taluka level hospitals. The linkages with the community have not yet been created as a routine. Without these linkages, these services are underutilized and the equity component is being affected. In urban areas, focal laxity in slide preparation in fever cases was also noticed.
- ▶ Observations of initiatives under RNTCP program were varied. Community awareness about the symptoms, disease and the how to avail services are low in Perambalur but satisfactory in Ramanathapuram.
- ▶ Good efforts have been made to reach out to the private practitioners. The notification gazette has been used as a catalysing tool to inform of the mandatory nature of notification, the legal provision applicable if there is no notification from private sector and the patient support in place from RNTCP side including NIKSAY Poshan Yojana for TB patients.
- ▶ The involvement of the IMA has paid a major role in improving notification from private sector. The district has also put in place a

feedback mechanism whereby the details of the TB patients notified by the private sector are provided to them.

- ▶ NLEP is in place as per the programme mandates in both the district. Village and Slum survey, surveillance and case finding activities were reported to be in place.

Telangana

- ▶ From the community perspective, it was observed that beneficiaries are aware that all the services for communicable diseases can be availed over and above the CHC level but are unaware that certain services can be availed at Community/SC level. In addition, they feel that comprehensive services are not available at PHC level and level below.
- ▶ The population-based enumeration has been completed and screening of population has been initiated. Leprosy and TB, however, were not included in the CBAC (Community-Based Assessment Checklist) form.
- ▶ Telangana has reported an increase in the number of Dengue and Chikungunya cases in the current year (up to August), as compared to 2017. Zero Case Fatality has been reported so far. Eight districts have been identified as high priority districts and intensified surveillance activities are being carried out in these districts.
- ▶ Poor uptake of newer drug regimen like Bedaquiline and shorter regimen was observed. District DR-TB Centre in Karimnagar was inaugurated last year but due to unavailability of a nodal medical officer, the centre now caters to DR-TB patients on OPD basis only.
- ▶ The state has reported a slight increase in the Annual New Case Detection Rate (ANCDR) for Leprosy from 0.72 /10,000 population in 2016-17 to 0.77 /10,000 population in 2017-18, which can be attributed to increased case finding efforts like the Leprosy Case Detection Campaign (LCDC). The efforts need to be sustained to ensure the achievement of national targets for elimination of Leprosy.

Tripura

- ▶ Awareness among the community members regarding signs and symptoms for common communicable diseases is low. However, the knowledge of ASHAs, and MPWs regarding signs and symptoms of the communicable diseases was satisfactory.
- ▶ There is a sense of complacency in the programs of malaria and TB. Even the suspected cases, which are reaching the system, are not being tested.
- ▶ Active screening and testing of symptomatic malaria cases are not done as required. It was observed that even the fever cases are not promptly screened and tested for Malaria.
- ▶ In Unakoti district, Tripura, supplies of anti-malarial drugs, RDT's, microscopic slides, lancets were found to be inadequate.
- ▶ Appropriate vector control measures are being taken at the community level in South Tripura District. LLINs have been distributed to all the houses visited and are being correctly used. However, there were certain issues reported regarding insufficient quantity of nets distributed per household and quality of Indoor residual spray.
- ▶ Documentation was found to be inadequate and varying at different levels of the facilities, under reporting of cases too was observed in Tripura.
- ▶ There was a lack of awareness on Nikshay Poshan Yojna amongst both community and service providers including ASHAs.
- ▶ The quality of treatment provided to TB patients was reported to be unsatisfactory.
- ▶ IDSP is being implemented in both the districts. The Rapid Response Teams are also in place. In South Tripura District, health facilities are reporting under IDSP on regular basis.

Uttarakhand

- ▶ Community was well aware about Malaria and Dengue, and the role of mosquitoes in the

spread but they sought treatment from private practitioners for fever related treatment as they believed that there is lack of medicines and doctors at govt institutions.

- ▶ Diagnostic services for Tuberculosis were available free of cost to the community as found during discussions, but multiple visits were required before the treatment was initiated.
- ▶ Delayed DBT disbursal for incentive for diet was reported in Uttarkashi and Haridwar had paid to 73% (1583/2158) eligible beneficiaries (Apr-May'18).
- ▶ Schedule H1 register was maintained and reports were submitted to DTO, by the 4 sample chemist shops visited in Haridwar. This was not the case in Uttarkashi.
- ▶ ASHAs of Uttarakhand have not been trained in malaria for the last six years and no testing or treatment kits have been made available.
- ▶ State, districts and blocks have formed Rapid Response Teams (RRT) to investigate and mitigate the impact of epidemics. Team at State level includes Food Safety Officers (for Food borne disease OBs) and Veterinary Officers (for Zoonotic disease OBs)
- ▶ Most of the Medical Officers were found to be untrained under IDSP and whosoever was trained has not undergone refresher training in recent past.
- ▶ Open drains and stagnant water were found in most of the villages visited.

Uttar Pradesh

- ▶ ASHA's focus in the community is largely on MCH services, and NCDs and Vector borne disease health issues are largely neglected or overlooked.
- ▶ Vector control activities were almost negligible in the community (both rural and urban) resulting

in high density of mosquitoes. Preventive activities conducted in districts like spraying, anti-larval activities, vector control programme and insecticidal activities was found to be patchy in Varanasi and non-existent in Farrukhabad.

- ▶ Fever rate in the community is high but slide examination rate is very low and needs to be monitored. UPHC Farrukhabad had stock out of malaria testing kits therefore slide examination was not being conducted.
- ▶ The TB notification rates are low in both the districts (Farrukhabad-30% and Varanasi-36%).
- ▶ Only 10% TB patients have been benefited by DBT in the State under NikshayPoshan Yojana. Farrukhabad & Varanasi reported DBT for 4% & 10% TB patients respectively.
- ▶ No stock outs for Anti-tubercular drugs and diagnostics reagents and other logistics was reported.
- ▶ Contact tracing activities were not satisfactory (evident from two sub Centre- Gadalpur & Barjhala sub center). State is investing a lot in ACF activities but it remains largely neglected.
- ▶ Public health actions like home visit, family counselling, HIV testing, contact tracing, universal drug sensitivity adherence & outcome are not being ensured for the TB patients from private sector.
- ▶ Leprosy case detection campaign, focused leprosy campaign and SPARSH leprosy awareness campaign is not satisfactory and needs strengthening.
- ▶ The overall hygiene and sanitation condition were poor in all visited villages. Open drains, tying of cattle in the premises near to water source (majorly hand pump) and adjoining cooking area gives a grim picture of Swachh Bharat Abhiyan. Source of drinking water is hand-pump and use of boiled water during rainy season was not observed.

NCD (NON-COMMUNICABLE DISEASES)



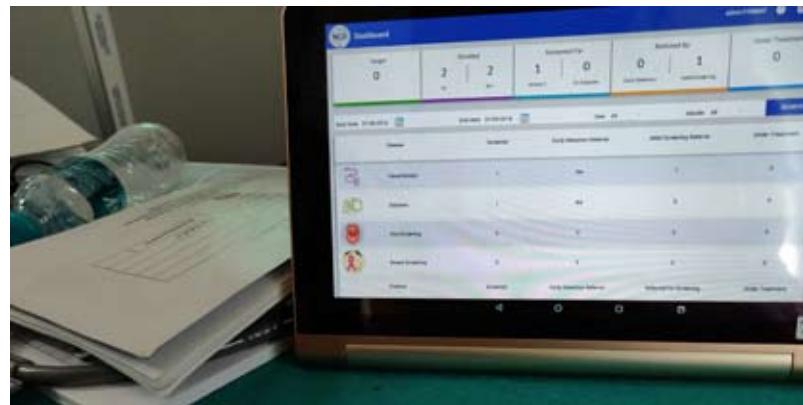
5.1: NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIOVASCULAR DISEASES AND STROKE (NPCDCS)

Implementation of Universal Screening of Non-Communicable Diseases for individuals of 30 years and above age group started in beginning of year 2017 and has been envisioned as a step to expand the range of services to be delivered under Comprehensive Primary Health Care (CPHC). Universal Screening of common NCDs envisages that risk assessment, screening, referral and follow up for common NCDs (hypertension, diabetes, cancers of oral cavity, cervix and breast) amongst all women and men aged 30 years and above is to be included in the service to be delivered as a part of CPHC. Population enumeration, Health promotion, community-based risk assessment through use of a checklist by ASHAs, sub-centre level screening by ANMs and continuum of care through referral, treatment initiation, medicines dispensation and follow up are the critical activities planned.

This section summarizes the CRM findings with regards to roll out of Universal Screening of Common NCDs in nineteen states visited during twelfth Common Review Mission.

KEY OBSERVATIONS

Implementation of universal screening, prevention and management of common NCDs initiative was



observed in different stages across the states. Certain states were also implementing state specific initiatives for screening of women for NCDs, such as Mahila Master Health Scheme in Andhra Pradesh and Sampoorna clinic in Uttar Pradesh. However, it was observed that, Sampoorna clinic was not completely functional at DH in one of the districts of Uttar Pradesh, Farrukhabad, as cancer screening services were not being provided.

HEALTH PROMOTION AND COMMUNITY MOBILISATION

Health promotion is an integral part of the Universal Screening of common NCDs. The state findings indicated a need to focus more on IEC and health promotional activities along with the service delivery. Only few states like Gujarat, Jammu and Kashmir and U.P. mentioned about availability of some IEC material displayed at the facilities in regards with NCD programme. However, it was also reported that due to text heavy posters, the IEC materials displayed in facilities in Uttar Pradesh

were not readable and hence community did not pay attention to it.

Community in most of the states did know about NCDs like hypertension and diabetes and their associated risk factors. Although, the programme was already implemented in all the districts visited during the CRM, yet none of the states reported the community being aware of NCD services being available at the level of primary health care facilities. Community was preferring higher level of centres to get screened, as well as to get the medicines for common NCD conditions like hypertension and diabetes. In addition, medicines were being dispensed for a duration of 5-7 days at the public facilities. This was one of the reasons the community availed services from nearest private practitioner/facility as the medicines were dispensed for a longer duration there and also the distance was lesser than that for public facilities.

It was observed that OOPE for a patient of hypertension and diabetes was majorly on medicines, transport and multiple visits to the health care facility. None of the states reported of any health promotional activity being undertaken at the level of community. In states like Rajasthan and Tripura, high use of tobacco was seen amongst men and women, but no initiative was undertaken to address these issues in the community. Community platforms like VHSNC/MAS were not aware of their roles and thus not actively involved in conducting meetings or initiatives at the community level to prevent NCDs and promote healthy life style.

POPULATION ENUMERATION AND SCREENING

Population enumeration has been initiated in most of the states, however not much has been reported on line listing of the target population and status of family folders. In Jammu and Kashmir, ASHA diary has been revised by the state to document the information on individuals of age thirty years and above. However, the block level functionaries and ASHAs were yet to be explained the purpose of collecting this information.

In June 2018, the Community Based Assessment Checklist (CBAC) was revised to include questions related to Tuberculosis and Leprosy, however, except for Himachal Pradesh and Maharashtra, none of the states reported of using the revised checklist for risk assessment.

Filling of CBAC form in Jammu and Kashmir, was being undertaken by ANM/MPW and thus ASHAs are not aware of the risk assessment checklist. ASHAs are not involved in CBAC and thus they have limited knowledge on risk behaviours of individuals in the community and the ANM/MPWs consider it as an additional documentation.

Universal screening was not reported and mostly opportunistic screening was being done for hypertension and diabetes in most of the states. Only few states like Gujarat, Assam, Rajasthan and Telangana reported of screening at the SC level. States like Andhra Pradesh, Punjab and Uttar Pradesh reported screening also being done for NCDs under existing state specific programme. Chhattisgarh and Jharkhand reported of workforce being trained for VIA to screen for cervical Cancer.

HUMAN RESOURCES

In NPCDCS districts visited, functionality of NCD clinics was variable; and HR shortage was reported across the districts except in Gujarat. At CHCs, NCD clinic was reported to be non-functional in Rajasthan, Jharkhand and one district in Punjab. In Bihar, NCD related services in NPCDCS districts were provided only up to the level of DH and there was no screening or reporting done at block and APHC level. Deployment of staff in NCD clinic-Medical Officers and Staff Nurses to other units in DH/CHC such as OPD, delivery ward was reported in states of Assam and Bihar. This was further affecting functionality of NCD clinic.

- ▶ Building the capacity of frontline workers and service providers forms the first step for implementation of universal screening, which was initiated or had been completed in all the states visited. However, quality of training varied and therefore certain competencies were lacking in trained service providers. In all

the HWC facilities visited during CRM, ASHAs were trained/oriented in Universal Screening of NCDs except in Bihar and few facilities in Madhya Pradesh and Uttar Pradesh. Although in most of the states, like Andhra Pradesh, Himachal Pradesh, Jammu and Kashmir, Rajasthan and Punjab, training duration for frontline workers was reduced, thereby affecting their knowledge and skills.

Other issues related to training were noted in Rajasthan where training of ASHAs was conducted by trainers who had not been previously involved in ASHA training. Similarly, in Jammu and Kashmir, training modules were provided in English to the frontline workers, which they were not able to read. Joint one day training of ASHAs and MPWs was not reported from any states. Planning for training was also observed to be lacking as MPWs were trained in state like Bihar, but ASHAs were not trained and therefore, process of population enumeration and community-based risk assessment was not yet initiated.

MPWs- F were trained in use of NCD module of CPHC application in Bihar and Jharkhand. In Assam, CHOs were also trained in universal screening of NCDs. In Jammu and Kashmir, ANMs at the SC-HWCs were trained on NCD module and were well versed with the application. However, they were currently not using the application for entering the data, and requested if hand holding can be done for some time so that they get confident to use the application on their own.

MO and staff nurse at PHC were trained in universal NCD screening in Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Jharkhand and Maharashtra, however no such training was conducted in Uttar Pradesh, Madhya Pradesh and Rajasthan. This is affecting continuum of care, as staff at PHCs is not oriented to the programme. Fourteen-day training of staff nurses for cervical cancer screening using VIA as per the guidelines was not reported in any of the state. Tamil Nadu has planned 1-month training of



nurses and in Maharashtra, training was ongoing at the time of visit. In Chhattisgarh, staff nurse at PHC was trained for six days and in Jharkhand, a staff nurse at DH was trained for five days and were conducting screening using VIA.

Lack of clarity about Universal Screening of NCDs guidelines was noted among programme officials in few states like Rajasthan, which has affected the planning, training and service delivery. In Jammu and Kashmir; however, the district NCD officials were very efficient and well-aware of the guidelines, but due to human resource shortfall across the facilities, they were unable to deliver the services.

Tamil Nadu has adopted a different model for provisioning of screening for NCDs. State has engaged one Women Health Volunteer for each SHC where ASHA is not there to undertake population-based screening of NCDs. A 3-day training session has been undertaken to orient these WHVs. In HWCs, second VHN is posted, who is facility based and undertakes various activities like NCD screening, facility based diagnostic tests, and dispensing medicines against valid prescriptions etc.

DIAGNOSTICS

Diagnosis is a crucial part of rolling out the programme as demand for diagnostics will increase after screening. However, in many districts visited, supply of consumables was not streamlined and issues were faced in procurement and supply of especially gluco-strips (Arunachal Pradesh and Himachal Pradesh). In Chhattisgarh, strips were procured using JDS funds. In Arunachal Pradesh, strips supplied during screening camps had expired two months before the visit, thus screening process was stopped. In most of the states, suspected individuals were referred to PHC (or MMU as in case of Andhra Pradesh) for diagnosis confirmation of Hypertension and Diabetes and to DH for cancer confirmation. However, semi auto analysers were not available in any of the PHCs visited, and diagnosis of diabetes was done using capillary blood glucose measurement, which is not

suggested as per standard treatment protocols. In most of the states, cancer confirmation tests are available in tertiary care centres. Some of the tests like biopsy, FNAC, PAP smear, mammography needs to be made available at DH/SDH level as per IPHS. This will reduce the loss to follow up of suspected cancer cases screened at SHC/PHCs. Calibration of equipment at peripheral facilities was reported to be lacking in Tripura, where weighing machine was showing wrong results. User fees were charged in few states like Jammu and Kashmir, Uttarakhand for diagnostics even at PHC level.

MANAGEMENT OF NCDs

Availability of antihypertensive and antidiabetic medicines as per EML was reported in most states like Gujarat, Rajasthan, Chhattisgarh, Assam, Andhra Pradesh, Tamil Nadu and Maharashtra. Antihypertensive and antidiabetic medicines were available at sub centre level in only four states- Assam, Andhra Pradesh, Tamil Nadu and Rajasthan. However, in Rajasthan, medicines were not being utilized at SHCs due to lack of clarity about dispensation power by MPW (F) and CHOs. In some of the states (Assam, Himachal Pradesh), medicines were prescribed only for duration of one-two weeks, which again increases the patient's hardships and might disturb continuity of care. Erratic supply of medicines was also observed in states, which further reduces community trust in public health facilities. Findings from Punjab reported of change in treatment plan of patients due to irregular supply of medicines, which is clearly against standard treatment protocols. In Madhya Pradesh and Uttar Pradesh, medicines were available at facilities according to essential medicines list; however, utilization was low. Most patients in these states were taking treatment for hypertension and diabetes at private facilities and did not know about treatment facilities at DH/ CHC/PHC. In Uttarakhand medicines were being prescribed from outside, even though these medicines were available in the facility. In Jammu and Kashmir, certain combination medicines for

hypertension were prescribed from outside as these were not available in EML leading to high OOPE.

Cardiac Care Unit was reported to be non-functional in districts of Jharkhand, Maharashtra, Punjab, one district of Bihar and one district of Gujarat. Non-availability of specialist was reported as the reason for non-functionality of CCU in Jammu and Kashmir. Chemotherapy was reported to be available only in Gadchiroli district hospital of Maharashtra and in other states, patients had to travel to tertiary care centres for chemotherapy.

REFERRAL & FOLLOW-UP

Continuum of care is essential for chronic disease management. Still, referral and follow up mechanism was found to be weak across states like Assam, Chhattisgarh, Bihar, Himachal Pradesh, Uttar Pradesh, Jammu and Kashmir and Tripura. This includes back referral of controlled/stable cases from higher facilities- CHC/SDH/DH to PHC/SHC, which was not reported in any state.

The documentation for identified cases is not proper and recorded in any of the states. A line list of patients with hypertension and diabetes at SHC/ PHC was missing in most states. Moreover, it was observed in Tripura, that although such list was prepared by ASHAs, it was not being used at SHC or PHC for tracking patients. Referral cards/diaries also act as a tool for follow up, which were either not observed or not used properly for strengthening follow up mechanism. Lack of follow up mechanisms for positively diagnosed cases has emerged a critical challenge, and in absence of records for identified cases it is difficult for the service providers to follow up for treatment compliance. There is no mechanism to confirm if the suspected cases at the SHC level, are reaching the PHC/CHC MO to get a confirmatory diagnosis and a treatment initiation.

In Tamil Nadu, a good practice was observed where, the Women Health Volunteers were instructed to exclusively cover those missed during the week's screening and also follow up of those who dropped from treatment/ confirmatory tests at PHC on every Saturday.

In Punjab, India Hypertension Management Initiative (IHMI) was functional at district hospital Gurdaspur. Under IHMI, one portion of the card is given to the beneficiary and other is kept at the facility, to track for follow up. Follow up for patients is done under IHMI, but the counsellors had to call the patients from personal numbers.

RECORDING & IT SYSTEM

Reporting and recording were done as per formats in most states except, Chhattisgarh and Himachal Pradesh. Digital system for recording data was being used only in Andhra Pradesh, where MMHC application is being used for recording data of screening and treatment details for women above 30 years. NCD module of CPHC application was not being used in any state. In Bihar, MPWs- F were trained for application use, however ASHAs were yet not trained in NCD screening and hence, population-based screening was not initiated. Tablet procurement process is taking long time in most states, thereby delaying the use of application. In Madhya Pradesh, MPWs were asked to purchase tablets and were reimbursed. Non-availability of login ID and password was observed in Jharkhand and Rajasthan for application and portal respectively. In Himachal Pradesh, health workers reported problems with up-loading data on-line due to duplicate patient registration numbers. In Jammu and Kashmir, MPW were trained and tablets were available, but data entry was not being done.

RECOMMENDATIONS FOR NPCDCS

- ▶ States should expedite the training for all cadres on a priority basis as per the standard guidelines, including one day joint training of ASHAs and ANM/MPWs.
- ▶ For states, where the training for front-line functionaries has been conducted for a shorter duration, a refresher should be planned to cover for the remaining days, with main focus on health promotion, reporting & recording, and follow up mechanism.

- ▶ Role and responsibilities of ASHAs and ANM/MPWs in health promotion activities to be discussed during monthly meetings by the block level officials. Involvement of community-based platforms like VHSNC/MAS/PRI/ULBs to be ensured for health promotion and screening activities.
- ▶ It should be ensured that the revised CBAC are available at the level of SHCs, and the workforce is reoriented on the format.
- ▶ States need to ensure that ASHAs do the line listing and population enumeration and are able to mobilize the listed individual to be screened at the SHC.
- ▶ States to expedite the screening of four common NCDs- hypertension, diabetes, breast cancer and oral cancer at SHCs on a priority basis.
- ▶ There is also a need to plan a simultaneous roll out of the programme in urban areas.
- ▶ Diagnostics availability to be ensured at SHC, PHCs and also at secondary care facilities to maintain continuum of care after screening.
- ▶ Availability of medicines to be ensured across levels of facilities especially SHCs to reduce out of pocket expenditure. Clear guidelines to be communicated to block level officials and service providers regarding medicine prescription and dispensation.
- ▶ Prescription audit is recommended to check on prescription of irrational medicines.
- ▶ States should also strengthen reporting and recording mechanism to ensure the follow up of positively diagnosed individuals.
- ▶ States to ensure procurement and availability of IT hardware, including tablets for MPWs and smartphones for ASHAs. There is need to initiate training of workforce on NCD module of CPHC application.
- ▶ Examples from states like Tamil Nadu and Punjab can be followed and district officials can map the facilities, in order to ensure referral to appropriate centre for confirmation and back referral for continuation of care.

STATE SPECIFIC FINDINGS OF NPCDCS

Andhra Pradesh

- ▶ Both the districts visited were included in NPCDCS programme. Also, State is providing NCD services (seven services-HT/DM/oral/ breast/cervical Cancer/hormonal assay/vision) to the women above 30 years of age, through Master Mahila Health Scheme (MMHS) since 2016.
- ▶ Currently, universal screening of common NCDs is being rolled out only in rural areas under HWC-PHCs.
- ▶ At the level of SHC, opportunistic screening is being conducted for Hypertension and Diabetes, while screening for cancer is not being conducted.
- ▶ Training of front-line workers i.e. ASHAs and MPWs is not in congruence with the operational guidelines.
- ▶ At the level of community, older version of CBAC is being used by FLWs, which does not include questions related to tuberculosis and leprosy.
- ▶ Medicines for diabetes and hypertension are available up to the level of SHC. Essential medicines for NCDs were available.
- ▶ MMHC application is being used for recording data of screening and treatment for women above 30 years.
- ▶ Community had knowledge regarding hypertension and diabetes and they reported visiting PHCs/CHCs for regular screening of NCDs. However, knowledge regarding cancer is less in the community.

Arunachal Pradesh

- ▶ Basic facilities like internet access and mobility support are lacking at district NCD clinic.
- ▶ Shortage of HR observed at NCD clinic.
- ▶ Universal screening of common NCDs is being rolled out in only five Sub centre and

screening is being done only for hypertension and diabetes. However, currently, screening was not being done for diabetes as glucometer strips had expired two months back and there was no further supply.

- ▶ Suspected individuals are referred directly to the District Hospital, and linkages with primary care facilities was missing.
- ▶ Community awareness on Non-Communicable Diseases was lacking in both the districts.
- ▶ Most patients were availing treatment from private health care facilities for hypertension and diabetes. It was observed that, medicines outside EML were being prescribed thereby increasing OOP even if treatment is availed at public health facilities.

Assam

- ▶ Population enumeration and CBAC form usage has been started in 16 SHC- HWCs. Primary care team of these HWCs (MLHPs, MPWs and ASHAs) were trained in universal screening and management of NCDs.
- ▶ Shortage of HR- MOs and councillors was observed at NCD clinics. Clinic was not functional on all working days as staff nurses were deployed at other units like OPD, delivery ward etc.
- ▶ At SHC-HWCs, fixed day screening was being conducted twice a week. Opportunistic screening was conducted at PHC, CHC and DH.
- ▶ Essential medicines and diagnostics for NCDs were available at all the levels of primary health care facilities.
- ▶ Medicines for hypertension and diabetes were prescribed only for a week and patients were called weekly for refilling of medicines.
- ▶ No follow up mechanism of suspected cases for diagnosis and treatment compliance of diagnosed cases was observed in any of the health facilities.
- ▶ Community members were aware about increased prevalence of hypertension, diabetes and about availability of medicines and

diagnostics for hypertension and diabetes at HWCs.

Bihar

- ▶ District NCD clinics were functional in both the districts. NCD clinic staff was in place, however, due to constant rotational deputation of MOs, NCD clinic was not properly functional.
- ▶ ASHAs were not yet trained in universal screening and management of NCDs and thus, screening was not yet started in the HWC-APHC. In addition, as the SHC were not upgraded to HWCs, no community-based activity was started.
- ▶ Cardiac Care Unit was found functional at both the districts.
- ▶ Community members reported not being screened for any NCD during camps or at facilities.
- ▶ On interaction with community it was reported that the community was aware that treatment for hypertension and diabetes is available only at DH.

Chhattisgarh

- ▶ Process of population enumeration, filling CBAC and family folders has not started in both the districts.
- ▶ MOs, AMOs, Staff Nurses and MPWs have received three days training on NCD.
- ▶ At a PHC- HWC at Raipur, the staff nurse was trained in VIA for CA cervix screening for six days. Suspected women were referred to AIIMS Raipur which is 40 kms away (1.5 hours).
- ▶ At UPHC in Korba, opportunistic screening of all individuals above 30 years visiting the facility was done for hypertension and diabetes.
- ▶ At DH, CHC and other PHCs, symptomatic examination was being done for hypertension and diabetes.
- ▶ Essential medicines and diagnostics for NCDs were available at all levels.

- ▶ Glucometer strips were being purchased from JDS (RKS) funds.
- ▶ System of referrals from HWCs to higher levels of facilities was observed to be weak.
- ▶ No counselling was done on NCDs by MPW-F or Mitanins.
- ▶ NCD register was in place at HWCs, but with no proper documentation of diagnosis and treatment. No record of referral and follow-up was maintained at the facility.
- ▶ Community members were not aware about the NCD services being available at the HWCs.
- ▶ Community members were also not aware about the nearest facility in the urban slums while in rural areas they do visit the nearest facilities for refilling medicines or visit district hospital or purchase it from the local market.
- ▶ NCD screening was done at camps in the community but people who were already diagnosed with NCDs were not being screened in the camp.

Gujarat

- ▶ Universal screening and management of NCDs has been initiated in both the districts.
- ▶ Total 68 CHC NCD clinics have been established out of sanctioned 93 clinics in the state. NCD clinics were functional in all CHCs in Porbandar and at District Hospital in Narmada.
- ▶ 90% of HR was filled in Porbandar District and 100% HR was filled in Narmada district sanctioned under NPCDCS.
- ▶ CBAC forms were regularly filled by the ASHA.
- ▶ Fixed day for NCD screening was identified in the Sub centres. It was aligned with sub-centre monthly plan in allocated villages.
- ▶ Anti-hypertensive and anti-diabetic medicines were available in visited health facilities in both districts.
- ▶ Screening registers were maintained and verified at all facilities.

- ▶ Screening for cervical cancer was done through PAP smear in CHC and higher facilities.
- ▶ Cardiac Care Unit was sanctioned and functional in Porbandar District.
- ▶ Cancer chemotherapy was not available in both the districts and nearby referral medical college facility was within 100 KM from both the districts.
- ▶ IEC was good in all health facilities. IEC corner for patients and relatives was unique concept observed at CHCs and DHs.

Himachal Pradesh

- ▶ Implementation of Universal Screening of NCDs is still in the early stage in both the districts.
- ▶ ASHAs, Staff Nurses and MOs have been trained in this initiative, though the duration for this training was shorter than recommended in the national guidelines and training for cervical cancers screening (using VIA) has still not been initiated.
- ▶ Population enumeration based on e-health card has been initiated. Revised CBAC forms were being filled by ASHAs.
- ▶ Instruments for screening (e.g. sphygmomanometer and glucometers) were present in the facilities visited and health workers were trained in their use, but there was lack of clarity on procurement of consumables (e.g. glucometer strips).
- ▶ Medicines for diabetes and hypertension were available in the majority of facilities visited, though dispensing of these medicines was limited to a one-two week supply, necessitating frequent visits to the facility.
- ▶ Service providers were aware of referral pathways for complicated cases though a systematic referral mechanism was lacking.
- ▶ No register was being maintained at the facility for patients taking treatment for hypertension and diabetes, and health workers reported problems with up-loading data on-line due to duplicate patient registration numbers.

- ▶ Knowledge of common NCDs was limited in community and many adult members of the family did not recall ASHA visiting them for completion of CBAC and informing about NCD screening. IEC regarding prevention of NCD not visible in community.

Jammu and Kashmir

- ▶ State is rolling out Universal Screening of common Non-Communicable Diseases (NCD) in 700 sub centers across six districts i.e. Anantnag, Baramulla, Doda, Jammu, Kupwara and Udhampur.
- ▶ Frontline workers, staff nurses and Medical officers were not trained as per the guidelines and thus were not clear about their roles and responsibilities in the programme, especially health promotion activities and recording and reporting mechanisms.
- ▶ Frontline workers were provided with English modules, which they were not able to read.
- ▶ NCD clinics were functional at all the CHC/ SDH/DH visited, but reported a lack of human resource across the facilities.
- ▶ Population enumeration is not yet initiated as per the guidelines. MPWs-F are doing the population enumeration and filling the CBAC in community. It was also observed that revised CBAC form was not being used at any of the facility.
- ▶ The documentation for activities is not yet maintained as MPWs-Flack clarity on maintaining records and following up on individuals suspected for any NCDs.
- ▶ Recently the screening was done in a camp mode, where MPWs visited every individuals' house and undertook door to door screening for hypertension and diabetes. Cases suspected for either conditions, were referred to the PHC for confirmation.
- ▶ Screening for diabetes and hypertension was available across the facilities, and oral cancer screening was being reported from all the facilities where a dentist is positioned. None of the facilities reported of Clinical Breast Examination being done to screen for Breast Cancer. Currently cervical cancer screening using VIA was also not being undertaken at any of the facilities visited.
- ▶ It was observed that proper line listing of identified cases was not being maintained at either of the districts visited.
- ▶ Currently not all diagnostics were available at the HWCs according to guidelines. At the PHCs visited, the diagnostics tests were available and user charges were defined.
- ▶ At the level of SHC/PHCs, medicines for hypertension and diabetes were not available as per the list of essential medicines and patients were being referred to SDH/CHC for medicines.
- ▶ At the level of CHC/SDH, some medicines being prescribed by the medical officers were not from the essential medicine list and hence patients were buying medicines from private pharmacies located in proximities of the health facility thus incurring OOPE.
- ▶ In district Doda Cardiac care Unit (CCU) was not functional at the DH, while in district Kupwara, as well established CCU was available but in absence of a Cardiologist/physician in charge, it was not being used.
- ▶ Follow up mechanism was not in place and service providers lacked clarity on how to ensure that treatment compliance for identified cases.
- ▶ Tabs were made available to the MPWs and NCD module of CPHC application was installed and MPWs were oriented in its use; however, currently it was not being used for data collection.
- ▶ Community members were well aware of the common NCDs, risk factors and their complications.
- ▶ Most of the patients in the community were currently undergoing treatment either from the district Hospital/specialists or private health facility.

- ▶ Few community members also reported of taking medicines from nearby Sub Divisional Hospital/Community Health Centre. However, at public health facilities, medicines were being dispensed only for 5-7 days, and this was also reported as one of the reasons of visiting a higher facilities or private practitioner
- ▶ Distant and hard to reach areas have no public transportation round the clock and thus the major expenditure incurred by the patients was on transport which varied from Rs.500 to Rs. 2,000 per visit.
- ▶ OOPE incurred by patients visiting a higher facility/private practitioner or buying medicines from outside varied from Rs. 1200 to Rs. 5,500 per month (Transport- Rs.500 to Rs. 2,000 per visit; Consultation fee for private: Rs. 200-500 and Medicines: Rs. 500 – Rs 3,000 per month).

Jharkhand

- ▶ State is implementing Universal NCD screening initiative in 3 districts i,e Ranchi, Bokaro and Dandbad. Universal screening for common NCDs was not yet started in both the districts visited, however, training was completed and population enumeration, filling of family folders and CBAC forms was underway.
- ▶ Sahiyas and MPWs-F had received 5-days training in 2017 and 3-days training in 2018, respectively in universal screening of NCDs with no one-day joint training of Sahiyas and MPWs-F and had fair knowledge regarding the programme.
- ▶ No staff nurse had been trained in two weeks for VIA for cervical cancer screening in the state. In District Hospital, Bokaro, one staff nurse had got training in VIA for 5 days and she was conducting VIA screening for cervical cancer.
- ▶ MOs in both the districts had received 3-days training in NCDs.
- ▶ Training regarding NCD portal/application has also been conducted and distribution of tablets has been started.
- ▶ Family folder in Chas block, Bokaro, with only name and details of the Mukhiya of the household was recorded by Sahiyas due to an error in printing of family folders. Revised CBAC forms were not available.
- ▶ MPWs were not receiving the CBAC forms from the Sahiyas, due to their busy schedule in Measles-Rubella campaign since end July-mid September, 2018 and therefore, no screening has undertaken during this period at the HWCs, Bokaro.
- ▶ There was no referral linkage for management of suspected cases as the NCD clinics at CHC level were not functional.
- ▶ NCD clinics were only functional at district level but no dedicated physician or trained MOs was posted there.
- ▶ Cardiac Care Units are not established in both the district hospitals visited.
- ▶ The demo version of the NCD module of CPHC application was available with the MPW-F but no sim card, user IDs and passwords had been provided in Bokaro district.
- ▶ Internet connectivity was not available at the HWCs.
- ▶ Knowledge regarding NCD app was weak amongst the MPWs and MOs trained in the application.
- ▶ During community interactions in Bokaro, it surfaced that community (rural and urban areas) was unaware regarding NCD services at public health facility.
- ▶ Most of the patients were visiting private doctors for getting their blood pressure and blood sugar tested and getting medicines (transport costs- Rs. 30/person, sugar testing-Rs. 30, doctors' fees-Rs. 250 and medicines cost- Rs. 150-300/month).

Karnataka

- ▶ Universal screening of NCDs is in progress at 6 districts in the state (Chikmagalur, Raichur, Mysuru, Gadag, Udupi, & Haveri districts), which included both the districts visited in CRM.

- ▶ NCD cell and clinics were functional in both the districts visited.
- ▶ Anti-hypertensive and anti-diabetic medicines were available in the health facilities visited.
- ▶ Opportunistic screening is being carried out in all the facilities. However, universal screening as per guidelines including VIA method is in initial stages.
- ▶ Disaggregation of data for new and old cases was not observed at facilities.
- ▶ Cross referrals between RNTCP, NACP and NPCDCS (DM) programmes are helping in detection of co-morbidities.
- ▶ Few good state initiatives were noted such as-
 - ◆ Integration of staff under NCD, NTCP and NMHP
 - ◆ Screening for Oral Cancer completed in 2 PHCs (Telgi at Vijayapura and Yediyur at Tumkur) in association with BIOCON,
 - ◆ Outreach camps conducted by NCD team in association with SAST (CSR activities)
- ▶ Essential medicines and diagnostics for NCDs were available at all levels
- ▶ Chemotherapy unit has been recently started at DH, Gadhchiroli in collaboration with Tata Memorial Hospital.
- ▶ MoU has been signed in Satara with ONCOLIFE for cancer care, however there was no monitoring mechanism for ensuring quality assured services. The MoU mentioned care to be provided without any charges to patients, however, interaction with community indicated that they were being charged for services.
- ▶ Records for those screened, confirmed, diagnosed and under treatment for NCDs cases are kept systematically in Satara.
- ▶ In Satara, there was general awareness among the elderly population on hypertension, diabetes mellitus & oral cancer. The same awareness for 30-60 years population was not adequate and non-compliance for screening is high in many facilities visited in Satara. In contrast, Gadhchiroli had no IEC / BCC in the field on NCDs with universal screening yet to start.

Maharashtra

- ▶ ASHA had filled CBAC forms and screening of all individuals above 30 years is completed in Satara, however systemic identification, confirmation and treatment is in progress. In Gadhchiroli, CBAC filling has been completed in 5 identified HWC areas.
- ▶ ASHAs/MPWs/ MLHPs were trained and oriented for universal screening and management of NCDs.
- ▶ Revised CBAC forms were available and all identified facilities had initiated universal screening, except VIA.
- ▶ Opportunistic screening for hypertension and diabetes was being conducted at all Health facilities including DH & SDH.
- ▶ Suspected cases were referred to PHCs for confirmation and on getting confirmation, line listing was maintained for follow up at SHCs.

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Madhya Pradesh

- ▶ In HWC-PHC in Raigarh district, MO and Staff nurse had been trained in universal screening and management of NCDs.
- ▶ Lack of awareness among officials regarding incentives for population enumeration and Universal Screening of NCD was observed.
- ▶ It was observed that, population enumeration and screening through house to house visit was being conducted by MPW-F and ASHAs with only 2 days orientation.
- ▶ Medicines were available as per EML across the facilities, but very low utilization was noticed.
- ▶ It was reported that, MPWs were asked to purchase tablets on their own, which will be later reimbursed.
- ▶ Procurement of Tablets is under process and internet connectivity was available at PHC.

- ▶ It was reported through community interaction that, most of the patients with hypertension and diabetes were availing treatment at private healthcare facilities.

Punjab

- ▶ Universal screening and management of NCDs is yet to start in both districts
- ▶ NPCDCS has started in 2016 but actual implementation is yet to take place. NCD clinics were functional district Gurdaspur, although with inadequate staff and were non-functional in Moga district.
- ▶ ASHAs were trained in universal screening of NCDs, but the duration was shortened to three days and ASHAs thus had limited knowledge about the programme and were not aware about the CBAC forms.
- ▶ MPWs-F have knowledge about blood pressure monitoring, screening of breast and cervical cancer through VIA.
- ▶ Opportunistic screening was being conducted at health facilities in Gurudaspur, but not in Moga. Screening was also done through camps.
- ▶ It was observed that user fees were being charged for ECG and X-ray.
- ▶ Due to irregular supply of medicines, treatment protocol was being changed and patients were prescribed different medicines as per the availability of medicine. E.g. a patient with hypertension who has been taking amlodipine was prescribed other hypertensive medicine, when amlodipine was not available.
- ▶ Cardiac care unit/ HDU is not available at DHs of both the district. Dialysis unit with 2 machines with one for septic patient is available at Moga DH but not operational as there was no medical specialist in the district.
- ▶ India Hypertension Management Initiative (IHMI) is functional at district hospital Gurdaspur. Under IHMI, one portion of the card is given to the beneficiary and other is kept at the facility, to track for follow up. Follow up for patients is

done under IHMI, but the counsellors have to call the patients from personal numbers.

- ▶ Community members were aware about NCDs, risk factors and its symptoms.
- ▶ Community members were seeking treatment for NCDs mainly at NCD clinics in the public facilities utilizing the state services like Mukhyamantri Cancer Rahat Kosh.
- ▶ Patients had to bear OOPE because of cost of diagnostic and erratic supply of medicines to continue the treatment. The OOPE is up to INR 2000 per month.

Rajasthan

- ▶ Under (NPCDCS), NCD Clinics have been established at all 33 District Hospitals and 227 CHC/SDH of Rajasthan.
- ▶ Universal Screening of NCDs has been rolled out in 5 districts of the State (Jodhpur, Bikaner, Baran, Churu and Hanumangarh).
- ▶ At DH level, functionality of NCD clinics is limited in Baran district while in Jodhpur, NCD clinic of Paota District Hospital has been shifted to SN Medical College. NCD Clinic at visited CHCs are not operational in both the district.
- ▶ Lack of clarity about Universal Screening of NCDs guidelines was noted among programme officials at all levels which has affected the planning, training and service delivery, as observed at all visited health facilities including SHC- HWCs.
- ▶ Service providers at the linked PHCs were not oriented towards CPHC and universal screening of NCDs adequately. Training on VIA has not been started. Duration of training for frontline workers was reduced, thus affecting their skills.
- ▶ Population enumeration and screening of NCDs (HT and DM) initiated at SHC- HWCs. Most family folders and CBAC forms were filled by ASHAs based on their interaction with the female members. Thus, most men during the visit, were unaware about the initiative and NCD screening services.

- ▶ Counselling on lifestyle changes and wellness activities and IEC regarding universal screening has not yet been initiated in the districts.
 - ▶ Confusion among FLWs noted about target group for NCD screening i.e, individuals over 30 years or 30-65 years
 - ▶ Universal screening of HT and DM initiated but oral and breast cancer screening is yet to be started.
 - ▶ Opportunistic screening of HT and DM was reported at CHC and DH and symptom-based examination for oral cancer (CHC and DH) and breast cancer (DH) was done.
 - ▶ Medicines for NCD (HT& DM) are available at all levels but are not being utilized at SHCs due to lack of clarity of programme guidelines about dispensation of medicines by MPW (F) and CHO's
 - ▶ Follow-up of positive cases for treatment adherence and referral linkage with primary care facilities is not in place at CHC/DH.
 - ▶ CPHC IT application is not being used due to non-availability of tablets NCD- CPHC MO portal has been installed at the UPHC -HWC but the portal was not being used due to non-availability of login ID and password.
 - ▶ Community members in the visited areas were not aware about the risk factors associated with NCDs. High level of consumption of tobacco products among all and use of tobacco-based tooth powder was observed to be common among women in Baran district.
- the money to the Corporation as the wage for the volunteers @3100/-per month. This salary is for both screening and follow up activities. A 3-day training session has been undertaken to orient these WHVs.
- ▶ In HWCs, second VHN is posted who is facility based and undertakes various activities like NCD screening, facility based diagnostic tests, and dispensing medicines against valid prescriptions etc.
 - ▶ Medicines for hypertension and diabetes are available at the SHCs, which are issued on the basis of the prescription of MO.
 - ▶ Population enumeration had not yet started. According to the guideline, enumeration would be done of the population aged 18 and above for risk factor assessment and aged 30 and above for screening for common NCDs. C-BAC forms have been printed, which need to be updated with information about TB and Leprosy.
 - ▶ The suspected cases are referred to PHCs for management of high blood sugar and hypertension and screening of cancers. VIA positive cases are confirmed by colposcopy in the DH.
 - ▶ Opportunistic screening for Diabetes, Hypertension, Cervical and Breast cancer is being done at PHC, CHC and DH.
 - ▶ Every Saturday, the WHVs have been instructed to exclusively cover those missed during the week's screening and also follow up of those who dropped from treatment / confirmatory tests at PHC.
 - ▶ However, follow up and compliance was reported as an issue because there is no incentive linked with follow up for WHVs. The WHV is covering 5000 population as against ASHA covering 1000 population.
 - ▶ It was observed that, most of the women and men who are screened by WHV at home do not go to the PHC for screening and management of diabetes and hypertension. The drop out from screening at home to reporting to the PHC for diagnostic confirmation is over 70% in UHC-SHCs.

Tamil Nadu

- ▶ State has adopted a different model for provisioning of screening for NCDs. It has decided to engage one Women Health Volunteer for each SHC where ASHA is not there to undertake population-based screening of NCDs. These WHVs are self-help group volunteers who are engaged through a non-health department, Tamil Nadu Women's Development Corporation, where the SHGs are registered. Department of Health transfers

Telangana

- ▶ In 12 out of 31 districts of the state, population enumeration has been completed and population above 30 years has been screened under the state specific universal screening programme.
- ▶ It was observed that the latest version of CBAC form was not been circulated to the districts, hence Leprosy & TB were not included in the CBAC form.
- ▶ Also, the screening primarily focused on Diabetes and Hypertension while there was limited oral, breast/cervical cancer screening.
- ▶ The follow-up of the NCD patients was poor in Karimnagar and Jayashankar, Bhupapally. The frontline workers had a list of referrals but did not have a line list for number of patients diagnosed with diabetes/ hypertension, which will help in maintaining continuum of care.

Tripura

- ▶ Population enumeration using CBAC forms (older format) has already been completed by ASHAs in the month of February-March 2018. The filled forms are submitted to the MPWs posted at the SHC-HWC.
- ▶ However, few forms submitted by the ASHAs were found to be incomplete. Also, the ASHAs were not very clear about the purpose of filling the CBAC forms.
- ▶ Screening was limited to hypertension and diabetes and cancer screening was not being conducted.
- ▶ NCD clinics have been setup in CHCs, SDH, DH and opportunistic screening for hypertension and diabetes is conducted at NCD clinics.
- ▶ There is an application - 'mHealth', in which data regarding screening- hypertension, diabetes, BMI is recorded.
- ▶ There was no system for regular calibration of equipment. Weighing machine in a facility was

showing wrong results and the staff being aware about the same was recording approximate value.

- ▶ List of people at risk prepared by ASHAs is submitted at the SHC-HWC. However, list is not used to identify the cases missed/ not screened. Similarly, the list of people diagnosed at SHC-HWC with NCD was not shared with the nearest PHC. It was observed that, health card distributed to the patients was not used by doctors/ at NCD clinics.
- ▶ Awareness in the community regarding signs and symptoms of common NCDs was observed to be very poor. Use of tobacco is rampant in the community among both men and women. Smoking bidis or chewing tobacco with pan is very common among men; while women majorly chew tobacco with paan.
- ▶ It was reported during community interaction, that most of the times medicines were not available and patients had to purchase medicines for hypertension and diabetes, incurring Rs. 400-800, causing many to stop taking medications.

Uttarakhand

- ▶ Universal screening of NCDs had been initiated in HWCs of Haridwar district, and it was not yet planned in Uttarkashi district
- ▶ Community Based Assessment for NCDs was being done by ASHAs using CBAC forms, however, the forms were not filled properly.
- ▶ Screening of Hypertension and Diabetes was being conducted at PHC- HWC, however, cancer screening was not being done.
- ▶ Lack of awareness and little evidence of follow up was found in the community.

Uttar Pradesh

- ▶ In Farrukhabad district, ASHAs have been oriented on NCDs and have started filling CBAC forms and getting incentives for the same. In Varanasi, ASHAs were not trained in NCD screening.

- ▶ IEC materials like posters and pamphlets were available; however, they were text heavy with crowded messages and instructions thus, making it illegible. Beneficiary interaction indicated that, most patients were not able to understand the message.
- ▶ Symptom based examination for hypertension and diabetes was being carried out in CHCs and DH in both districts.
- ▶ In Farrukhabad, cancer detection had not commenced at block or district levels including in the Sampoorna clinic. At Varanasi, Sampoorna Clinic is established and had facilities for cancer screening.
- ▶ Medicines were largely available at CHC and DH, though in community discussions, members reported shortages and the need to purchase medicines from shops.

5.2: NATIONAL ORAL HEALTH PROGRAM (NOHP)

The National Oral Health Programme has been launched across the country to provide integrated, comprehensive oral health care at the existing health care facilities. The programme aims to improve the determinants of oral health, reduce morbidity from oral diseases and integrate oral health promotion and preventive services within the health care system.

KEY OBSERVATIONS

Oral health problems were found to be wide spread in the community for various reasons such as low level of awareness about dental hygiene and high use of oral tobacco. Limited awareness was noted in the community about the services available in the health facilities. National Oral Healthcare Program is being implemented in many states, albeit partially covering usually the District hospital and CHC/SDH components.

In Andhra Pradesh, general awareness regarding oral health conditions and health seeking behaviour of the community was found to be

good and preference was towards accessing care at public health facilities but in majority of the states such as Bihar, Maharashtra, Telangana, Tripura, Chhattisgarh, Madhya Pradesh, Rajasthan and Gujarat, a general lack of awareness about availability of oral health services was reported.

Relevant and effective IEC material regarding the common oral health conditions was displayed in facilities in Maharashtra, Punjab and Chhattisgarh but most of the states had insufficient display of IEC/BCC material. NOHP in Assam has been reported to be in the nascent stage.

Dental clinics were functional at District Hospitals in most of the states. In addition to the district hospital, dental clinics and OPDs were functional at the SDH and rural hospitals in the states of Bihar, Punjab, Maharashtra and Chhattisgarh. Uttarakhand had functional clinics only at the CHC and Sub-district hospitals.

Range of services provided was limited to dental extractions in Bihar whereas Dental surgeons were performing root canal treatment (except capping), fillings, wiring, scaling and extractions in Rajasthan, Tripura and Chhattisgarh. Private Unorganized sector in the states of Uttar Pradesh and Jammu & Kashmir (street side shops) were reported to be catering to a significant number of patients in the community. Private dentists in Chhattisgarh have been empanelled under the RSBY and engaged on PPP basis in Jammu and Kashmir.

None of the states had implemented the programme at the PHC or sub-centre level. Hence orientation and training of front-line workers was observed to be deficient in all states.

All the requisite equipment for dental OPDs were available in UP and UK whereas gross shortage of dental equipment such as dental chairs was observed in Bihar, Maharashtra, Punjab and Andhra Pradesh. Poor Bio-Medical Waste management was also seen in Bihar.

A new innovation in the form of a dental fortnight has been introduced in the state of Punjab as part of community outreach activities. Camps are regularly conducted in some states such as Punjab, Jammu &

Kashmir and Rajasthan. Mobile dental vans are also being utilized to improve the community outreach in Maharashtra and Rajasthan.

RECOMMENDATIONS

- ▶ Community outreach activities need to be prioritized to create awareness in the community about preventive measures and range of services offered in the public health system.
- ▶ Efficient display of IEC material should be ensured in all the facilities and IEC/BCC activities should be taken up in the community.
- ▶ Training of frontline workers at SHCs and service providers at PHCs should be organized to build referral linkages with the secondary level to facilitate continuum of care in the current context of delivery of comprehensive primary health care services.
- ▶ Non-availability of laboratory services at Dental clinics warrants for a review of the existing programme guidelines to meet the health needs of the community

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Health seeking behaviour of the community was found to be good with a preference for seeking treatment at Public health facilities for oral care.
- ▶ At CHC and DH services for dental extraction and minor surgeries were being provided
- ▶ No visible IEC activity and oral health promotion activity at community level.
- ▶ Shortage of dental hygienist affected service delivery at peripheral level.
- ▶ Several dental units in the E. Godavari were non-functional due to lack of service providers or non-functional equipment

Assam

- ▶ High level of prevalence of dental carries and gum ulcers was noted linked with low level of

community awareness and common practice of chewing ofpan and betel nut being followed in the community

- ▶ Limited dental care facilities were available in both the districts.

Bihar

- ▶ Dental surgeons are providing services at CHC and District Hospital.
- ▶ Services were usually restricted to dental extraction due to gross shortage of equipment and consumables.
- ▶ Pre-cancerous patients were prescribed antioxidants and referred to medical college.
- ▶ Bio Medical waste management was found to be unsatisfactory.
- ▶ No community outreach activities are being done however collaboration with RBSK for referrals has been established.

Chhattisgarh

- ▶ In Korban, fluorosis was reported to be a major area of concern along with low awareness on oral health related conditions among the community.
- ▶ The clinics at CHC, UPHC and DH in Korba were well equipped OPA unit whereas the condition of clinic was poor at DH Raipur.
- ▶ Services provided include, OPD, fillings, extractions, oral prophylaxis, dentures, minor surgeries, uncomplicated impactions and referral of pre-cancerous lesion to Government Dental College, Raipur.
- ▶ The recurring costs were borne under JDS and nominal user charges are levied for laboratory work.
- ▶ Private dentists were also reported empanelled under the RSBY.

Gujarat

- ▶ Availability of atraumatic restorative procedures at the PHC – HWCs and dental procedures at CHCs largely missing.

Himachal Pradesh –

- ▶ Despite adequate clinical provision for dental services (dental chairs, dental equipment, dental surgeons and support staff) at some civil hospitals and DH, lack of systematic roll-out of the National Oral Health Programme was reported

Jammu & Kashmir

- ▶ Community members rely mainly on the unorganized sector and, to a lesser extent on the organized private sector for oral health care needs,
- ▶ Outreach activities were being undertaken in the community for oral health check-ups in schools and villages.
- ▶ Three private hospitals have been involved in PPP mode

Jharkhand

- ▶ Dental clinics are functional in the district hospitals in both districts.
- ▶ Additional staff has not been recruited under NOHP and existing dental surgeons are managing the cases and attending the OPD in both District and Sub district hospitals.

Madhya Pradesh

- ▶ Dental units are functioning with trained manpower at DH but no community awareness is present in both the districts.
- ▶ No camps are being conducted.

Maharashtra

- ▶ General lack of awareness on common dental diseases and availability of oral health services in both districts
- ▶ Dentists were available at the visited RH, SDH and DH in both districts while a Periodontist was available at DH Satara and Prosthodontist at RH Chamorshi. However only one dental

chair was available at each DH despite availability of 2 dentists and 1 hygienist at each facility.

- ▶ Service provided included restorations, wiring, scaling and extractions in both district while in Satara, denture services were also being provided.
- ▶ Mobile dental van was conducting outreach and examining about 60 patients a day in Gadchiroli.
- ▶ Lack of availability of proper lab services was noted in both districts

Punjab

- ▶ Although the community is aware about the availability of dental services at SDH and DH level there is low awareness in the community about dental hygiene.
- ▶ Functional dental OPDs are available at secondary care level but with insufficient staff and equipment
- ▶ IEC is displayed at dental OPDs on dental hygiene and manifestations of use of tobacco.
- ▶ Dental fortnights and camps are being conducted regularly in the districts.

Rajasthan

- ▶ State has introduced Mobile Dental Vans (one van per divisional headquarter to cover all the districts) under RBSKin rural and under-served areas. Two-day camps are organised at block headquarter, CHC, PHC, colleges and schools or any location suggested by RCHO, BCMO or RBSK Mobile teams.
- ▶ Activities under the National Oral Program are limited to dental OPD only.
- ▶ At the visited CHCs, dental OPD services are being carried out by one Medical Officer (Dental) having an OPD load of 8-10 patients per day while at District Hospitals the average OPD is around 30-40 patients per day. Services rendered in the clinic include minor

restoration, extractions, minor surgeries and oral prophylaxis.

- ▶ Despite availability of dental surgeons at secondary level facilities, the referral linkage with the primary health care facilities has not been developed.
- ▶ At PHC level, no services related to NOHP were reported beyond symptom-based examination and referral of suspected cases of oral cancer. Community Health Officers and FLW team posted at SHC HWC have not yet been sensitized about services available under NOHP.

Telangana

- ▶ Community members were largely aware of the availability of dental services in the DH but still preferred private service providers.
- ▶ At District Hospital, the Dental department is being run in an old dilapidated building
- ▶ All basic equipment required to perform basic dental procedures are available but on an average up to 2 procedures are performed per day

Tripura

- ▶ Both the districts have dentist/ dental surgeon in place but there is no dental technicians/ hygienist/ assistant posted in South Tripura District.
- ▶ Approximately, 15 to 18 cases per day are treated. Most cases are related to extraction, scaling and minor restoration.
- ▶ For any other services such as RCT, dentures etc, the patients are referred to IGM Hospital Agartala.

Uttarakhand

- ▶ Facilities like CHC, Laksar and SDH Roorkee were providing services related to oral health. SDH Roorkee had a dentist with a dedicated room and equipment for dental surgery in place.

- ▶ Referrals from RBSK teams are managed at these clinics.

Uttar Pradesh

- ▶ Awareness on importance of oral hygiene was less and practices are limited to patchy use of toothbrushes or datoon. Community members relied on the unorganized sector for dental needs.
- ▶ In none of the visited villages camp or outreach services for oral health have been reported by frontline workers or community.
- ▶ Regular dental services are provided at the DH in a clinic staffed by a dental surgeon, hygienist and assistant, and equipment as per guidelines. However, dentures, pit and fissure sealants are not provided due to lack of equipment. In Varanasi NOHP has not been implemented, however services are available up to CHC level.
- ▶ RBSK teams screen for oral and dental conditions and few cases were referred to CHC and DH. However, the staff acknowledged that long travel distances would discourage rural children for regular follow-ups.

5.3 NATIONAL TOBACCO CONTROL PROGRAMME

National Tobacco Control Programme (NTCP) in the year 2007-08 to (i) create awareness about the harmful effects of tobacco consumption, (ii) reduce the production and supply of tobacco products, (iii) ensure effective implementation of the provisions under COTPA (iv) help the people quit tobacco use, and (v) facilitate implementation of strategies for prevention and control of tobacco. Hence the main thrust areas under NTCP are -Training of health and social workers, NGOs, school teachers, and enforcement officers; IEC activities; School programmes; Monitoring of tobacco control laws; Coordination with Panchayati Raj Institutions for village level activities and setting-up and strengthening of cessation facilities including provision of pharmacological treatment facilities at district level.

Currently, the Programme is being implemented in all 36 States/Union Territories covering around 612 districts across the country.

KEY OBSERVATIONS

Consumption of tobacco products in the community was found to be high in the states of Bihar, Tripura, UP and Chhattisgarh (tribal population) in spite of adequate awareness regarding the harmful effects of tobacco.

In Bihar, greater Emphasis on IEC activities were observed in District hospitals and PHCs along with active collaboration with RBSK for increased IEC. Advocacy and IEC activities were also being conducted for school students in Jharkhand. The mitanins in Chhattisgarh are involved in counselling activities against tobacco addiction.

Statutory warnings have been displayed at public places under COTPA in Gujarat. COTPA is being implemented in Jharkhand and Punjab. On the other hand, in some states such as Uttarakhand and Chhattisgarh COTPA rules were being openly flouted.

Drug de-addiction services are being provided through the district hospital in Bihar, Arunachal Pradesh. Tripura has tobacco cessation clinics and has also covered many Public schools, Private Schools and colleges under NTCP. Uttar Pradesh has also established a completely staffed tobacco cessation clinic in Farrukhabad. Tobacco Cessation Centre (Sparsh) present in district Korba, Chhattisgarh works in close coordination with the Dental clinic in the District Hospital.

State cells have been established in Bihar, Jharkhand and Arunachal Pradesh. District cells are functional in Bihar, Punjab and have recently been established in Arunachal Pradesh also. Human resource at the state and district levels was found deficient in many states leading to inefficient implementation of NTCP.

RECOMMENDATIONS

- ▶ Collaboration with PRIs and NGOs for targeted interventions to generate community awareness

and ensure compliance to COTPA needs to be explored.

- ▶ Orientation of service providers towards COTPA in order to ensure efficient implementation of the act.
- ▶ Sensitization of the community and health staff (including service providers) on harmful effect of Tobacco needs to be strengthened.
- ▶ Augmentation of programme management teams at all levels is essential for effective planning and monitoring
- ▶ Strong coordination is needed between NTCP and NOHP to synergise their efforts
- ▶ Gram Panchayats and VHSNC/ MAS need to be oriented towards their possible role in monitoring the sale of tobacco products in and around their villages /schools

STATE SPECIFIC FINDINGS

Arunachal Pradesh

- ▶ Community was aware about the harmful effects of tobacco but had no information about the Tobacco Control Laws. This could be linked with lack of orientation of village level committees, gram panchayats, NGOs and frontline workers.
- ▶ No special efforts were made for IEC to create awareness in the community.
- ▶ District level coordination committee involving PRI and other departments has been constituted very recently for better implementation and monitoring of COTPA rules. State level coordinating committee has also been constituted.
- ▶ One de-addiction centre in the visited district was established where quarterly group discussion is held for the addicts.

Bihar

- ▶ Consumption of tobacco products was noted to be high in the community.

- ▶ District has created awareness by promoting IEC activities at District Hospital, APHC and Block PHC/CHCs. However, no warning boards are present at the shops selling tobacco products.
- ▶ State has initiated collaboration between NTCP and RBSK team such that RBSK team can distribute pamphlets in schools for awareness.
- ▶ State Tobacco Control Cell and District Tobacco Control cell is present but positions of state and district consultants are vacant.
- ▶ Challan booklets have been printed and distributed however only the police is collecting challans.
- ▶ Drug de addiction Centre (10 bedded) is present in the District Hospital with in-patient facility. Nicotine gum and patch are provided to patients by local purchase, however at the time of the visit the gum and patches were unavailable.

Chhattisgarh

- ▶ Despite awareness about ill effects of tobacco among the community, tobacco consumption was found common in district Korba.
- ▶ In village Sanghli there were no shops around school that sell tobacco while village Madhai had kiosks around school to sell tobacco.
- ▶ Mitanins are aware of ill effects of tobacco and are involved in counselling against quitting tobacco.
- ▶ Gudakhoo – a form of tobacco powder used as a manjan (for brushing teeth) is highly prevalent in state, equally among men and women, across all age groups.
- ▶ Health workers have limited success in counselling community against its use.
- ▶ Tobacco Cessation Centre (Sparsh) in district Korba works in close coordination with the Dental clinic in the District Hospital.

Gujarat

- ▶ Rampant use of different forms of tobacco and its products were observed
- ▶ Statutory warnings against use of tobacco in public places have been displayed under COTPA.

Jharkhand

- ▶ State NTCP cell has been established and State and District level coordination committees and working groups have been constituted.
- ▶ COTPA is being implemented.
- ▶ Staff posted at tobacco cessation centres (TSS) have not been trained yet.
- ▶ Outreach activities and advocacy were conducted during World Tobacco Day to sensitize school/college students and common people at public places like railway stations, bus stands etc. and to create awareness about the harmful effects of tobacco.
- ▶ Various IEC and IPC activities have been conducted in the state to facilitate effective implementation of the Tobacco Control Laws in both districts.
- ▶ Under COTPA, 9475 people have been fined in District Bokaro and 30500 people in District Ranchi in 2018-19.

Karnataka

- ▶ The Tobacco Control Programme activities including the awareness about Tobacco and implementation of provisions under the Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution), 2003 were being done. The Global Adult Tobacco Survey (GATS) indicates the use of tobacco has reduced between GATS-1 and GATS-2. The findings for the state of Karnataka are as follows:
 - a) The prevalence of current tobacco smoking in GATS-2 (2016-17) is 8.8%

- b) The prevalence of current smokeless tobacco in GATS-2 (2016-17) is 16.3%
- c) The prevalence of current tobacco use (both) in GATS-2 (2016-17) is 22.8%

District Anti Tobacco Cell established in all 30 Districts. Tobacco Cessation Centre established in 18 districts in state.

Punjab

- Tobacco control cell at district level is functional
- Chalaans are being issued for violation under COTPA.

Telangana

- No specific services were being provided at Community, SC and PHC level.
- No tobacco selling shop within 500 meters of school premises visited. However, the shops in the villages did not adhere to the norms of displaying the statutory warning against the harmful effects of tobacco.

Tripura

- Use of tobacco is rampant among both men and women and is culturally accepted in the community
- State has five approved tobacco cessation clinics, of which two are functional.
- Trainings of MOs, Staff nurses, ANM and MPWs under NTCP have been conducted; however, high number of service providers are found to be using tobacco on regular basis.

Uttarakhand

- Common use of bidi, khaini and tobacco was found among men, women and adolescents despite having awareness about ill effects of tobacco.
- The IEC and BCC campaign related to tobacco control program and product causing health

hazards not found

- Shops selling tobacco products had not placed the warning about selling tobacco products to a person below the age of 18 years. Shops selling tobacco products were found a school in one village
- IEC displayed at health facilities was focused on fines under COTPA.
- A total of 3636 persons have been challaned for smoking in public places and fine collected amounts to Rs. 2,85,285.

Uttar Pradesh

- Farukkabad is known for tobacco cultivation, and oral consumption of tobacco is a social norm.
- IEC posters on tobacco cessation were found within health centres but not in towns or villages.
- Tobacco cessation clinic at the DMH in Farrukhabad is being run by a young and earnest qualified social worker and by a psychologist, social worker and consultant in Varanasi.

5.4 NATIONAL MENTAL HEALTH PROGRAM (NMHP)

National Mental Health Programme (NMHP) was launched in 1982, to ensure the availability and accessibility of minimum mental healthcare for all, encourage the application of mental health knowledge in general healthcare and in social development; and promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

The District Mental Health Program (DMHP) was launched in the year 1996 and focused on -Early detection &treatment, Training of general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist, training of health workers in identifying mentally ill persons, IEC for Public awareness generation and Monitoring.

KEY OBSERVATIONS

National Mental Health Program has been implemented partially by most of the states that were visited. At present services were usually available through District Hospitals. NMHP has not been implemented in Bokaro district (Jharkhand), Punjab, South Tripura, Farrukhabad (UP). The programme was rolled out in Varanasi but activities could not be commenced as no HR has been recruited.

It was observed that the general awareness on mental health issues as well as availability of services in the community was lacking in most states such as Jharkhand, Maharashtra, Rajasthan, Tripura, Uttarakhand, Arunachal Pradesh, Chhattisgarh and Madhya Pradesh.

A mixed pattern was observed with respect to the services available at the district level in various states. Specialist services by a qualified psychiatrist were available in the states of Bihar, Rajasthan, Maharashtra (Gadchiroli district), Tamil Nadu, Telangana, Tripura (Unicoi district) and Karnataka. In addition, Karnataka is also offering tele-psychiatry services in Udupi district.

Notable achievements were observed in the form of well-functioning Drug deaddiction centres in Punjab and a rehabilitation facility in the DH in Tamil Nadu. States of Uttarakhand and Chhattisgarh have adopted the innovative approach of training their Medical Officers for providing primary mental health care services including de-addiction, to address the issue of HR inadequacy.

Few innovations include 'Dawa-Dua' project in Tamil Nadu where NMHP has collaborated with a dargah historically known to cure mental illnesses. A clinic has been set up in the dargah with adequate HR. In Raipur district (Chhattisgarh), virtual Knowledge Network with NIMHANS has been established to link Mental Health Specialists with Govt. community health professionals for incremental capacity building to provide "Best Practice Care" in rural and underserved areas.

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

Rajasthan which has trained both the FLWs and MOs. In Baran District, ASHAs were trained to screen patients using a checklist, following which, ASHAs and MPW (F) have so far screened 13,000 patients who are then mobilized for PHC level camps.

Significant outreach activities have been conducted in the form of camps and motivational talks particularly for school students by the states of Bihar, Gujarat, Rajasthan and Tripura. Chhattisgarh has established college counselling centers for students. A Toll-free helpline "**Mansamwad**" 1800-180-0018 has also been started in October 2017 under NMHP, Rajasthan

RECOMMENDATIONS

- ▶ Findings from few states have demonstrated the possibility of better community engagement and follow up through training of front-line workers, outreach camp and partnering with faith-based institutions. These models need to be reviewed and examined for the feasibility of scale up across other states.
- ▶ Strong IEC campaign is required to create awareness in the community about mental health illness and availability of services within the public health systems.
- ▶ In addition to the OPD services, the IPD services through establishment of a Mental Health Ward also need strengthening.
- ▶ Improved coordination with NCD cell, drug de addiction centre, and District Tobacco Control Cell is needed for providing services in a holistic approach.
- ▶ Linkages with the primary level facilities need to be developed to enable improved access to mental health services for the community and also to facilitate continuum of care.

STATE SPECIFIC FINDINGS

Arunachal Pradesh

- ▶ NMHP programme has been implemented in the State and Programme Management Units

are in place but the necessary infrastructure for setting up the centres at Sub centre, PHC and CHC level is lacking.

- ▶ Training has been provided to the staff and case registration and counseling of the cases has been initiated, yet the number of cases being treated between April to August 2018 was abysmally low with an average less than 4 cases a month. This could be on account of non-availability of diagnostic facilities, assessment tools, equipment and essential psychotropic drugs.
- ▶ IEC efforts to create awareness about the mental health issues and available services under the programme could not be seen in the district.

Bihar

- ▶ Functional centre at the District Hospital, Muzaffarpur had a Psychiatrist, Psychiatric Nurse, Community Nurse and Ward Assistant. Psychiatric Nurse was trained in NIMHANS. The centre had 8 out of 13 drugs.
- ▶ Services provided at the centre include - Diagnosis, treatment of mental health diseases (Psychosis, Neurosis, Depression, Mental Retardation, Schizophrenia) outreach and counselling. In addition, drug addicts are counselled and Mental disability certificates are also provided.
- ▶ Motivational talks/ camps were being conducted at schools, colleges, work places (Thermal Power Plant) as a part of outreach activities.

Chhattisgarh

- ▶ Awareness regarding the mental health services among people was found to be missing. Mental illness is considered a social stigma and people prefer visiting quacks or spiritual healers for treatment.
- ▶ In district Korba, Sparsh clinic was present in district hospital with almost 60 percent staff in place. The MO in-charge is under training from NIMHANS. Psychological test tools and medicines were available.

- ▶ 5 college counseling centers are run by the DMHP and the teachers and professors in these institutes are trained to cater mental health conditions of the respective institutes.
- ▶ Five batches of ANMs, 2 batches of ASHAs, 7 batches of AWW and 1 batch of Other Health professionals have been trained.
- ▶ In district Raipur, Virtual Knowledge Network with NIMHANS is one of the noble initiatives to link Mental Health Specialists with Government community health professionals.

Gujarat

- ▶ District mental health cells have been started in 24 districts and antipsychotic drugs were available at CHC, DH.
- ▶ MO training module for prescription is also prepared.
- ▶ Anti-stigma calendar and epilepsy band developed. Stress management classes and regular outreach camps for psychiatric disorders held in Narmada.

Jharkhand

- ▶ General lack of awareness was noted about mental health issues, attached stigma, and availability of services in the community in both districts.
- ▶ National Mental Health Program is not being implemented in district Bokaro.
- ▶ No IEC/ BCC materials on the subject or programme were visible in the community.
- ▶ The Ranchi Institute of Neuro Psychiatry and Allied sciences provides mental health services in the district and is apex centre in the state.
- ▶ Awareness and training of ASHA/ANM/MLHPs at Sub Centers on mental health programme is yet to be started.

Karnataka

- ▶ Static unit and National Mental Health Programme Unit with Psychiatrist and Psychologist are functional in District Hospital.

- ▶ Tele-psychiatry consultations are being held under PPP mode in Udupi district.
- ▶ 67 Outreach camps have been held in Udupi.
- ▶ Uptake of services is good in both districts.
- ▶ Endosulfan related cerebral illness is prevalent and is being managed well in the public health institutions.

Madhya Pradesh

- ▶ In Rajgarh and Betul, passive screening at DH was being done without any linkage with health institutions and outreach services.
- ▶ Community is not aware about any services provided by public health facilities.
- ▶ Mann Kaksha is functioning at District Hospitals in both the districts.

Maharashtra

- ▶ General lack of awareness on mental health issues, attached stigma, and availability of services was observed in the community in both districts.
- ▶ No IEC/BCC materials were visible in the community and at the visited facilities.
- ▶ DH Gadchiroli has a well-functioning mental health unit with one Psychiatrist while at DH Satara no specialist was available where a Clinical Psychologist was leading the unit.
- ▶ Awareness and training of ASHA/ANM/MLHPs at Sub Centers and MOs at the PHCs was lacking.

Punjab

- ▶ State Mental Health Authority has been constituted but District Mental Health Boards are yet to be constituted.
- ▶ District Mental Health ram is not implemented in any of the district visited.
- ▶ Deaddiction Centers are functioning well.

Rajasthan

- ▶ NMHP was first started with seven districts in 2015 and later expanded to all 33 districts of Rajasthan. 31 Psychiatrists have been appointed as District Nodal Officer (NMHP) with Administrative & Financial powers.
- ▶ A Toll-free helpline “**Mansamwad**” 1800-180-0018 has been started in October 2017 under NMHP, Rajasthan.
- ▶ Around 1200 MOs have been trained under NMHP at Psychiatric Centre, Jaipur, while 6378 paramedical/ASHAs have been trained under NMHP at District level
- ▶ About 900 ASHAs and 210 MPW (F) were trained in 2015-16 in Baran to screen patients with mental illness using a brief checklist.
- ▶ ASHAs and MPW (F) have so far screened 13,000 patients who are then mobilized for PHC level camps. However, at community and SHC level there was no awareness about this initiative.
- ▶ In Jodhpur district, 40 Medical Officers and all PHC MOs in Baran have been trained under National Mental Programme so far.
- ▶ PHC level camps were reported by district team in Baran during which patients were diagnosed by DH Psychiatrist, given medicine for one month and certificates are issued for Schizophrenia, Dementia, OCD and Bipolar – to facilitate access to monthly pension schemes.
- ▶ In District Hospital Paota, Jodhpur a Psychiatrist along with other team members is currently providing OPD services. De-addiction centre is available in Mathura Das Mathur Hospital. Apna Ghar an NGO has reportedly been providing rehabilitation services in Jodhpur city area where Govt. doctors are also providing free services.
- ▶ In DH, Baran the Psychiatrist is in position since 2016 along with one counsellor and one doctor. The team provides OPD as well as camp-based services. Daily OPD ranged from 40-50 per day.

Tamil Nadu

- ▶ National Mental Health Program is being implemented at the district level.
- ▶ In Ramanathapuram, an initiative to integrate spiritualism and psychiatry has been tried successfully at Erwadi Peer Dargah where mentally challenged people are taken or deserted. NMH has supported this programme under NMHP. A clinic is run by the state health with a team of specialist and paramedic stationed at the Darga itself (Dawa-Dua Initiative). A mental health hospital has been established nearby where both IPD and OPD are running. The hospital also has a rehabilitation centre run by an NGO where patients in remission are engaged in some handicraft work.

- ▶ In Haridwar, one psychiatrist provides services while in Uttarkashi, an MO trained at NIMHANS does the same.
- ▶ Basic psychiatric drugs were not available in Mela Hospital.
- ▶ Lack of IEC materials concerning the programme was noted across different facilities that were visited.
- ▶ Ten doctors from the State have been trained at NIMHANS, Bangalore and training of 10 more is under process but these doctors are specifically working for de-addiction services.
- ▶ No coordination was noted between NMHP and the drug de-addiction programme supported by NIMHANS.

Telangana

- ▶ In Jayashankar Bhupalpally district, high suicide rate and alcohol abuse was observed.
- ▶ Despite the presence of Psychiatrist, Mental Health Programme was not visible in the districts.

Tripura

- ▶ Services for mental health are not available in South Tripura district.
- ▶ In Unakoti district, one Psychiatrist and a Psychiatric Social Worker are in place.
- ▶ Tripura also has a mental hospital which can be roped in as a training and referral facility.

Uttar Pradesh

- ▶ NMHP has not commenced its activities in both districts Farrukhabad and Varanasi, although one psychiatric nurse has been appointed in Farrukhabad.

Uttarakhand

- ▶ The NMHP Program has not yet been completely implemented in the State.
- ▶ Community awareness about the programme was found lacking in both districts.

5.5: NATIONAL PROGRAM FOR CONTROL OF BLINDNESS AND VISION IMPAIRMENT

National Programme for Control of Blindness and Visual Impairment (NPCB&VI) was launched in the year 1976 with the goal of reducing the prevalence of blindness to 0.3% by 2020. Main objectives of the programme are to -reduce the backlog of avoidable blindness; develop and strengthen the strategy of NPCB for "Eye Health for All" and prevention of visual impairment; strengthening and up-gradation of Regional Institutes of Ophthalmology (RIOs) and partners like Medical College, DH/ SDH, Vision Centres, NGO Eye Hospitals; strengthening the existing infrastructure facilities and developing additional human resources, enhance community awareness and lay stress on preventive measures and expand research for prevention of blindness and visual impairment;

KEY OBSERVATIONS

NPCB is being implemented in most states visited and overall, progress has been observed in terms of cataract surgeries, school health camps, screening services etc. It was observed that Community awareness about eye donation, common ophthalmic

conditions and health care services was satisfactory and Govt facilities were being utilized by the people in states such as Bihar, Punjab, Chhattisgarh and Uttarakhand.

States of Maharashtra, UP and Rajasthan projected a different scenario with awareness being low and out of pocket expenditures being high with respect to ophthalmic healthcare services. ASHAs and other FLW had not been trained in any state.

NGOs have been playing a major role in organizing the screening and surgery camps across different states. Linkages between RBSK and school screening camps have been strengthened in states of Punjab, Tamil Nadu, Uttarakhand, Madhya Pradesh and Karnataka. Screening camps were being conducted even at the village level in the state of Punjab.

The cadre of Ophthalmic assistants in SDH and DH has been put to efficient use for rendering the screening services to the community in Bihar, UP, Uttarakhand, Chhattisgarh and Rajasthan.

As a general rule, most of the states were providing surgical services at the district hospital level with the help of Ophthalmologist and Ophthalmic Assistant. Inadequacies in the HR were observed in Rajasthan at the district level. The DH in one of the districts visited in Bihar was not equipped with a functional Operation theatre.

RECOMMENDATIONS

- ▶ IEC activities for eye donation and availability of the services in the community need to be expanded
- ▶ Strengthening of infrastructure, availability of equipment and functional eye OT needs to be prioritized at all DH.
- ▶ Training of ASHA and ANMs should be planned to equip them with skills to identify and mobilize individuals who require eye care services. Concerted efforts need to be made for regular screening and follow up of cataract cases.
- ▶ Orientation of HR at primary level facilities also needs to be undertaken to improve the referral and follow up.
- ▶ Collaboration with RBSK and training of Mobile Health Teams for identification and referral of children up to 18 years of age also needs to be strengthened.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Ananthapuramu district has 10 vision centres manned by ophthalmic assistants at CHC, Ophthalmic Assistant & surgeon at area hospital and functional OT at DH/Medical College
- ▶ Community was aware of the institutions to seek help for age related deterioration of vision and availability of free spectacles under the programme.
- ▶ Visibility of the programme in terms of IEC was not adequate in the community.
- ▶ Availability of Snellen's chart was reported at the SC level though vision testing is done rarely.
- ▶ Records for Visual impairment, Village Blind or Diabetic register were not maintained adequately
- ▶ At PHC level basic eye care is provided and from CHC level onwards vision centres were present.
- ▶ Vision centres of the CHCs along with providing free spectacles and treatment of minor ailments also had the facility to consult ophthalmic surgeons through telemedicine in PPP mode
- ▶ DH, Haripur and GGH Medical College have collaborated with L.V Prasad Eye hospital for Eye donation
- ▶ Dedicated Eye ward, OPD & functional Eye OT (Cataract, Glaucoma etc) are present from DH level onwards.
- ▶ Collaboration with RBSK is observed at district level only.

Arunachal Pradesh

- ▶ Early health seeking behaviour was reported by the community however preference is to seek care in private clinic due to non-availability of doctors and medicines.
- ▶ Community members were aware about eye donation but in absence of any sensitization none of them were motivated for donation
- ▶ In absence of training and sensitization, ASHAs were not aware about services such as provision of free spectacles for elderly, BPL and post operated cataract patients
- ▶ Screening of patients was only functional at UPHC, CHC and DH.
- ▶ BP measurement was available at SC, PHC, UPHC, CHC, DH but blood sugar was done at UPHC, CHC and DH for diabetic retinopathy.
- ▶ User fees are charged from patients for these tests done. Despite availability of medicines at the facilities visited, it was noted that medicines were being prescribed from outside
- ▶ District hospital was conducting OPDs and was equipped with a functional OT as well.
- ▶ Register for visual impairment and diabetic registers were only available at CHC and DH.
- ▶ Medical officers were not trained in community ophthalmology and there was no para medical ophthalmic assistant placed at PHC and UPHC.
- ▶ Tonometer, vision testing drum, Snellen chart was available at CHC and DH

Assam

- ▶ Cataract surgery, eye banking and school eye screening are the key services provided under NPCB.
- ▶ Spectacles are being distributed in schools after eye screening.
- ▶ Around 1.09 lakhs spectacles were also distributed to old people in 2017-18.

Bihar

- ▶ The state has functional eye OT in 14 District hospitals. Around 3,33,181 cataract surgeries were performed in 2017-18 wherein the contribution of Local NGOs was 46 %.
- ▶ Awareness in the community regarding eye donation was found satisfactory. Regular screening camps and talks were being organized in schools and villages usually by Government and 'Sansthaas'.
- ▶ No activity pertaining to the programme is being undertaken at the sub-centre and PHC level.
- ▶ In Muzaffarpur 5 Block PHCs have Ophthalmic Assistants where refraction testing services are provided. Ophthalmic Assistants conduct regular talks in schools for awareness of Eye diseases.
- ▶ Equipment and drugs such as Moxifloxacin eye drops, Vision Drums, Trial sets with Frames, Snellen and near vision charts and Battery-operated torch are present at the block level
- ▶ A functional eye OPD is present at the DH with Two Ophthalmologists and Two Eye Technicians
- ▶ No Functional OT, wards, infrastructure and equipment availability for conducting of Cataract surgeries or any kind of surgical intervention.
- ▶ All eye surgeries (major or minor) are referred to Medical College or done by the Ophthalmologist in collaboration with NGOs.

Chhattisgarh

- ▶ Mitanins were maintaining probable cataract patients list and accompanying them for surgery.
- ▶ In district Korba, HWC facility was providing fixed day services on 3 days a week for screening of refractory errors.
- ▶ Outreach services for refractory errors and cataract were provided by the ophthalmic assistant.

- ▶ In District Korba there is only one ophthalmologist who is providing specialist services and is actively involved in blindness control activities. At DH Raipur, Eye surgeon along with PMOA is responsible for OPD.
- ▶ Surgeries happen in MCH wing in a separate building which is about 5 to 6 km away.
- ▶ No record was available for ophthalmic referral to Medical Colleges.
- ▶ Optometrists were not inducing cycloplegia for prescribing glasses to children.

Gujarat

- ▶ Cataract operations, distribution of glasses, eye donation activities under blindness control programme at the Trust hospitals were found to be good

Jharkhand

- ▶ National Program for Control of Blindness (NPCB) is being managed by Nodal officer NCD at State level and Civil Surgeon at district level.
- ▶ About 85 vision centers are functional in the state and 30 are in the process of establishment. Eye bank in PMCH Dhanbad is functional and Eye bank of MGM Jamshedpur is in process of establishment.
- ▶ In 2017-18 total 90211 cataract surgeries have been conducted in the state under this programme. 1051868 school children have been screened for refractive errors and 7962 free spectacles have been distributed among school children and 941 among elderly.
- ▶ In both the districts, ophthalmologists and ophthalmic assistants are in place in DH.
- ▶ In Bokaro, no screening activities were being conducted by the ophthalmic assistants at the school.

Karnataka

- ▶ The programme is running well and having good linkages with RBSK.

- ▶ The screening of children (Udupi- 98319, Chikmagalur- 89956) and distribution of spectacles (Udupi-1264, Chikmagalur-1200) were progressing well.
- ▶ The cataract (7828-Udupi, 4851- Chikmagalur operations in 2017-18) & glaucoma surgeries were being performed at District Hospitals.
- ▶ Reimbursement of two NGOs for cataract surgery was pending due to lack of budget (approx. Rs. 17 lakh) because to delay in release of amount.

Madhya Pradesh

- ▶ Public private partnership has been developed with 2 NGOs for providing screening, diagnostic and cataract treatment services and 88 camps have been conducted in 2017-18 in rural area.
- ▶ Eye testing in schools is being done but free spectacles were provided to only 50% of the students with refractive error.
- ▶ At civil hospital Biora, ophthalmic surgeon is available but due to the unavailability of equipment like slit lamp, operations are not being done.

Maharashtra

- ▶ Lack of awareness noted among community, ASHA and ANMs about common ophthalmic conditions and available services in both districts.
- ▶ In Satara, individuals with eye problems (including cataract) were seeking care in the private sector and incurring OOPE as a result. In Gadchiroli, lack of health seeking behaviour was observed in individuals with vision impairments.
- ▶ Both the DHs had a well-equipped, functional eye OT.

Punjab

- ▶ Community was seeking treatment for low vision at public facilities. ANM and ASHA were aware about ophthalmic problems and eye camps are

organized in the villages. However, awareness was relatively low in Moga district.

- ▶ As part of RBSK, screening of children is being done for refractive errors and free spectacles are being provided. However, a lag time of around 5-6 months was observed in the distribution
- ▶ Free spectacles are provided to elderly for refractive errors and to post-operative cataract patients through RKS and donation funds due to anticipated delays in disbursement of funds allotted.
- ▶ Eye OPDs are functional at secondary care level in the districts while functional eye OT is available at DH level.
- ▶ At CHC level, only screening for cataract and refractory errors is done. There is lack of equipment at CHC level like slit lamps and tonometer.
- ▶ Ophthalmic surgeon is also being utilized for routine emergency duties at DH
- ▶ Eye donation kits were not available.

Rajasthan

- ▶ National Programme for Control of Blindness and Visual Impairment has been rolled out in both districts however community members are not aware about eye care services, eye donation and eye bank.
- ▶ At SHC HWC, Community Health Officer and other service providers have not yet been oriented in NPCB & VI.
- ▶ Screening of school children on refractive errors and other eye problems reportedly had not been organised in the visited school of Rajasni, Tiwari in Jodhpur.
- ▶ Diagnostics services for cataract and glaucoma are being provided at CHC in Jodhpur.
- ▶ Patients are generally referred to district hospitals but, in most cases, they seek treatment in private clinics.
- ▶ Eye care camps are organised by Lion's Club twice a year in the Mathania CHC in Jodhpur

and by Vishal hospital in Kelwara CHC in Baran. Free spectacles are also provided during such camps. However, at facility level there was no monitoring or engagement of the staff in camps and no follow up services were provided by the health facility.

- ▶ In District Hospital Paota, Jodhpur a dedicated Eye Care Unit is available with adequate human resources and necessary equipment.
- ▶ In District Hospital Baran, the Eye care unit has one nurse and two optometrists while the ophthalmologist has resigned about 3 months ago. Hence, the OPD has reduced from 60-70 per day to 20 per day.

Tamil Nadu

- ▶ Fully functional Eye Units are present at District Hospitals and adequate facility for care is seen in Taluka and other sub-district hospitals.
- ▶ Weekly Eye specialist services are available at the PHCs.
- ▶ Screening of school children through RBSK and subsequent referral to DEICs for necessary management is being done.
- ▶ There were no initiatives for outreach camps in the districts.

Tripura

- ▶ Cataract surgeries are being conducted at the SDH and DH level. In FY 2017-18, only 61% of the targeted cataract surgeries have been performed.
- ▶ SDH Belonia has one Ophthalmologist who conducts cataract surgery twice a week. Ophthalmologist of the district Hospital visits the SDH once a week for conducting surgeries.
- ▶ Optometrists are available in the facilities and are providing refraction services.

Uttarakhand

- ▶ Screening of school children is being done and free spectacles are being provided by the facilities starting from PHC and above

- ▶ The camps at the block levels are being organised at regular intervals with the support of local NGOs such as The Hans foundation.
- ▶ Screening of eye care is being done by para medics at PHC/ CHC/ SDH and DH but cataract surgeries are undertaken through NGO supported camps.
- ▶ Trainings for Para medics were done two years ago and need refresher
- ▶ Basic medicines related to glaucoma and trachoma found. Data related to screening for glaucoma and diabetes were found but advance treatment was mostly done through NGO partners.

Uttar Pradesh

- ▶ Eye screening camps were restricted to schools and the community was not aware of any outreach camps.
- ▶ Eye care services are available at CHCs in both the districts. In CHC Farrukhabad, optometrist (Paramedic Ophthalmic Assistant) was providing services,
- ▶ The eye unit in Farrukhabad is well equipped, and has acquired a new phaco machine, which is could not be used due to absence of training.
- ▶ In Varanasi other than DDU hospital, DH, BHU and NGO hospitals were providing eye care services.
- ▶ Cases of refraction, glaucoma and cataract surgery are monitored monthly in the districts.

5.6: NATIONAL PROGRAM FOR PREVENTION AND CONTROL OF DEAFNESS (NPPCD)

National Programme for Prevention and Control of Deafness (NPPCD) was initiated on pilot basis in the year 2006-07(January 2007) covering 25 districts of 10 states and 1 UT and has been expanded to 384 districts in a phased manner. The key objectives of NPPCD are to prevent the avoidable hearing loss on account of disease or injury, enable early identification, diagnosis and treatment of

ear problems responsible for hearing loss and deafness, medically rehabilitate persons of all age groups, suffering with deafness, strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme and develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

KEY OBSERVATIONS

Low level of community awareness towards common ENT problems was reported from Jharkhand, Maharashtra and Rajasthan. The key front-line functionaries like ASHAs and ANMs had not received any orientation on NPPCD. A strong collaboration with RBSK and NUHM exists to support camps in the state of Rajasthan.

In remaining states, it was observed that the programme is being implemented only at the district hospital level. States like Maharashtra and Rajasthan have appointed an audiologist and a speech therapist in addition to the ENT surgeon in their district hospitals. However, in Bihar, only ENT surgeon was available without any supporting staff.

In Rajasthan, the hearing aids are provided through the ministry of Social Justice and Empowerment in the districts and a strong collaboration has been established with NGO Bhagwan Mahaveer Viklang Samiti for the same. The DH in Rajasthan was fully equipped while DH in Bihar and DH, Ranchi were found lacking in the basic ENT equipment.

RECOMMENDATIONS

- ▶ IEC campaigns are required to create awareness among the community members.
- ▶ Rational placement of HR including audiologists should be ensured for early detection of hearing problems.
- ▶ Provision of basic equipment and manpower at the DH so that ENT surgeries may be performed at the DH.
- ▶ Training of frontline workers and service providers at level of primary health facilities

needs to be prioritized for early identification and timely referral of common ENT problems and provision of follow up care.

STATE SPECIFIC FINDINGS

Gujarat

Implementation is largely in coordination with the RBSK and School health programme (eg Cochlear implant for congenital deafness).

Bihar

- ▶ At DH level only ENT specialist was available.
- ▶ OPD cubicle is present at the DH. Only tongue depressor has been provided while ENT specialist brings his own equipment.
- ▶ Common ENT problems are treated and other cases are referred to the Medical College. Average of 1500 patients are seen monthly.

Jharkhand

- ▶ Community, ASHAs, ANMs and other workers were not aware about deafness programme.
- ▶ In Bokaro, no ENT surgeon has been appointed, hence no activity is conducted.
- ▶ RIMS Ranchi and DH Ranchi provided services related to prevention and control of deafness.
- ▶ CHC Kakin had one ENT surgeon, however no equipment has been provided for ENT examination.

Maharashtra

- ▶ Surgeon, audiologist and speech therapist are available in both the DHs but no concrete activities have been initiated so far.

Rajasthan

- ▶ The Programme is implemented in 21 districts of Rajasthan including Baran.
- ▶ Screening of Patients in Camps and OPD is done by the staff employed under NPPCD and ENT specialist.

- ▶ Strong collaboration with RBSK and NUHM exists to support camps.
- ▶ OPD services were being provided by existing HR. However, no specific equipment was available at the visited CHC.
- ▶ In Baran, the DH team comprises of one ENT surgeon, one audiologist, one audiometrist and one speech therapist. The OPD ranges from 15-17 patients per day. The facility is well equipped and provides OPD and surgical services. The team also supports the RBSK camp and participates in the NUHM outreach camps.

5.7 NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY

National Programme for Health care for Elderly was launched in 2010. The basic thrust of the programme is to provide dedicated health care facilities for care of senior citizens (>60 year of age).

The programme aims to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an Ageing population, create a new “architecture” for Ageing; promote the concept of Active and Healthy Ageing and support convergence with other line departments like Ministry of Social Justice and Empowerment.

KEY OBSERVATIONS

NPHCE has been implemented in many states, albeit restricted to district hospitals and medical colleges for tertiary level of health care.

Limited awareness in the community regarding accessibility of services was observed in the states of Bihar, Maharashtra, Telangana, Uttarakhand, Chhattisgarh, Madhya Pradesh and Rajasthan which is also leading to many patients seeking care from private institutions thereby increasing Out-of-Pocket Expenditure. In addition, it was observed that the concepts and understanding of NPHCE was inadequate among the frontline workers, district and block administration in many states.

RH in Maharashtra provides fixed day services to the elderly. In Farrukhabad district, UP, CHCs have a rehabilitation worker/physiotherapist. Similarly, Physiotherapy units are functioning well in 10 districts of Karnataka. Rajasthan is operating its programme at the DH with trained Medical Officer, GNMs, rehabilitation workers and a physiotherapist.

Some states such as Maharashtra, Tamil Nadu, Tripura, UP (Farrukhabad district), Uttarakhand, Madhya Pradesh, Rajasthan and Karnataka have dedicated geriatric beds in the District Hospitals. Jammu and Kashmir and is providing IPD services even in its Sub-district hospital. The Taluk hospitals in Karnataka are also offering OPD and IPD services to the beneficiaries. A dedicated team of doctors and paramedics are in place in the district hospitals of Tamil Nadu and Uttarakhand for providing geriatric health services. However, these were reported to be underutilized in both states. Some states such as Bihar, Jharkhand, Telangana, and Arunachal Pradesh have either not established any geriatric wards or have non-functional ones and hence have no dedicated staff for geriatric care.

In Tripura, most elderly population availed medical services through the 104-outreach service mobile van visiting the village on monthly basis. State has also initiated a social protection scheme for single elderly women whose annual income is less than Rs. 2 lakhs.

RECOMMENDATIONS

- ▶ Referral linkages between the primary facilities to the secondary and tertiary care facilities need to be strengthened.
- ▶ Operationalize services for the elderly at block level through regular camps/MMUs at designated frequency (monthly / fortnightly), orient outreach workers on detecting problems among elderly, facilitating care and compliance.
- ▶ Facilities to be made geriatric-friendly with the provision for Separate waiting lines for geriatric patients at OPD, Availability of Wheel chairs, Ramps, Side railings etc. to improve ease of access.

- ▶ Rehabilitative services for elderly to be strengthened at primary care level

STATE SPECIFIC FINDINGS

Arunachal Pradesh

- ▶ The programme has recently been started in the district.
- ▶ At the DH, separate geriatric clinic was operational but geriatric ward was not available
- ▶ No trainings have been planned for the ASHAs and ANMs and no referral linkages from the primary facilities to the secondary and tertiary care facilities was noted
- ▶ Most of the equipment prescribed under the programme is not available in the facilities except ordinary walker and infra-red lamp.
- ▶ Out of pocket expenditure on diagnostics and medicines was reported by patients

Assam

- ▶ In Barpeta district, 8 out of 13 approved positions were vacant.
- ▶ Elderly patients are provided facility-based care only in CHCs.

Bihar

- ▶ No separate waiting queue, space, clinic or service for geriatric patients at the primary and secondary level of health facilities.
- ▶ A ten bedded Geriatric ward is available at the DH; however, it was not equipped with all the necessary equipment.

Gujarat

- ▶ 16 Geriatric clinics were established in the state out of the 19 that were sanctioned.

Jammu & Kashmir

- ▶ Elderly population in various blocks of District Kupwara have to travel to Sub-Division

Hospital for seeking consultations as there are no distinct geriatric services at HSC and PHC levels in the districts.

- ▶ SDH has a geriatric ward at the SDH, staffed by staff nurses, with a medicine specialist in charge.
- ▶ Though DH had a well functional Elderly care clinic was observed, yet a high out of pocket expenditure was reported on diagnostics, medicines and transportation.
- ▶ At the time of visit, diagnostics like Lipid profile, thyroid and electrolytes were not available at the facility, and patients had to go to a nearby private diagnostic lab to get it done.

Jharkhand

- ▶ Separate geriatric wards have not been established.
- ▶ Services are being provided by existing staff working in DHs, CHCs and PHCs.
- ▶ During current financial year 14203 elderly persons attended OPD in both the districts and were provided various services like IPD care, lab investigations, rehabilitation services and referral services etc.

Karnataka

- ▶ Geriatric OPD and Wards are functioning in Taluk Hospital & District Hospital.
- ▶ NPHCE programme has been rolled out in all the districts in a phase wise manner in the state.
- ▶ Nine districts namely Shivamogga, Kolar, Udupi, Tumkur, Chikmagalur, Dharwad, Vijayapura, Chitradurga and Gulbarga have constructed separate Geriatric wards.
- ▶ Physiotherapy units are functioning in these 10 districts.
- ▶ Laboratories are strengthened and significant progress has been made in appointment of contractual staff.

Maharashtra

- ▶ Most of the elderly in Satara district avail services from the private sector while most in Gadhchiroli were unaware of their health status.
- ▶ The elderly cited distance, indifferent behaviour and lack of assured services as reasons for avoiding public health facilities.
- ▶ RH and DH in Gadhchiroli were providing fixed day elderly care services with the DH having 10 dedicated beds. Satara did not have these provisions.

Madhya Pradesh

- ▶ Elderly people in both the districts do not seek services at Govt. facilities due to lack of awareness about the programme
- ▶ Only 1 separate clinic is available at DH but case load is very less (2 to 3 per week). About 10 dedicated beds have been provided in Rajgarh DH and 2 in DH Betul.

Punjab

- ▶ There is no structured Elderly Care Program in both the districts that were visited.
- ▶ However, community interactions highlighted the need for such services to cater to the need of elderly population
- ▶ Only available services are through regular OPDs.

Rajasthan

- ▶ Jodhpur has implemented the programme with placement of one Medical Officer, four GNMs, nine Rehabilitation Workers and one Physiotherapist - trained in National Programme for Health Care of Elderly.
- ▶ At the visited SHC, PHC and CHC there was no activity observed under NPHCE.
- ▶ Geriatric Care at Satellite Hospital Mandor, Jodhpur was found functioning with HR trained in NPHCE.

- The well-equipped 10 bedded ward exists with 2 beds dedicated for the bed ridden patients; however, its bed occupancy rate was only 5-7%.

Tamil Nadu

- At the District hospitals, Care for Elderly is ensured with a dedicated team of doctor and paramedic in place. However, services were found to be underutilized.

Telangana

- The state has initiated a social protection scheme for single elderly women whose annual income is less than Rs. 2 lakhs.
- Most of the elderly population availed medical services through the 104-outreach service mobile van visiting the village on monthly basis.
- However, dedicated elderly clinics were not observed at SC, PHC, CHC or SDH / DH.

Tripura

- Geriatric ward (10 beds) for elderly (above 60 years of age) had been identified in the district hospitals. However separate queue for elderly patients was not maintained.
- Understanding of geriatric care concepts at district and block level was poor even among the service providers and managers.

Uttarakhand

- Lack of awareness in the community and frontline workers in both districts about NPHCE was observed.
- The patients from the community usually prefer local private doctors for common geriatric problems and SDH Roorkee in case of emergencies.
- No services were available at HSC/PHC/CHC level.
- Lack of display of IEC at all levels of facility was observed.

- Mela Hospital, Haridwar had two dedicated wards for geriatric population, however the wards have not been utilized in the past one year.

Uttar Pradesh

- In Farrukhabad, geriatric care starts at CHC level with 6 out of 10 CHCs, having a rehabilitation worker/physiotherapist.
- A 10-bedded geriatric ward at the DMH, staffed by 5 staff nurses, with a medicine specialist-in-charge is operational in Farrukhabad.
- In DH Farrukhabad there were 3 rehabilitation therapists (1 occupational and two physiotherapists) running a well-equipped rehab clinic. In Varanasi the position of physiotherapist is vacant.

5.8 NATIONAL PROGRAM FOR PALLIATIVE CARE (NPPC)

NPPC was launched in 2012 with the goal to ensure availability and accessibility of rational, quality, pain relief and palliative care to the needy, as an integral part of Health Care at all levels, in alignment with the community requirements.

KEY OBSERVATIONS

The roll out of NPPC is in a nascent stage even in those few states where it is being implemented. Rajasthan has implemented the NPPC programme in Jodhpur district and trained its medical officers in the programme. Karnataka has also completed training of some of its staff in order to establish care centres in 5 districts. In Telangana, MO was aware of the programme but none of the programme specific activities were conducted through PHC. In states of Jharkhand, Punjab and UP, the programme has not been rolled out in the visited districts.

As was observed with other NCD programmes, there was a general lack of awareness about the programme and its services among the community, ASHA and ANMs in both districts of Maharashtra, Punjab, Telangana, Tripura and Rajasthan.

Few states have been able to roll out certain services at the district hospital level but it was found that these services were being underutilized. A palliative care unit was available in District Hospital, Satara in Maharashtra which had one counsellor and one social worker but oral morphine was not available for pain relief. At District Hospital in Telangana, a dedicated ward has been constructed for palliative care activities, however, it is not functional yet.

RECOMMENDATIONS

- ▶ A comprehensive plan needs to be developed at state and district level for establishing referral linkages of secondary level facilities with the primary care facilities for delivery of services at primary care level and at the community level.
- ▶ Follow-up mechanism needs to be developed for treatment adherence especially in the current context of CPHC.
- ▶ A detailed review of the programme may be undertaken to assess the challenges faced by states in programme roll out and monitoring.

STATE SPECIFIC FINDINGS

Karnataka

- ▶ The National Programme for Palliative Care is being implemented in 5 districts namely Dharwad, Raichur, Mysore, Mangaluru and Bengaluru Rural.
- ▶ Accordingly, state co-ordinator has been appointed and training of 2 specialists, 2 staff nurses and 1 pharmacist has been completed.
- ▶ Care centers are expected to be established in these 5 districts

Maharashtra

- ▶ General awareness about the programme and its services was lacking among the community, ASHA and ANM in both districts.
- ▶ Counsellor at DH Satara had a format for follow up of patients by ASHAs.

- ▶ Oral morphine was not available in both districts for the patients.
- ▶ A palliative care unit was available in DH Satara which had one counsellor and one social worker catering to about 610 patients in 3 blocks.

Rajasthan

- ▶ The programme is being implemented in Jodhpur district.
- ▶ 20 Medical Officers have been trained in National Programme for Palliative Care, however, roll out of the programme is still in the infancy stage.
- ▶ Community level awareness on palliative care was found lacking.
- ▶ Service providers at SHC HWC, PHC and CHC are yet to be oriented about the programme.
- ▶ No dedicated Palliative Care unit was functioning at the DH.

Tamil Nadu

- ▶ At the District hospitals, in patient facility for Pain and Palliative Care is available.

Telangana

- ▶ MO was aware of the palliative care programme but none of the programme specific activities were conducted through PHC.
- ▶ At District Hospital, dedicated ward has been constructed for palliative care activities, however, it is not functional yet.

Tripura

- ▶ Understanding of palliative care concept at district and block level were poor even among the service providers and managers.

5.9: NATIONAL PROGRAM FOR PREVENTION AND CONTROL OF FLUOROSIS (NPPCF)

NPPCF was initiated in 2008-09 and is being expanded in a phased manner. About 100 districts

of 17 States were covered during first phase and subsequently nearly 90 more districts were added. Activities undertaken as part of the programme are - Surveillance of fluorosis in the community; Capacity building; Establishment of diagnostic facilities in the medical hospitals; Management of fluorosis cases including treatment surgery, rehabilitation and Health education for prevention and control of fluorosis cases.

NPPCF is being implemented in the states of Jharkhand, Telangana, Andhra Pradesh, Assam, Chhattisgarh, Jammu & Kashmir, Madhya Pradesh and Karnataka. It was launched in Varanasi district of Uttar Pradesh but none of the activities have commenced under the programme.

KEY OBSERVATIONS

Korba district in Chhattisgarh has adopted an innovative and convergent approach to combine the outreach activities for fluorosis, dental screening and tobacco addiction. Water samples are being analysed in the state of Jharkhand, Telangana, Madhya Pradesh and Chhattisgarh and Karnataka. In addition to the water analysis, Telangana is also conducting urinary analysis for fluoride levels apart from school and community surveys to identify patients of dental and skeletal fluorosis. The progress was reported to be slow from other states.

Ananthapuramu district in Andhra Pradesh and Doda district in Jammu & Kashmir have mapped out all the endemic villages after conducting a survey. However, no programme activity has been initiated in Ananthapuram while in Doda only equipment has been purchased. Fluorosis lab has not been established in Uttar Pradesh.

Assam has not established piped water supply in the endemic district of Kamrup R even after coordinated efforts under NPPCF. Similar delays were observed in the provision of an alternate source of potable water by the Public Health Engineering department in Korba.

Human resource for the programme has not been recruited by Andhra Pradesh and high proportion of

vacancies were reported from Karnataka. Training of district nodal officers and lab technicians has not been conducted yet in Jharkhand, Jammu & Kashmir and Uttar Pradesh.

RECOMMENDATIONS

- ▶ Proactive measures should be undertaken for the implementation of NPPCF across all levels of facilities in the endemic districts.
- ▶ Capacity building of state and district staff including lab technician should be conducted along with the establishment of dedicated fluorosis labs.
- ▶ IEC activities should be planned in all the endemic districts to raise awareness regarding fluorosis and its prevention.
- ▶ Strong coordinated efforts to be made with Public Health Engineering dept. in order to expedite provision of potable drinking water to the affected community.
- ▶ Community engagement through platforms such as VHSNC and MAS should also be improved for better planning and monitoring
- ▶ Building of proper referral linkages to enable access to services across levels of care needs to be prioritized.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Surveys have been carried out in the Ananthapuram district and a total of 151 villages have been identified as endemic.
- ▶ Except for identifying villages endemic for fluorosis, no other activity is being currently conducted in the district.
- ▶ Awareness of the community about sign and symptoms and prevention of fluorosis is lacking.
- ▶ No IEC activity is done under the programme.

Assam

- ▶ Kamrup R is a fluorosis endemic district and NPPCF programme is implemented in the district. However, piped water supply was not available in villages that were visited.
- ▶ It was reported that Public Health Engineering Dept. has not started piped water supply activity despite coordinated efforts were made under the NPPCF.

Chhattisgarh

- ▶ NPPCF has been implemented in Korba.
- ▶ The worst affected block Paudiuproda has a well-established laboratory for diagnosis of fluorosis.
- ▶ Water testing RD kits are being provided to the affected villages.
- ▶ There is a delay from PHE Dept. to provide an alternate source of potable water.

Gujarat

- ▶ Incidence of “ Musculo – skeletal disease (MSD) is there in the State. Dental Fluorosis was not observed in the schools visited.

Jammu & Kashmir

- ▶ Mapping was done in 2012 for Doda.
- ▶ Procurement of equipment has been done. Recruitment and trainings are required for the staff in both the districts of Kupwara and Doda.

Jharkhand

- ▶ The programme was initially implemented in four districts, subsequently 9 new districts have been added including Ranchi.
- ▶ Water samples are being examined and in last year out of 70 samples 30 were found positive.
- ▶ Out of 1168 patients 104 were suffering from dental fluorosis and 33 from skeletal fluorosis.
- ▶ State needs to procure ion meters and hire staff approved under this programme.

- ▶ Training of district nodal officers and lab technicians has not been conducted yet.

Karnataka

- ▶ District fluorosis laboratories are working well in the 19 endemic districts of the state.
- ▶ Field surveys, lab testing of water and urine samples, IEC, trainings etc. are being conducted.
- ▶ Pregnant women's haemoglobin and levels of fluoride in urine is being monitored.
- ▶ Posts of 3 district consultants are lying vacant.
- ▶ Testing of fluoride levels in the RO plants in villages needs to be done.

Madhya Pradesh

- ▶ As per the survey around 400 villages in Rajgarh are prone to Fluorosis but no dedicated staff is positioned.
- ▶ Survey sampling of water for Fluoride content in Athnair, Bhaisndehi have shown fluoride content to be above permissible limits (Betul).
- ▶ A lab has been set up at DH Rajgarh but Lab Technician is yet to be trained.
- ▶ Fluoride content was found to be above the permissible limit in Betul (Athner, Bhaisdehi) but lab setup is not available in DH.

Telangana

- ▶ In the 2017-18, about 106 villages were surveyed in Nalgonda, Mahabubnagar and Karimnagar districts.
- ▶ School survey: 114 schools were covered in which 3038 children were screened and 1590 (52%) children were suspected of dental fluorosis.
- ▶ Community survey: 7449 persons were examined and 2676 (36%) were suspected to have dental fluorosis and 1546 (20%) were suspected to have skeletal fluorosis.
- ▶ Water Analysis: Conducted in 106 villages wherein 314 water samples were tested and 113 samples were found to be having levels above 1.5 ppm.

- Urinary Analysis: 3523 samples were analysed and 1944 samples were found to have levels above the prescribed limit.

Uttar Pradesh

- In Varanasi, although NPPCF has been launched but no activities have commenced.
- Fluorosis lab is not available and training for MOs and health staff has not been conducted.
- District has combined outreach services for 3 different programmes-fluorosis, dental reening and tobacco addiction. Work plans are prepared every month and activities are carried out accordingly.
- District has planned a project in coordination with PHE department to have a separate water supply to the affected villages.

5.10 NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAMME (NIDDCP)

National Goitre Control Programme (NGCP) was launched in 1962 which was later renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP) with a view of wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf mutism, cretinism, still births, abortions etc. The programme is being implemented in all the States/UTs for entire population. The goals of the programme are to bring the prevalence of IDD to below 5% in the country and ensure 100% consumption of adequately iodated salt (15ppm) at the household level.

KEY OBSERVATIONS

The Community was found to be largely aware about the benefits of consuming iodized salt in most states but it was also observed in Uttarakhand that certain marginalized sections were using rock salt. Salt testing is being carried out in endemic districts by health workers in Jharkhand and Karnataka. Telangana has also trained its FLWs but the number of samples being tested has reduced dramatically over the past 2 years.

IEC activities are also being conducted by ASHAs and other stake holders in endemic districts to create awareness among the community members in Telangana and Jharkhand. But in some states, lack of understanding among the service providers and stakeholders was also seen.

Though the community awareness is satisfactory, the programme sustainability has to be ensured as human resource has not been recruited by some states such as Jharkhand, kits are not available in Maharashtra and Tamil Nadu has not spent any funds in the current fiscal year for the programme.

RECOMMENDATIONS

- Proactive measures for monitoring and implementation of NIDDCP in endemic districts.
- Role of community-based platforms such as VHSNC and MAS can also be explored to ensure the availability of iodized salt in the community.
- Availability of salt testing kits to be streamlined.

STATE SPECIFIC FINDINGS

Gujarat

Iodine testing kits were not available with peripheral workers for salt testing.

Jharkhand

- ASHAs are conducting the salt testing in endemic districts and 80-90% samples have been found adequately iodized in last two years.
- IEC and IPC activities are being conducted by ASHAs and other stake holders in endemic districts to create the awareness among the community members.
- Staff has not been recruited under this programme.
- Programme not implemented in district Bokaro.

Karnataka

- ▶ Twelve out of thirty districts are endemic with Iodine Deficiency Disorders.
- ▶ The state IDD cell is working well with adequate number of salt and urinary iodine excretion tests.
- ▶ 18 % of salt samples tested have inadequate iodine (state report).
- ▶ The Iodine testing kits are available and the health workers are skilled in its use.

Maharashtra

- ▶ Good awareness about consumption of iodized salt noted in the community in both districts. However, awareness about the ill effects of iodine deficiency was lacking.
- ▶ Salt testing kits were not available with ASHAs.
- ▶ Service providers were aware of the importance of consuming iodized salt.
- ▶ Since, largely iodized salt is consumed in the community, the service providers did not perceive IDD as a major issue.

Tamil Nadu

- ▶ In the current fiscal year, funds have not been utilized under this programme.

Telangana

- ▶ The State has conducted surveys in Rangareddy, Nirmal, Siddipet, Jogulamba (Gadwal) Districts to assess the magnitude of Iodine Deficiency Disorders (IDD).
- ▶ Campaigns in the District are being conducted to create awareness about IDD and usage of iodized salt.
- ▶ ASHA, ANMs, and AWWs have also been trained for community awareness and monitoring, however effective implementation at the field levels was not observed.
- ▶ As per the State data, 61201 samples were tested for Iodine in 2014-15 and about 49938 (81%) of these samples had iodine levels above 15ppm. However, it was observed that in subsequent years, the number of samples tested has

reduced dramatically and in 2018-19 only 275 samples were tested of which 230 (83%) samples continued to have iodine levels above 15ppm.

Uttarakhand

- ▶ Most of the community members were using packaged salt but certain community members from marginalised sections were using rock salt, which was a general practice in the sub section of the community.
- ▶ Women with new born were informed about use of iodized salt but otherwise a large population was ignorant about it.
- ▶ Sample collection and monthly testing was not being done.
- ▶ There was a lack of understanding/ ownership among the service providers related to IDD.

Uttar Pradesh

- ▶ Community was found to be aware about the importance of Iodine and confirmed that iodized salt is widely available.

11. EMERGENCIES, BURNS and TRAUMA

NPPMBI was launched in 2014 to reduce incidence, mortality, morbidity and disability due to Burn Injuries, improve awareness among the general masses and vulnerable groups, establish adequate infrastructural facility and network for burn management and rehabilitation interventions and to carry out Research for assessing behavioral, social and other determinants of Burn Injuries in our country for effective need based program planning for Burn Injuries, monitoring and subsequent evaluation.

KEY OBSERVATIONS

Most of the states have mechanisms in place to manage Emergencies, Burns and Trauma only at the secondary or tertiary levels. Community members avail services from public facilities, either CHC or preferably DH in cases of accidents or emergencies; an impressive innovation by Chhattisgarh is the usage of SMART CARD wherein the people can seek care in any nearby health

facility in Cases of emergency. Dedicated areas for injection and suturing were observed in few HWCs in Chhattisgarh. Emergency services provided by the HWCs include dressings, suturing, administration of IV Fluids, first aid services and antibiotics.

Basic first aid services for stabilization, suturing of wounds and splint for fractures were available at the majority of CHCs and civil hospitals visited in HP. At the district hospitals in most of the states, management of common medical emergencies (chest pain, MI, shortness of breath, poisonings, animal (dog and snake) bites and convulsions) was available.

In Punjab, it was observed that there was a shortage of HR in the form of anaesthetists at the CHC. The casualty MO and attendants in Chhattisgarh were not trained for BLS/ALS.

One more remarkable initiative that is worth mentioning is 'the boat ambulance' started by Gujarat to reach out to the fishermen in distress. The boat was well equipped and all the required resources (HR, Medicines, Consumables, Stretcher etc.) were available and functional. The HR was also properly trained.

RECOMMENDATIONS

- ▶ Emergency services (for both medical and surgical emergencies) need strengthening across all the tiers of primary health care.
 - ◆ A comprehensive review of the capacities of the health facilities at all levels for managing medical and surgical emergencies need to be undertaken.
 - ◆ Strong referral linkages with tertiary care centres need to be developed
- ▶ Protocols for triage need to be developed and followed in all facilities

STATE SPECIFIC FINDINGS

Chhattisgarh

- ▶ In case of emergency, people call 102/108 for transport of patients to health facility and also use 112 for help.

- ▶ Dedicated area for injection and suturing is available at the HWC visited.
- ▶ **At secondary level facilities CHC/DH - TRIAGE** was not observed, Casualty MO, attendants were not trained for ALS/BLS. Other support services for emergencies like drugs, consumables, minor OT are available at CHC and DH. Resuscitation for trauma cases is available at DH.
- ▶ In Case of emergency people usually seek health care in any nearby health facility using the SMART CARD facility at Government facilities and empanelled private health care facility.

Gujarat

- ▶ Even though planning and establishment of emergency care services is weak, the initiative for reaching out to the fisherman in distress through 'the boat ambulance' is working well.
- ▶ The boat is equipped well and the required human resources are in place. The HR was also adequately trained.

Himachal Pradesh

- ▶ Basic first aid services for stabilization of patients were available at majority of CHCs and civil hospitals visited.
- ▶ Anti-rabies vaccine and anti-snake venom were available.
- ▶ Common medical emergencies were managed at the district hospital.

Jharkhand

- ▶ Emergency Services were limited to the tertiary level of health care in district hospitals.
- ▶ 108 has helped improve the provision of services in cases of emergency, burns and trauma.

Punjab

- ▶ In case of road accidents or an emergency situation the community avails services from public facilities, either CHC or preferably District Hospital.
- ▶ At CHC there is an availability of emergency room but in absence of anaesthetist and orthopaedic surgeon, serious cases are stabilized and referred to DH/Medical College.

NUHM

(NATIONAL URBAN HEALTH MISSION)



NATIONAL OVERVIEW

The National Urban Health Mission (NUHM) aims to provide comprehensive primary healthcare services to the urban poor including but not limited to the homeless, rag-pickers, rickshaw pullers, slum dwellers etc. with special focus on residential, occupational and social vulnerabilities. Findings from CRM-11 held last year, had shown significant progress in NUHM implementation across all the participating states, in comparison to the initial plodding years. In contrast to CRM-11 which focused on assessing the programme components, CRM-12 has adopted a slightly different but a more holistic approach, keeping in mind the outcomes in the form of services received by the beneficiaries, while assessing programme implementation.

A specific and significant observation of CRM-12 has been from the community perspective. Various active interactions have been done to look into community awareness and their health seeking behaviours, popularization of ANM, ASHA and MAS in their areas and understanding other service related factors like out-of-pocket medical expenses, quality of healthcare, emergency transportation etc. As a common observation from Bihar, Jharkhand and Uttarakhand, people do not trust the quality of treatment provided in government health facilities, and hence forced to turn to private doctor or pharmacist or even informal healthcare providers. ASHA and MAS were mostly formed and functioning in most states except the states of Uttarakhand, Tamil Nadu and Jammu & Kashmir, where this cadre has not been created. In fact, community interactions in the aforesaid states, found that there was very less

awareness about the nearby health facilities, public health schemes, free drugs and diagnostics scheme etc. This clearly is one of the reasons behind under-utilized health facilities. Further, high out-of-pocket expenditure was reported from Uttarakhand, Jharkhand, Punjab and Bihar which has created mistrust and indifference towards the public health facilities among the population in these states.

As the States gained more understanding on urban health and its components during the last few years, the activities under NUHM have gained pace. Similar to last year's findings, majority of states visited this year too had shown well established and operational urban health facilities in almost all the participating states, both in terms of infrastructure development as well as institutional arrangement. Uttarakhand however displayed an extremely poor NUHM implementation where all the facilities had been non-functional since March 2018 in anticipation of MOU renewal of private public partnership. The state has not been able to develop their own capacity for operationalizing UPHCs. On the other hand, interaction with community in Haridwar, revealed a willingness to avail services from public health centers, had the facilities been functional and provided free drugs and diagnostics.

Community outreach activities through UHNDs and special outreach camps have also increased this year, but were found largely RCH and immunization centric. Activities to initiate NCD screening, however, are gaining pace. Almost all States have initiated work on GIS mapping but have not initiated vulnerability assessment as yet. Urban ASHAs are mostly in place and working except in Jammu & Kashmir,

Uttarakhand and Tamil Nadu, where ANM/AWW/UHN is largely handling the community outreach. But because of absence of standardization or low population-UHN ratio, the services in the community are not being delivered as envisaged. MAS were functional across most states and reportedly conduct regular monthly meetings. MAS in Gujarat have been reported to conduct exceptionally good work at the field, where all members were acting as drivers of change and a role model for good health practices in urban vulnerable areas.

Status of convergence has largely been unsatisfactory throughout. After the increase in convergence meetings at the State level, ULBs have been sensitized but their involvement in service delivery still needs to be pushed in most states. A very poor convergence has been observed in Andhra Pradesh, Bihar, Jharkhand, Punjab and Uttar Pradesh. In contrast, ULB ownership of NUHM

implementation was found exceptionally good in Karnataka and Tamil Nadu. In TN-corporation area, the ULB sanitation department staff is placed in UPHC premises and the UPHCs in Madurai have established Bio-gas plant in the premises that is fed by the garbage from the associated slum and market area.

Capacity development of all stakeholders and service providers has been identified as a major strategy in improving the performance of NUHM in almost all states. Other identified areas of improvement were completion of mapping both GIS and vulnerability; rational deployment of human resource, both community volunteers and facility HR; facilitation towards convergence at State and district, quality certification of UPHCs, RKS formation and release of untied grants to the urban facilities. With the launch of Aayushman Bharat, the range of services being provided by UPHCs



needs to be expanded from just maternal and child care to incorporate all the 12 packages of service delivery as per CPHC guideline. Hence, with UPHCs providing complete package of comprehensive primary healthcare, it becomes crucial that good quality and assured referral networks in the form of upward and downward linkages of the UPHCs should be formed and sustained.

KEY OBSERVATIONS

COMMUNITY OBSERVATIONS

Community Awareness and Health Seeking Behaviours:

Community interactions were reported from 8 out of 18 states and the results found were a varied mix of observations and experiences. Living conditions in slums were largely filthy and below average standards across all states except TN, where housing was well made under various urban development schemes. Utilization and faith towards the public health system was satisfactory in Himachal while very poor in Uttarakhand, Bihar and Jharkhand. Community awareness on health facilities, health schemes, services and health determinants was good in Himachal Pradesh, UP, Tripura, while extremely low in Bihar, UK, Maharashtra, Punjab and Jharkhand. Especially the community in Bokaro was unaware of most facilities like outreach camps, 108 services and government insurance schemes etc. Community in Bihar revealed an absolute distrust towards government health facilities; however, people do seek RCH and immunization services from Public facilities.

Community Health workers:

The number and performance of urban ASHAs and ASHA-population ratio was found satisfactory in Karnataka, Telangana, Tripura, Arunachal, UP and Gujarat which automatically made the community awareness and community activities of these states better than the rest. In Telangana, ASHAs, MAS, ANMs, and AWWs were actively involved in counselling in schools and UHNDs on Menstrual Hygiene and Sanitation practices.

In Bihar and Himachal Pradesh, the ASHA-population ratio was extremely low, while in J&K, Uttarakhand and TN there were no urban ASHAs. In TN, UHN was responsible for conducting home visits in slum population, but due to very low UHN-population ratio, it was almost impossible for 1 UHN to cover the complete population, as a result community awareness was found weak. In AP, it was observed that ANMs were not visiting community and their interaction with urban ASHAs was minimal, due to which ASHAs were not properly mentored. This makes them less known in the community as a result, community awareness on health determinants was found weak.

Though a reasonable number of ASHAs were present in Punjab and Jharkhand, their knowledge on different programme components was found inadequate, thus affecting both MAS performance and community awareness.

Number and functioning of MAS was satisfactory in Chhattisgarh, Gujarat, Karnataka, UP, Tripura and Telangana but the percentage of MAS against sanctioned number was lowest in Tamil Nadu that is 16%. Performance of MAS has been reported very poor in Jharkhand, Bihar, Himachal, AP and Punjab. In AP, MAS accounts have been opened but a large amount of funds remain under-utilized

Patient transportation & Expenses incurred:

High out of pocket expenses were reported from Uttarakhand, Bihar, Jharkhand, Punjab and Himachal Pradesh. While in Uttarakhand the community was not aware about free public transport facilities, most people in Himachal were already availing public transport services and even the response time of 108 ambulances was found satisfactory during community interactions.

In Jharkhand, no government transport facility including 108 ambulance or MamtaVahan was available to residents from Bokaro slums, even for emergency conditions. In Punjab, people were aware about free transport facility for sick, trauma and pregnant cases, but community still preferred to seek health services and treatment from private sector. As reported in the interviews, this was largely

due to shortage of medicine at UPHCs which levied heavy out-of-pocket expenditure to individuals in the community.

FACILITY OBSERVATIONS

Range and quality of services through UPHCs

UPHCs across most states were providing general OPDs, maternal and child health services, day care for emergencies and minor procedures, diagnosis, management and follow-up for common NCDs. Andhra Pradesh is using digital platform of e-UPHCs to provide services unlike other states. In addition to routine services, e-UPHCs provide telemedicine services for four identified specialties in PPP mode. The quality of service delivery was found satisfactory. Besides the regular OPD, RCH and NCD screening, UPHCs in Tamil Nadu provide weekly specialist services through Polyclinics.

UPHCs in AP, Arunachal and Karnataka were found to provide a range of aforesaid good quality services. Himachal has additionally launched an innovative 'Tele stroke Project' for ensuring thrombolysis services to patients with Stroke within the 'Golden Hour' and immunization certificates for school admissions. Population based NCD screening for hypertension, diabetes mellitus and cancer has been started or will be initiating soon in most states, though not much reported from the UPHC areas. In Jharkhand, while the range of services was satisfactory, diagnostic services were not available at the facility.

In Uttarakhand, urban health facilities were non-functional since March 2018, leading to a halt in not only facility based OPD services, but also regular immunization through outreach activities.

With regards to Quality, most facilities in Arunachal are Kayakalp certified. They have functional infection control committees and service provision is satisfactory. Internal quality assessment has not been initiated for Bihar, Punjab and Tamil Nadu. In Rajasthan, no UPHCs functioning under PPP mode had initiated quality assessment processes. In Chhattisgarh and Rajasthan, bio-medical-waste-management needs urgent attention.

UPHC preparedness: HR, infrastructure, drugs and diagnostics

Adequate HR in line with the Gol NUHM guidelines was found in Arunachal Pradesh, Telangana, Tamil Nadu and Maharashtra. Arunachal in-turn, had surplus HR which was irrationally placed. Irrational placements for some positions were also found in Punjab. Positions of SNs and pharmacists were not filled in Andhra Pradesh and ANMs were handling their work. Similarly in the absence of pharmacists in Bihar, their work was managed by ANMs. Attrition rate of medical officers was very high in Karnataka. Position of public health managers were largely absent from most states like Andhra Pradesh, Arunachal Pradesh, Bihar, Himachal and Maharashtra. In Himachal Pradesh too, most positions were filled, except for the positions of LTs which were largely vacant. In Rajasthan, while positions of GNM, pharmacist and LTs are all filled, 50% positions against the sanctioned ANMs were vacant. Telangana and Tamil Nadu had adequate HR as per the Gol guidelines.

Drug availability in Tamil Nadu and Himachal Pradesh was satisfactory. EDL was found painted on walls of the UPHCs in these states. In Himachal Pradesh, drugs stock was adequate and was found to be distributed under free drug scheme. Bihar also reported to have adequate drugs with well-maintained inventory. Availability of drugs as per EDL was missing in Jharkhand, Maharashtra and Punjab. Diagnostic services were satisfactory in states having adequate LTs. It was observed that the facility in Maharashtra and Punjab were not performing laboratory tests as per their list.

UPHC performance: Mapping, average OPD, outreach sessions

Outreach sessions both UHNDs and Special outreach were found to be conducted regularly in Karnataka, Telangana, Rajasthan and Tamil Nadu. Though TN do not conduct Special outreach but its UPHCs provides fixed day specialist services through polyclinics. Evening OPDs and fixed day specialist services are being conducted in

Karnataka too. Himachal Pradesh is conducting regular UHNDs but no special outreach camps. Maharashtra, Punjab and Chhattisgarh also found to have inadequate outreach sessions. UHNDs were not being conducted in the Bokaro slums but were occasionally conducted in Ranchi. In Arunachal Pradesh, though the UHNDs were regularly conducted, but no micro plan was available at the facility.

In case of mapping, none of the states were found to conduct vulnerability mapping (VA) except Arunachal Pradesh, where the VA is completed with support from Urban Development Departments and 81 Anganwadi Centres. GIS mapping has been completed in UP, Karnataka and Punjab and under progress in Rajasthan, where they have initiated a process of listing and mapping of notified and un-notified urban poor settlements in identified cities. However Himachal Pradesh, Maharashtra and Tamil Nadu need to speed up the process of GIS mapping. In TN, GIS mapping has not yet been undertaken in most of the cities and vulnerability mapping has not been planned. Slum mapping has been done and displayed as handmade drawing without much value out of the maps displayed.

Convergence with ULBs, Medical Colleges and referral centers

Tamil Nadu is displaying the best and the most innovative example of Intersectoral Convergence. In Corporation areas, the ULB sanitation department staff are placed in UPHC premises, while in Madurai, health department was organizing health check-up camps every month in Night shelters for homeless old people. Garbage generated at the market places and the slum areas was utilized to produce bio gas at the biogas plants established within the urban PHCs. Similar to TN, convergence of health department with corporation was found satisfactory in Karnataka.

For the rest of the States, convergence with ULBs and other departments like water and sanitation was found grossly inadequate. Convergence with ULBs was especially poor in state of Jharkhand,

Bihar, AP, Maharashtra and Uttar Pradesh. These states need to take immediate actions to speed it up. Himachal Pradesh shows a moderate convergence with ULBs but good convergence with other departments and programmes like RNTCP and IDSP. None of the states reported to have convergence with medical colleges. The referral mechanism to secondary and tertiary care centres was also found good in Himachal Pardesh and not reported in other states.

Financial / governance issues

RKS accounts for distributing the facility untied funds was largely open throughout all the reported states. In Arunachal Pradesh, however, the amounts to RKS have not been released from the state treasury for a long time, because of which the payments of ASHAs was reportedly stuck from the past 3-4 months. This led to high dissatisfaction and reduced work-motivation in community health providers.

Fund utilization was found grossly inadequate in Chhattisgarh, Rajasthan and Maharashtra. In Chhattisgarh, huge irregularities and disparities under finance were observed. Similarly, Jharkhand and Bihar also need to improve their financial records. In contrast to these states, observations from Maharashtra report that all the financial records were properly maintained at facility and state levels.

RECOMMENDATIONS

- ▶ All types of mapping including spatial GIS, facility and slum mapping and vulnerability assessment of the identified slums areas should be completed on priority
- ▶ States should make sure that all the key positions under the state, district and city programme management units are filled and functioning.
- ▶ All the vacant facility positions under management and service provider's category should be filled. State should also focus on rational deployment of HR under all categories. Irrational or extra positions should be appropriately relocated or curtailed as per the Gol-NUHM guidelines

- ▶ State level meetings for strengthening convergence with ULBs and other concerned departments should be organized regularly and roles and responsibilities of various departments under NUHM should be clearly identified and communicated among all stakeholders
- ▶ NUHM trainings as per the training module and CPHC guidelines released by GoI should be completed for officials at all levels of implementation, including Secretary, MDs, DHS, SPMUs DPMUs, CPMUs and service providers.
- ▶ UPHCs identified to be converted as HWC across the states should be made as hubs for providing comprehensive primary health care which incorporates range of services in 12 packages including NCDs and national health programmes. For this, population screening should be started on priority
- ▶ States should make sure that all the UPHCs have registered RKS and the state is regularly releasing untied funds to the respective UPHC accounts. There should be clear understanding over the dissemination and utilization of untied grants
- ▶ Process of drug procurement should be streamlined to ensure assured drug availability at all the UPHCs
- ▶ There is a need to reinforce coordination among ANM, ASHA and MAS through regular meetings of ANMs with all ASHAs & MAS of their catchment area. There should be special emphasis on their catchment areas, work profiles and level-wise monitoring
- ▶ ASHAs and MAS should be trained to create awareness in the community about factors including but not limited to nearest public health facility, services being provided, frequency, days of outreach services, information on referral transports and information on other social determinants like cleanliness and hygiene, nutrition, disease prevention and health promotion
- ▶ All the urban health nodal officers in states and districts should be oriented and engaged in quality assurance committee. States should further expedite the process of baseline assessment of UPHCs
- ▶ Wherever necessary, States should expedite the MoU process for operationalizing UPHCs in PPP mode. Under the PPP arrangements, the MoU must clearly define the responsibility of private partner and develop a framework to monitor performance of PPPs in terms of defined time bound deliverables and measurable outcomes

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ The state is using digital platform in the form of e-UPHCs to provide services in the community.
- ▶ Besides regular OPDs, ANC and immunization, the UPHCs are managing few NCDs like hypertension and diabetes mellitus. The e-UPHCs are also providing telemedicine services for four specialties (Medicine/ Orthopedics/ Endocrinology /Cardiology) in PPP mode.
- ▶ ANMs are not visiting the community. Due to this the urban ASHAs don't get adequately and properly coached and mentored; Fixed day UHND sessions were not being done in the slums.
- ▶ MEPMA (SHG) units have been converted into MAS and yearly untied grant is being released directly from state and a large amount of these funds have remained unutilized.
- ▶ Separation of MAS from MEPMA is desirable for effective community process activities.
- ▶ CPMUs or city Health Society (CHS) and City were not constituted in the cities. Technical linkage between UPHCs and Teaching Hospital (though they are co-terminus) was very poor.

Arunachal Pradesh

- ▶ State has well framed institutional arrangements such as SHS, CPMU and Infection Control Committees at UPHCs.
- ▶ All the ASHAs are knowledgeable and enthusiastic, except in East Siang (Rural). IDSP

data has been reviewed weekly to rule out outbreak of diseases. It is worth mentioning that visited facilities were neat and clean and scored good under Kayakalp initiative.

- ▶ Accounts of MAS member have been opened, but once member has been localized or shifted from one place to another, their accounts have not been transferred automatically; it requires their signature for operationalization of the account.

Bihar

- ▶ As per state data, out of the 100 sanctioned UPHCs, 89% are functional and 85% of these, have their own accounts. 75% of the target of 843 MAS has been formed but bank accounts have been opened only for 48%. Also 79% of the targeted 562 ASHAs have been selected by the State.
- ▶ Each ASHA was catering to an approximate population of 4000. Hence, there is a need to expedite the selection process of ASHAs
- ▶ The timings of the OPD was from 12 noon to 8 PM. This gave a leverage for the working class, who could visit the centre even after the office hours.
- ▶ The Stock of medicines was ample and the medicines were stored in proper and safe manner.
- ▶ The community visits government health facilities for severe illnessIn case of minor ailments they usually visit chemists or pharmacists.
- ▶ However, the trust of community is more in the private health facilities because they give different drugs for different ailments. Not many drugs are made available from the DH. The community also does not trust the quality of treatment given at the government health facilities. Long waiting time leading to loss of wages is a deterrent for availing government health facility at the District hospital.
- ▶ The community was also aware of the increasing burden of big diseases- the non-communicable diseases.

▶ The community felt the need of improving investigation facilities at the government health facilities as they lead to out of pocket expenditure.

▶ Due to absence of MBBS MO, the BAMS practitioner was prescribing allopathic medicine. And similar case was reported in three of the four UPHCs in Muzaffarpur. Thus, provision should be made for MBBS MO to be posted at these UPHCs.

Chhattisgarh

- ▶ The construction and upgradation of the UPHCs are being done mainly from the CSR funds of the State Government and partly from Central Government. Therefore, there is a need to review the funding mechanisms of these UPHCs from the Central and the State government in respect of the recurring expenditures for effective functioning of the facilities funding mechanisms.
- ▶ The State has structured the functioning of the UPHCs for providing the IPD services at the UPHCs upgraded as the Health & Wellness Centres (HWCs) which are different as per the norms of UPHCs in NUHM framework.
- ▶ The major component of MAS expenditure was found to be emergency expenses, food for malnourished children, pregnant women etc. Such initiatives were based on local felt needs and a process of decision making in the MAS meetings.
- ▶ The books of accounts were maintained in most of the UPHCs but the same were not timely updated including the centres upgraded as HWC. No books of accounts or bank pass book was available at the Swasthya Suvidha Kendra (SSK) in respect of the F.Y. 2017-18 and 2018-19. Therefore, financial mechanisms could not be commented upon.
- ▶ Other Irregularities: There have been cases of advance payment to contractors without any approval on file for civil works. (UPHC-Dholipara). Contract for supply of free JSSK diet to the JSY beneficiaries has not been renewed timely at the facilities. However, the payment

has been done regularly. Irregularity in respect of the quality of the diet and the timings was also observed.

Gujarat

- ▶ Most of the urban population either was not aware of or not found to be approaching public health facilities.
- ▶ In general, community awareness on general health, disease conditions and services offered, other than RCH, at public health facilities was found to be inadequate.
- ▶ The community has limited awareness of social benefit schemes of the government.
- ▶ For immunization services, community preferred public health facilities.
- ▶ Linkages with Anganwadi centers were found to be good.
- ▶ NCD screening was initiated
- ▶ Preventive actions in the form of survey, fogging and anti-larval activities were initiated in health facilities
- ▶ The MPWs had limited interaction with community in terms of home visits, record keeping etc.
- ▶ The mechanism/procedure for identification and referral of burns, trauma, dental problems and follow-up of suspected non-communicable diseases including mental illness was yet to be put in place.
- ▶ MAS are acting as a driver of change and a role model for good health practices in urban areas in the state
- ▶ Many of High risk pregnancies, identified at DH, were not back tracked at peripheral level by Female Health Workers (FHWs)

Himachal Pradesh

- ▶ There was general community awareness of government health schemes (including health insurance), entitlements and services provided.

Awareness and performance of RNTCP across the state was promising.

- ▶ The State has launched an innovative ‘Tele stroke Project’ for ensuring thrombolysis services to patients with Stroke within the ‘Golden Hour’.
- ▶ Immunization certificates for school admissions – this provided another opportunity to highlight the importance of childhood vaccination for parents.
- ▶ Record keeping at DH: Use of partographs, completed bed head tickets, input-output charting was frequently observed at public facilities.
- ▶ No services are provided through PPP mode. Linkages with AWW are good; linkages with ULBs and ward members are reasonable. HMIS reporting is present.

Jammu & Kashmir

- ▶ There is less focus on implementing NUHM
- ▶ There are hard to reach districts and community healthcare workers (ASHA or MAS), which is affecting service delivery in Doda urban.
- ▶ Team reported that Doda-Urban can be considered for NUHM implementation.

Jharkhand

- ▶ A post-natal mother in Ranchi, informed that doctor suggested her to conduct USG twice from private health facility as USG conducted in the public facility is not very clear.
- ▶ Members complained regarding the unavailability of medicines for dysentery, iron tablets, cough syrup, cetirizine etc. at the UPHC, Bokaro.
 - ◆ Due to un-availability of functional sphygmomanometer & thermometer, MO in UPHC is not able to diagnose hypertension or fever.
 - ◆ Patients requiring laboratory tests or severe cases are referred to Sadar/ District Hospital, Bokaro, but no transport

arrangement is provided by the facility. There is no ambulance facility.

Karnataka

- ▶ The National Urban Health Programmes are running well. The ASHAs and ANMs are in place and are knowledgeable having all the equipment and uniforms etc. They are well trained and are performing their duties as per roles and responsibilities.
- ▶ Good linkages with ULB representatives. Evening OPD in UPHCs & Special Outreach camps being conducted.
- ▶ The meetings of Arogya Raksha Samiti are regularly held and documented
- ▶ Attrition of Medical Officers is high. ANMs expect higher remuneration. MO and
- ▶ ANM were demanding a fixed transport allowance up-to the tune of Rs. 2000 per month per person to facilitate their field visits rather than provision of vehicle.
- ▶ 35 Urban Kiosks are in place in Mangalore and infrastructure has been established on CSR basis which is a good initiative. The funds are being transferred as per the achievement of the UPHCs and the community processes are well implemented.

Madhya Pradesh

- ▶ Two UPHCs in Betul and One in Rajgarh had good infrastructure but were functioning with only para-medical staff recruited and filled up partially.
- ▶ Utility to be ensured through community awareness and availability of Medical officer (Betul)

Maharashtra

- ▶ The urban health specific trainings have been provided by HFWTC Pune but none of these trainings were imparted as per GoI guidelines. This had led to inadequate knowledge among health providers

- ▶ The UPHC had well demarcated functional areas for lab and other services. Cash books, ledger and all financial records were maintained properly with due diligence. The records for RKS (agenda, meeting minutes, vouchers etc.) meeting were being properly maintained
- ▶ However, UPHC had utilized only 20% fund disbursed to them. OPD timings were from 10-12 in morning and 4-6 in evening and none of them were suitable for people living in slum.
- ▶ Although the daily no. of OPD was 60 but only 10-12 patients were prescribed investigations and the total investigations being done were about 20-25. This indicated that even some of the mandatory tests for detection of HTN & DM were not being undertaken.
- ▶ Knowledge of UPHC functionaries including MO was not adequate on various urban health services including organizing special outreach services and its periodicity

Punjab

- ▶ The basic infrastructure of the UPHC in Gurdaspur district was very poor. There is a lack of transport and referral linkages in the urban areas
- ▶ Though there are open drains outside the houses in slum area but as per community no anti-larval spray/measures taken
- ▶ The community is availing treatment from private sector due to shortage of medicine at UPHC therefore the community have to incur out of pocket expenditure
- ▶ Outreach activities like outreach camp (ORC) & UHND are minimal in the areas visited. There is no involvement of urban local bodies (ULB).

Rajasthan

- ▶ The state has made significant progress under community processes. All UPHCs have been mapped in Pregnancy, Child Tracking & Health Services Management System (PCTS) including mapping of all wards

- ▶ The state has also contracted out 38 UPHC facilities and attached health kiosk (if any) under public-private partnership (PPP) agreements. Service delivery at these facilities was sub-optimal with high staff turnover and poor management
- ▶ Mobile Medical Units (MMUs) present which cover a range of services for communicable and non-communicable diseases, reproductive and child health, screening activities, diagnostics and referral linkages
- ▶ Only 7 of the planned 17 health kiosks for FY 2018-19 are operational. In addition, under the recently launched 'Ayushman Bharat' scheme, it was reported that 25 UPHCs have been upgraded to Health and Wellness Centres (H&WC)
- ▶ Low fund utilization was primarily attributable to the slow progress in civil works (construction of only 60 Urban Primary Health Centre (UPHC) completed against the set target of 140) and high vacancy in sanctioned posts
- ▶ PICME software is being used to upload RCH data and also for civil registration of birth and death. UHNs are proficient in uploading the data real time. In Madurai an innovative app based software has been developed to spot the garbage in the city area and necessary action is initiated
- ▶ It is seen that in the training of the paramedical staff there is a gap.
- ▶ Signage and branding is not uniform across the state. Citizen Charter at UPHC needs to be all encompassing. Referral channel and destinations of referral are to be mentioned in the Citizen's Charter
- ▶ Major state issues were underutilized Delivery Points, Lack of proper training at every level, Timings, Community based activities are suffering due to absence of ASHA/MAS and lack of coordination between AWWs and the UHN except during UHNDs
- ▶ Monitoring of RCH activities is done by the local Block PHC in-charge during monthly meetings

Tamil Nadu

- ▶ All UPHCs are running in government buildings. Each centre has an identified Labour Room area with NBCC embedded in it. In some centers USG machines have been installed.
- ▶ The utilization of services in the corporation and also the district society area by the slum population is very poor. The OPD attendance by the slum poor is about 16-20%.
- ▶ The staff attached to the Delivery Point is not SBA or Dakshata trained.
- ▶ All the UPHCs are DoT Centers but none has been designated as Microscopy Centers
- ▶ In spite of the fact that the urban slums are cauldron of all the endemic disease, especially Dengue, Leprosy and other neglected tropical diseases, no reliable and systemic case detection and reporting are in place

Telangana

- ▶ 84% UPHCs are reporting in HMIS
- ▶ It was observed that in the rural areas, the staff was well versed with services to be offered; however, this was related to only RMNCH+A activities.
- ▶ Underutilization of services due to non-availability of the medical officer as per OPD timings (5 out of 6 UPHCs facilities in Karimnagar had a vacancy of part-time MO and Pharmacist)
- ▶ Mahila Arogya Samitis are established and functional at the slum levels.
- ▶ Gap analysis and Quality Assessment for all urban facilities needs to be undertaken.
- ▶ NCD activities have recently been initiated as a pilot project which needs to be expanded and CBAC forms including leprosy and TB should be used.

Tripura

- ▶ With almost non-existent private sector nursing homes and hospitals, majority of people, 93% in rural and 89% in urban, come to public health facilities for inpatient care.
- ▶ The State has most of the health infrastructure in terms of buildings and human resources (except specialists) in place. But the systems of drugs procurement and logistics, referral transport, training, and supervision including performance and quality monitoring were found to be hugely deficient.
- ▶ The team was made to understand that drug procurement has been delayed due to delay in tendering process. Most medicines and supplies were found to be purchased by patients (including paracetamol, antibiotics, cough syrup, syringes etc.) leading to high OOPE.
- ▶ Free Diagnostic Services are yet to be implemented fully in the state. Varying user charges across facilities was observed. The rates for the tests are decided by RKS. Services were mostly free for BPL and JSSK beneficiaries except in some cases where even BPL are charged.
- ▶ Capacity building initiatives were found to be inadequate. The technical knowledge of the staff and skill retention after training is below the expected levels. Teams could not find VHND micro-plans and due lists for immunization except in a UPHC. Supervision and monitoring is non-existent.
- ▶ Based on the State level data one could infer that there is high vacancy against the sanctioned posts e.g. in Medical Officers including specialists there is 50% vacancy, whereas among LTs 38% posts are vacant.
- ▶ The State doesn't have a separate specialist cadre. Without specified sanctioned posts for specialists, it is impossible to plan properly and provide assured services. None of the CHCs visited has any specialists as there are no sanctioned posts.

Uttarakhand

- ▶ In the slums visited in Haridwar, i.e BHEL slum colony and rag picker's colony, most people interviewed visited private doctors or unregistered medical practitioners for basic medical services to save on travel cost and time
- ▶ The OOPE incurred on drugs and diagnostics was high among most people interviewed including for migrant population
- ▶ Urban health facilities closed down in the State since March 2018, leading to a halt in regular immunization services and challenges in accessing free and quality public health services including HBNC, by the community.
- ▶ As per the interviews from migrant population, no fogging for prevention of mosquitoes had been done in the past 6 months
- ▶ Most of the population interviewed preferred delivery at private institutions or home compared to delivery at CRW Hospital, which was more than 5 kms away from the slum
- ▶ Owing to closing down of UPHC in the area, the community was not able to avail immunization services, since outreach camps for routine immunization sessions have discontinued
- ▶ Community toilets were found to be functional in the slum area.

Uttar Pradesh

- ▶ In both the districts NUHM has been rolled out and mapping exercise has completed.
- ▶ Awareness of the community was adequate and ASHAs had good reach in the community. Urban ASHAs displayed good knowledge about the health programmes.
- ▶ Facilities visited had morning and evening OPD services (preventive and curative services).

- ▶ UPHCs in district Farrukhabad had stock out for malaria testing kits and patients were being referred to DMH for the same.
- ▶ UPHCs are yet to initiate IUCD services.
- ▶ UPHCs in district Farrukhabad had stock out for malaria testing kits. UPHCs are yet to initiate IUCD services
- ▶ Mahila Arogya Samiti's has been formed in both the districts and monthly meetings are being conducted. Convergence with other bodies have been found challenging in both the districts.
- ▶ The reporting of private sector is also a challenge.





COMMUNITY PROCESSES

Gender and Convergence

NATIONAL OVERVIEW

The launch of Ayushman Bharat early this year has prioritized delivery of Comprehensive Primary Health Care (CPHC) as its key component to lead India's journey to Universal Health Coverage. It is well established that strong community level linkages and ownership is vital to the success of any Primary Care initiative. The CPHC efforts through Health and Wellness Centres (HWCs) will leverage last 14 years of investments made for Community Processes under the National Health Mission and further strengthen outreach, continuity of care and health promotion strategies for new service packages.

At present there are about 9.55 lakh ASHAs in position against a target of 10.21 lakh across 34 states and UTs. Training of ASHAs in various rounds of module 6 and 7 has progressed well across most states. Overall 97% ASHAs have been trained in Round 1, 92% in Round 2, 84% in Round 3 and 56% in Round 4 of Module 6 and 7. In addition, about 1,63,910 ASHAs have been trained at the identified centres on NCDs.

The Home-Based Young Child (HBYC) care initiative was launched as part of the POSHAN Abhiyan in 2018 to extend the home visits by ASHAs for children from 3 months to 15th months at the interval of 3rd month, 6th month, 9th month, 12th month and 15th month.

In August 2018, the ASHA benefit package was introduced acknowledging significant contribution and commitment of ASHAs. The package included-

Extending benefits of Life insurance and accident insurance to eligible ASHAs and ASHA Facilitators by enrolling eligible ASHAs and ASHA Facilitators (AFs) under -

- ▶ Pradhan Mantri Jeevan Jyoti Beema Yojana (premium of Rs. 330 contributed by GOI);
- ▶ Pradhan Mantri Suraksha Beema Yojana (premium of Rs. 12 contributed by GOI)

KEY OBSERVATIONS

- ▶ The CRM reports from all nineteen states acknowledge the pivotal role played by ASHAs in linking public health systems with the community and in successfully building a strong community rapport. These both lay a strong foundation to address healthcare priorities specified under the paradigm of Comprehensive Primary Health Care (CPHC).
- ▶ However, CRM findings point towards efforts required for streamlining and increasing performance of the support systems to ensure equitable coverage, functionality and programme management needed for ASHAs, Village Health Sanitation and Nutrition Committees (VHSNCs), Mahila Arogya Samities (MAS) across all states. States have commenced training of ASHAs in new seventh package of services on Non-Communicable Diseases (NCDs) but backlogs of trainings related to RMNCH+A will need to finish on priority in certain states. Considering reductions in duration of training for NCDs in certain states, mechanisms to monitor training quality through field-based reviews



and refreshers will need to be implemented. Action is also required to streamline persistent challenges of irregular refilling of ASHA kits and resolve delays in payment of ASHA incentives for vertical programmes.

- ▶ Avenues to improve performance of VHSNC as institutions for collective action on health at the community level will need to expand through capacity building of Panchayati Raj Institutions (PRIs) and increasing coordination and building capacities of Gram Panchayats to support and monitor VHSNCs, support and supervise delivery of community level health programmes such as Village Health and Nutrition Day (VHND), Urban Health and Nutrition Day (UHND) and functioning of Health and Wellness Centres-Sub Health Centres (HWC-SHCs).

ASHA

Selection

- ▶ All states (except Bihar, Uttar Pradesh and Tamil Nadu) report having more than 95% ASHAs in position in rural areas against the selection targets. Even Bihar and Uttar Pradesh

have selected about 93% ASHAs under NRHM and only Tamil Nadu has 57% rural ASHAs in position, owing to the state's decision to limit implementation of ASHA programme only in tribal areas.

- ▶ Well-defined mechanisms to ensure community ownership in selection of rural ASHAs has been reported from Madhya Pradesh, Jharkhand, Chhattisgarh, Jammu and Kashmir, Tripura and Punjab.
- ▶ Reports from few states such as Bihar, Jammu and Kashmir and Rajasthan highlight a population coverage way above specified norms for ASHAs in rural areas and build a need to revise selection targets. For example-in Muzaffarpur and Kupwara district of Bihar and Jammu and Kashmir respectively, selection target for ASHA has been fixed taking into account population as per Census 2011, as a result, ASHAs are covering 1500-2000 population. Likewise, a high population coverage is reported in districts of Rajasthan where ASHA positions have been sanctioned based on the number of Anganwadi Centres (AWCs). Thus, rural areas with a mini AWC or no AWC do not

have ASHAs and such areas with no ASHAs are allocated to ASHAs from neighbouring villages. The high population coverage may adversely affect reach to the marginalized population and delivery of community-based services.

- ▶ With regard to selection of ASHAs in urban areas, reports from Rajasthan, Madhya Pradesh, Andhra Pradesh, Arunachal Pradesh and Chhattisgarh highlight selection of more than 90% ASHAs. Shortfalls in selection of urban ASHAs have been specifically reported as challenge in Jammu and Kashmir and Bihar where districts have 45% and 61% urban ASHAs in position respectively. Findings from Jharkhand report on lack of clarity amongst City Programme Managers under NUHM regarding selection of urban ASHAs and ASHAs in Bokaro city are covering a population of 10,000-11,000.
- ▶ On an average, the ASHA drop-out rates have been around 2-5% across the states. Some states like Assam, Tripura and Andhra Pradesh have done remarkable work in retaining ASHAs (no ASHA drop outs in past 6 months.) However, Arunachal Pradesh has reported a very high drop-out rate of around 20%. Low incentives, family pressure, migration, enrolment in ANM training courses and non-performance emerged as major issues affecting ASHA retention.
- ▶ A lack of clarity amongst ASHA programme staff on norms and process of identifying a non-functional ASHA is reported only from Uttarakhand.

Trainings

- ▶ ASHA training structures in terms of state and district trainers are fairly robust in all states but few states such as Bihar, Madhya Pradesh and Uttarakhand have highlighted issues with trainers' attrition.
- ▶ Training of ASHAs in rural areas has progressed and different states are in varying stages of completion of ASHA training in four rounds of Module 6 and 7. Majority states have trained above 90% rural ASHAs up to Round 2 of Module 6 and 7 while a significant proportion (more than 30-40%) of ASHAs in six states such
- as Arunachal Pradesh, Andhra Pradesh, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh still require to be trained in Round 3 and 4 of Module 6 and 7.
- ▶ ASHA trainings are to be planned in residential mode and require robust logistic support. A good and replicable practice emerged from Korba district in Chhattisgarh, where the district, mobilised funds worth 1.5 crores from Member of Parliament grants to construct a Mitanin Training Centre. Five training centres – one in each block headquarter of the district have also been constructed.
- ▶ On the other hand, Andhra Pradesh, Arunachal Pradesh, Bihar and Jammu and Kashmir highlight lack of adequate residential training facilities within health department and delay in scheduling ASHA trainings. Dedicated NGO training agencies were engaged to address such requirements in few states such as Madhya Pradesh, Bihar and Uttarakhand. While Madhya Pradesh continues with its NGO model for logistics support, trainings could not move forward in FY 2017-18 on account of a long-drawn process of re-appraisal of NGOs, issuing fresh contracts, refresher training and evaluation of ASHA trainers to improve training quality. Both Bihar and Uttarakhand discontinued use of NGO training agencies, resulting in complete halt of ASHA trainings in Bihar for the last three years. However, with dedicated efforts of the ASHA programme staff, trainings have been reinitiated from July 2018 in Bihar. Withdrawal of NGO support in Uttarakhand has adversely impacted programme management, appropriate skilling of ASHAs as per norms and handholding of ASHA support staff (new ASHAs are attending only 2-3 days of refresher trainings as against structured trainings of 5 days in respective rounds of Module 6 and 7).
- ▶ Expansion of service packages under CPHC calls for training of ASHAs in new service area of common NCDs. While majority states have commenced work in this regard, only two states-Madhya Pradesh and Jharkhand have undertaken this training as per the specified protocols of conducting a five-days training

of ASHAs. Himachal Pradesh, Rajasthan, Andhra Pradesh and Tripura conducted just one- day training of ASHAs in NCDs while Rajasthan completed this training in two days. In Bihar, ASHAs were asked to complete the tasks of population enumeration and filling up Community Based Assessment Checklist (CBAC) forms without undergoing any formal training in NCDs.

- ▶ Overall, one of these reasons- training delays, non-residential mode of training, inadequate duration and lack of structured monitoring mechanisms seem to be affecting quality of ASHA trainings. Therefore, barring a few states- Chhattisgarh, Punjab, Karnataka and Gujarat, all other states indicate knowledge and skill attrition and highlight a need of refresher training for ASHAs.
- ▶ The process of ASHA Certification in association with National Institute of Open Schooling (NIOS) has been initiated in thirteen of the nineteen CRM states-namely Arunachal Pradesh, Assam, Chhattisgarh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Maharashtra, Karnataka, Punjab, Tripura, and Uttarakhand. So far, 102 state trainers and 272 district trainers have been certified; 29 state training sites and 44 district sites have been accredited by NIOS. A total 2015 ASHAs from Arunachal Pradesh (20), Assam (471), Jharkhand (550), Karnataka (301), Madhya Pradesh (114), Maharashtra (279) and Tripura (280) have been certified by NIOS by passing the examination held in January, 2018.

Support structures

- ▶ States like Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Uttar Pradesh, Uttarakhand and Tripura have dedicated ASHA programme staff at all four levels- state, district, block and cluster. Major vacancies in the support structure for ASHA are observed in Bihar.
- ▶ Some states are using existing programme management cadres for ASHA related support functions. Rajasthan deploys a cadre of PHC

supervisors; Himachal Pradesh and Jammu Kashmir have given additional responsibilities to ANMs and Andhra Pradesh has assigned the functions of an ASHA Facilitator to multi-purpose health supervisor (female) and has designated their PHC- Public Health Nurses as Block Community Mobilisers (BCMs).

- ▶ Gujarat has ASHA Facilitators but programme is managed by existing staff of district and block management unit. Chhattisgarh is the only state that has also positioned additional Block level coordinator for Swasth Panchayat Yojna and VHSNC.
- ▶ Good functionality of ASHA Facilitators in improving coverage of service users, organizing cluster meetings, mentoring for skill upgradation has been specifically reported from Madhya Pradesh, Jharkhand, Chhattisgarh and Uttar Pradesh.
- ▶ Bihar and Uttarakhand report limited functionality of ASHA Facilitators due to limited clarity on functions of supportive supervision and their dual function as an ASHA. A similar lack of clarity in mentoring ASHAs is also observed amongst PHC Supervisors from Rajasthan and is largely limited to monitoring of formats on Maternal Child Health & Nutrition (MCHN) days.
- ▶ Mechanism of regular programme reviews at cluster, block and district levels have been explicitly reported only in Andhra Pradesh, Jharkhand, Madhya Pradesh and Chhattisgarh. Jharkhand and Chhattisgarh have structured annual training on supportive supervision of ASHA programme staff and relates well with role clarity on their functions at field level.
- ▶ Early efforts to plan career progression opportunities for ASHA programme staff are reflected in Madhya Pradesh where post graduate ASHA Sahyoginis are being skilled to serve as District Trainers and plans are also underway to train some of them as BCMs.
- ▶ While all states have made significant efforts in building the support structures for ASHAs at all

levels, the supportive supervision function of the support structures is yet to be completely realized in improving performance and functionality of ASHAs.

DRUG & EQUIPMENT KIT

- ▶ Like previous CRM findings availability of Drugs and Equipment kit with ASHAs appears a persistent challenge in certain states.
- ▶ Only Andhra Pradesh, Rajasthan, Madhya Pradesh and Jharkhand have regular replenishment of ASHA drug kits from PHCs (Health Sub-Centres in Jharkhand).
- ▶ Other states like Himachal Pradesh, Jammu and Kashmir (J&K), Uttarakhand, Uttar Pradesh and Punjab reported erratic refilling of the drug kits.
- ▶ None of the ASHAs in East Siang district of Arunachal Pradesh were provided drug kits.
- ▶ While availability of drug kits is not a challenge in Rajasthan, state has not included Amoxicillin syrup in ASHA kit to provide a pre-referral dose for neonatal sepsis.
- ▶ HBNC kits have been made available to ASHAs in all states and items such as weighing scale, thermometer and watch are available with all ASHAs. Jharkhand had even added an umbrella, water bottle and bags in the HBNC kit.
- ▶ HBNC equipment like baby weighing machine and thermometers are required to be provided to Mitanins in Chhattisgarh and were found to be non-functional with most of the ASHAs in Rajasthan.

INCENTIVES

Monetary Incentives

- ▶ The average incentive received by ASHAs is around Rs. 3000-4,000 and includes the incentive for routine and recurrent activities for ASHA. The average monthly incentives earned by ASHAs ranges from Rs. 1500 in Tripura to Rs. 7500 in Telangana.

- ▶ In addition to the incentive for routine and recurrent activity, certain states are also providing fixed honorarium to ASHA from state funds. These include Chhattisgarh (75% top-up incentive from April 2018 onwards), Rajasthan (Rs.2500/month from ICDS), Himachal Pradesh (Rs. 1200/month), Arunachal Pradesh (Rs. 1000/month), Tripura (100% top- up incentive), Uttarakhand (Rs. 5000/annually), Karnataka (Rs. 3500/month). Gujarat and Telangana are also offering fixed monthly honorarium to ASHAs.
- ▶ Assam has introduced a voucher system for verifying HBNC visits by ASHAs where a voucher booklet is given to the mother at the time of her delivery and when the ASHA visits the mother for her HBNC visit, she is given one voucher by the mother duly signed as a testimony of her visit.
- ▶ Aided by online bank transfers, PFMS, IT-based Incentive Tracking systems such as ASHA Soft; mechanisms for payment of ASHA incentives have streamlined in many states.
- ▶ No or minimal delay in payment of incentives is observed in Assam, Chhattisgarh, Madhya Pradesh, Rajasthan, Himachal Pradesh, Uttar Pradesh, Punjab, Bihar and Maharashtra.
- ▶ Delay in payment of incentives provided under vertical programmes was majorly observed in Arunachal Pradesh (3-6 months), J&K (3-4 months), Uttarakhand (6 months), Tripura (5-6 months) and Jharkhand (6 months).
- ▶ Rigid norms for ASHA payments are observed in Madhya Pradesh, where escort function has been made mandatory to receive JSY incentive for ASHAs.
- ▶ Assam, Madhya Pradesh and Rajasthan are using ASHA payment software which has helped them create a database of all ASHA's up to the block/village level and has facilitated auto-computation of incentives based on entry of online reports and vouchers.

Non-Monetary Incentives

- ▶ In the past few years, several states have introduced non-monetary incentives to ensure

motivation of ASHAs and include several social welfare measures, building career opportunities, supporting educational equivalence, higher education, etc.

- ▶ The social welfare schemes for the ASHAs are most well developed in the states of Chhattisgarh, Jharkhand and Jammu and Kashmir. Chhattisgarh alone offers a range of different benefits under the ‘Mukhya Mantri Mitanin Kalyan Kosh’ such as life insurance cover, educational incentive for- 8th, 10th, 12th, graduation and post-graduation, scholarship to Mitanin’s/ASHAs children from 9th to 12th std, emergency assistance, free treatment at all government health facilities, maternity benefit extending even for Mitanin trainers, Block Coordinators and Swastha Panchayat Coordinators, 6-months maternity leave, financial assistance under Kanya Vivah, old-age assistance to Mitanins, financial assistance to family in case of death of Mitanin, Swavlambhan Pension Yojana, livelihood promotion and skill development, etc.
- ▶ Chhattisgarh has also adopted a system of reservation of seats for ASHAs in ANM and Staff Nurse Courses. A similar reservation policy has also been adopted by Madhya Pradesh (wherein there is a 25% reservation in ANM training institutes & 10% in GNM training institutes for ASHAs). However, in Punjab, though there is reservation for ASHAs in ANM/GNM courses, the ASHAs were neither aware nor enrolling themselves in these courses.
- ▶ Jammu and Kashmir has recently approved an amount of Rs. 800 per ASHA per annum under the Social Security Scheme for ASHAs. Also, financial assistance to the ASHAs in case of permanent disability, loss of life, emergency or hospitalization for diseases like cardiac disorder, kidney failure, hepatitis or any other life-threatening disease will be provided after approval from the State Health Society.
- ▶ The state of Jharkhand too has introduced welfare schemes- ‘Sahiya Sahayta Nidhi-Central Scheme’ wherein financial assistance is provided to all Sahiya, Sahiya Saathi, State Trainer Team (STT) and Block Trainer Team

(BTT) members in rural areas under various situations like death, disability, accident, education, serious illness, etc. The state also awards best performing ASHAs and VHSNC annually.

- ▶ Rajasthan has launched the ‘ASHA Jyoti’ programme in 2015 to improve educational level of ASHAs and cost is borne by NHM. Himachal Pradesh has planned a medical insurance scheme for ASHAs to be rolled out shortly within few months.
- ▶ In addition, states of Tripura, Jharkhand and Bihar have built ‘ASHA Ghar’/ ‘ASHA Rest rooms’ in the referral / high case load facilities. However, these rooms were largely dysfunctional or of sub-quality standards in Jharkhand (except for the DH Bokaro) and Bihar.

MECHANISM OF GRIEVANCE REDRESSAL

- ▶ Some form of grievance redressal mechanism has been established in all states except Rajasthan, Tripura, Telangana and Bihar.
- ▶ In Uttar Pradesh and Jharkhand, the states have set up grievance boxes at their health facilities. Maharashtra, Himachal Pradesh and J&K have set up the Grievance redressal system of ASHAs through the 24*7 helpline numbers. All grievances made to 104 helpline number were marked to the concerned officials for the redressal and was monitored by the District level Officials.
- ▶ In Uttar Pradesh, ASHAs have put forth a demand to enable a tele-mobile based grievance redressal mechanism which will enable complaints to be registered on real time basis.
- ▶ ASHAs in Jammu and Kashmir strongly recommend an active grievance redressal mechanism at the block level instead at district level.

ASHA FUNCTIONALITY

- ▶ Findings from all nineteen CRM states suggest that ASHAs are motivated and committed to their work. Overall, ASHA functionality is seen to

be better where- ASHAs have been appropriately trained, ASHA programme staff/ASHA facilitators are proactive and are providing on the job- mentoring and necessary supportive supervision.

- ▶ ASHAs have a good rapport with the community that also seek her assistance for their healthcare needs (except in Uttarakhand and Bihar). They are seen to be reaching the marginalised communities except in Uttar Pradesh and Bihar.
- ▶ On an average, ASHAs are spending about 3-4 hours a day on ASHA related activities. It ranged from 2-3 hours in Tripura to 7-8 hours in Jharkhand (not including the time spent in accompanying patients to referral hospitals). In Rajasthan, ASHAs reported that they had to spend extra time for daily visit to the AWC for signing registers and supporting Anganwadi Workers (AWWs) in their daily activities.
- ▶ Limited role of ASHAs in RCH related services such as completing follow-up visits to beneficiary households, improving health education of the community and counselling to adopt healthy behaviours emerged through community-based interactions particularly from states of Madhya Pradesh, Uttarakhand, Uttar Pradesh, Bihar, Himachal Pradesh, Jharkhand, Karnataka, Assam and Gujarat. Issues related to inadequate birth preparedness have been reported from Telangana, Punjab, Chhattisgarh, Uttar Pradesh and Assam. This could partly be attributed to complexity of changing behaviours and lack of efforts by the support system to upgrade skills of ASHAs through on the job- mentoring and guidance. Provision of specific counselling tools, communication kits etc. are available but greater attention is required on use of these tools during home visits to improve their beneficiary interactions



and enable community to take decisions for healthy living.

- ▶ Although many states have started the process of population enumeration and filling of CBAC forms, a major focus of ASHA activities continue to be on RMNCH+A activities and relates to her past trainings and proportion of beneficiaries for these services in her area. Despite this, recall of certain topics such as 'warning/danger signs' in new-borns, complementary feeding, follow-up and referral of SAM children, use of ANTARA was low in states of Rajasthan, Himachal Pradesh, Assam, Uttarakhand, Tripura, Telangana and indicate an urgent need of refresher trainings for the ASHAs.
- ▶ In states such as Rajasthan, Uttar Pradesh and Tripura where preliminary steps for NCD screening have been undertaken, ASHA's performance in the area of population enumeration, CBAC filling and undertaking health promotion activities was adversely affected due to inadequate duration of training in districts. The ASHAs in J&K and Tamil Nadu were not involved in population enumeration and CBAC filling and hence were unaware of the programme.

- ▶ In addition to the routine activities, the Sahiyas in Jharkhand are also involved in conducting regular meetings of Participatory Learning Approach (PLA) in-coordination with the Sahiya Saathi/ASHA Facilitator, AWWs and BTTs.
- ▶ Jharkhand seems to be the only state that is continuing with the system for Performance monitoring included in the National Guidelines for ASHA Facilitators. This has facilitated close monitoring of the non-performing Sahiyas and removal of non-performers, if scores continue to remain poor over a period of 6 months.
- ▶ In contrast with the findings from other states, mobilization of pregnant women by rural Mitanins to private health facilities for ultrasound and delivery is reported from Chhattisgarh and needs a deeper exploration to validate whether these are random instances limited only to Korba and reasons behind such private sectors referrals by Mitanins.

VILLAGE HEALTH SANITATION & NUTRITION COMMITTEE (VHSNC)

- ▶ VHSNC is a platform that ensures community participation to support implementation, monitoring and action-based planning for healthcare activities. There is wide variation in the performance of VHSNCs across the country and in many states, VHSNCs are yet to emerge as institutional platforms for aforementioned functions.
- ▶ Andhra Pradesh has demonstrated a good model of VHSNCs. The committees have been constituted as per the guidelines, achieved 100% target for establishment, conducted regular monthly meetings and utilized nearly 90% of the untied funds. Other states which have constituted about 90% VHSNCs against the target are Madhya Pradesh and J&K.
- ▶ Madhya Pradesh has ‘Gram Sabha Swasthya Gram Tadathrya Samiti’ where chairman of the committee is a female Panch and ASHA is the treasurer. In Rajasthan, the community representation in constitution of the VHSNCs was inadequate as most of the members are ex-officio.
- ▶ Very few VHSNCs are functional in Punjab, Arunachal Pradesh and Uttarakhand. In Jeerapur block, Rajgarh district, Madhya Pradesh, most of the VHSNCs were non-functional leading to non-utilization of funds. Jharkhand and Rajasthan also demonstrated wide intra-state variation in the functionality of the VHSNC. In Jharkhand, VHSNCs in Bokaro district were non-functional whereas in Kanke block of Ranchi district was found to be active. Similarly, in Rajasthan the VHSNCs in Baran were non-functional as opposed to the VHSNCs in Jodhpur.
- ▶ Regular meetings are being held monthly in the states of Andhra Pradesh, Telangana and Jharkhand while quarterly meetings are held in Himachal Pradesh and are thus, ineffective in generating a village level action on health and related social determinants.
- ▶ The last training of the VHSNC members in Rajasthan, J&K and Jharkhand was carried out at least 7-8 years back and the members themselves were unable to recollect the content of the training. Himachal Pradesh, Madhya Pradesh, Uttarakhand and Tamil Nadu have conducted VHSNC trainings in the recent past.
- ▶ As a good practice, the state of Madhya Pradesh and Uttarakhand have started training of ASHA Facilitators in PLA-linked activities to revive participation of VHSNC members through these meetings.
- ▶ On one hand, fund utilization by the VHSNCs has been poor in the states of Madhya Pradesh, Rajasthan and Tamil Nadu, whereas on the other hand, the VHSNC members in Jharkhand (Bokaro district) had to pool own money for carrying cleanliness activities in the village.
- ▶ Documentation related to the minutes of meetings and other activities was found only in Himachal Pradesh, Bokaro district of Jharkhand, and Varanasi District of Uttar Pradesh.

VISHWAS (VILLAGE BASED INITIATIVE TO SYNERGISE HEALTH, WATER & SANITATION)

- ▶ The ‘VISHWAS’ (Village based Initiative to Synergise Health, Water and Sanitation)

campaign was launched to build a collective initiative at community level, for improving water, sanitation and hygiene situation and its impact on health and quality of life. It is envisioned that it will strengthen the convergent action under the various initiatives of Swachh Bharat Mission (SBM) and will also build the institutional capacity of VHSNCs to fulfil their roles as visualized in the original design.

- ▶ Only Jharkhand and Uttar Pradesh reported rolling out the VISHWAS campaign. In Jharkhand (district Bokaro), training for 77 SahiyaSaathis was completed in the VISHWAS module and is being planned to be rolled out in the entire district. Platform of VHSNC meetings was also being utilised for discussing 2 topics (as given under VISHWAS campaign) every month, by the Sahiyas, with support from SahiyaSaathi in the village.
- ▶ In Uttar Pradesh, although the VISHWAS campaign has been launched, the frontline workers were unaware about the campaign. However, their understanding about cleanliness was satisfactory and discussion also indicated that village sanitation is a major agenda during the VHSNC meetings.

MAHILA AROGYA SAMITIS (MAS)

- ▶ Mahila Arogya Samitis (MAS) in the urban areas were created to address the peculiar challenges associated with the vulnerable populations in the urban slums and to take collective action on issues related to health, nutrition, water, sanitation and its social determinants at slum/ward level.
- ▶ In Rajasthan, the MAS have emerged as a strong collective at community level with regular meetings while in Madhya Pradesh, no MAS has been formed in Betul district and in Rajgarh district only few MAS have been formed, albeit their functionality is an issue.
- ▶ In Rajasthan and Jharkhand, regular monthly MAS meetings are being conducted. In Rajasthan, they are being conducted by the District NUHM nodal officer or the Public Health Manager on a monthly basis and are used as a forum for dissemination of information based

on the local health priorities.

- ▶ In Jharkhand MASmembers are actively involved in selection of urban Sahiyas/ward and are actively engaged in helping Sahiya in conduct of her activities. Sahiya, however, was not the member secretary of MAS as observed in Bokaro and it was reported that any member of MAS can become the president and member secretary of MAS.
- ▶ Untied funds for MAS are mostly used for purchase of identified equipment / items for AWCs such as blood pressure apparatus, weighing machine, furniture like chairs, carpet/dari, thermometer, wall paintings, making of boards, etc. as reported from Rajasthan and Jharkhand.
- ▶ MAS groups only in Rajasthan have been connected to National Urban Livelihoods Mission (NULM). Linkages with Mission for Elimination of Poverty in Municipal Areas (MEPMA) in Andhra Pradesh have led to increased functionality of MAS but there is no involvement of ASHAs or ANMs in the activities of MAS.

ROGI KALYAN SAMITI (RKS)

- ▶ Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society (HMS)/ Hospital Development Societies (HDS) is a registered society comprising of members from local Panchayati Raj Institutions (PRIs), NGOs, locally elected representatives and government officials responsible for proper functioning and management of the healthcare facility.
- ▶ The RKS has been formed, as per the recommended guidelines, in all states except in Madhya Pradesh (not at PHC level) and Tripura. In Arunachal Pradesh and Punjab, although the RKS has been formed, they are not functional while variability in their functioning was observed in Jharkhand. Uttar Pradesh has a unique structure-as per the State government orders, the RKS committee of every PHC is formed at CHC level and hence the PHC-RKS funds are also received at CHC.
- ▶ Regular annual meetings of the RKS committee were reported from the states of Andhra Pradesh,

J&K, Himachal Pradesh, Madhya Pradesh and Maharashtra. Meetings were irregularly held in Arunachal Pradesh, Tripura, Rajasthan (where the RKS was named as Rajasthan Medical Relief Society), Punjab and Jharkhand except in DH, Bokaro (last meeting held in March, 2017).

- ▶ Proposals pertaining to hospital matters and user charges, etc. are held during meeting and minutes and cash registers are maintained as reported in Jharkhand. Uttar Pradesh has developed a structured register to record minutes of the meeting of RKS, in order to streamline accountability of RKS committee.
- ▶ The major source of funds for the RKS across the country is the user fees charged and the untied funds received through NHM. However, in addition to this, Himachal Pradesh was also generating funds through renting of shops and premises within the facility campus, as well as through local donations. In J&K, the funds generated through the user charges (through OPD tickets and lab diagnostic tests) and were being deposited into Hospital Development Fund (HDF), which was a separate account from RKS fund.
- ▶ Regarding the fund utilization, in Uttar Pradesh, the PHC-MO (PHC Amritpur and Jahanganj) were completely unaware of RKS Fund utilization (of approximately 1.7 Lakhs/ PHC in FY 2017-18). Andhra Pradesh reported 100% utilization of the RKS allocated funds (including some funds which were left over from previous year) while states like Himachal Pradesh and J&K could only partially utilise the funds.
- ▶ The RKS funds were utilised for different purposes in different states. J&K utilised them for minor repairs, equipment purchasing, IEC materials and maintaining the basic amenities of the facility, whereas the funds were utilised for food and cleaning services in Uttarakhand. Himachal Pradesh was spending a part of their RKS funds for the bio-medical waste collection and management from the various healthcare facilities and for payment of salaries for additional support staff hired by the facility. A part of RKS funds

was being utilised to reimburse the patients for outsourced diagnostic services to SRL diagnostics via PPP mode in the states of Himachal Pradesh and Jharkhand.

- ▶ Misutilization of RKS funds from CHC, Kumarghat in Tripura was reported as they were being utilised for arranging boarding and lodging for guests, which is against the recommended guidelines.
- ▶ Andhra Pradesh has initiated some good practice for the RKS- has developed a portal for the RKS/HDS, linked to the CM Core Dashboard for monitoring and evaluation purposes.

CONVERGENCE

- ▶ Since health of an individual / society is governed by multiple factors, many of which fall beyond the purview of the health department, coordination of multiple agencies/ department is prudent to facilitate an uptake of “Health in All Policy” across all the states. This would also synchronise their efforts for achieving the objectives of CPHC under Ayushman Bharat. The 12th CRM effectively brought out the degree of convergence between the Ministries of Health and Women and Child Development at the field level.
- ▶ With issues pertaining to women and child’s health being one of the core areas of work for both divisions, good degree of convergence and mutual co-operation at the field was demonstrated in the States of Himachal Pradesh and Rajasthan.
- ▶ ‘Rajsangam’ is an exemplified initiative of Rajasthan, where ANMs-ASHAs-Anganwadi workers (now more popularly known as the Triple A) have created village level maps which support identification of focus areas for each front-line functionary, mapping of pregnant women (including the high risk), children (including malnourished and SAM children), immunisation status of children including their follow-up and continued care by the three front-line workers has been greatly facilitated by strengthening this platform. In Himachal Pradesh, mixed findings related to service delivery by AWWs at AWCs was observed.

- ▶ Another good example emerges from Andhra Pradesh, wherein, ‘convergence meetings’ are held regularly at the PHCs and quarterly at the district level. Moreover, ‘Health Sub-Committees’ have been constituted at SHC level in order to achieve convergence between department of education, ICDS water and sanitation etc. Also, active engagement of local Panchayati Raj Institutions (PRIs) in functioning of VHSNCs and RKS through involvement of Sarpanch, DRDA, MEPMA, etc was observed.
- ▶ Jharkhand too reported a fairly good level of convergence between ICDS (VHND, referral of SAM children to Malnutrition Treatment Centre (MTC) by AWW or Sahiya, etc.) and education department (National Deworming Day Programme, Anemia Mukt Bharat including WIFS, etc). Moreover, the Mukhiya and Jal Sahiyas of the village are responsible for construction of toilets in the village under Swachh Bharat Abhiyan (SBA). Involvement of VHSNC members in PLA meetings and providing monetary support for putting pandal for PLA meeting was observed in Bokaro district, Jharkhand. However, there was no involvement of urban local bodies in functioning of MAS in both districts visited in the state.
- ▶ A good example of operationalizing a one stop crisis centre for the management of gender issues came from States of Rajasthan (District Baran) and Punjab (District Gurdaspur). In Rajasthan they have named the centre as a “Sakhi Centre”.
- ▶ In Jharkhand (DH Bokaro), one family counselling centre as a one-stop counselling centre (organised by YMCA Bokaro) is planned to be operationalised soon for providing free counselling on social issues. Andhra Pradesh too has roped in local NGOs to raise awareness against domestic violence for e.g. in Ananthpuramu district, ASHAs have been involved with local organizations like Yellamma Mahila Sangham.
- ▶ Assam reported some gender-related issues like a strong preference for the male child in the community and minimal involvement of the males in family planning process which need to be addressed on a priority basis.

GENDER

- ▶ The health department through its large network, rooted in the community, has a huge potential of making the communities as well as the healthcare staff and facilities sensitive to the gender issues. The CRM teams gave a brief insight into the degree of gender issues sensitization across the country.
- ▶ Gender-related training of health service providers, medico-legal protocols for survivors of sexual violence, one-stop crisis centre and implementation of VISHAKHA Act, 2013 (against sexual harassment in the workplace) were unavailable in health facilities in Jharkhand. Sub-Divisional Hospital and District Hospital Bokaro have however, been equipped to deal with the medico-legal cases (domestic violence, sexual violence). Weak arrangement to ensure safety and security of staff members in Bokaro was observed.

- ▶ Having developed the needed workforce for ASHA support system at state, district, block and sub-block level, an urgent focus is required to revitalize their performance, improve quality of supportive supervision and programme management. States may plan robust performance appraisal of DCMs, BCMs and ASHA Facilitators through field validation of Community Processes initiatives to support poor performers. Feedback mechanisms by state counterparts, annual trainings for supportive supervision as practised in Jharkhand, and performance linked

monetary/non-monetary incentive mechanisms may be introduced to improve functionality of ASHA programme staff.

- ▶ Provision of Comprehensive Primary Health Care through HWCs and Universal NCD screening would require extensive programme support for necessary change management and states with significant vacancies of DCMs/ BCMs should expedite filling of these positions to support this function.
- ▶ Reduction in duration of ASHA trainings for Module 6 and 7 or for new service packages needs to be avoided by states in any circumstance as it has direct implications on knowledge and skills of ASHAs and limit achievement of programme objectives.
- ▶ Unresolved challenges of refills for ASHA kits need to be addressed for improving outcomes related to HBNC.
- ▶ All states would need to expedite action on implementing training of VHSNC members in VISHWAS and other necessary functions of organizing community-based health promotion, monitoring and planning village level action to improve public services at the village level.
- ▶ Avenues to improve performance of VHSNC as institutions for collective action on health at the community level will need to expand through capacity building of PRIs and increasing coordination and capacities of Gram Panchayats to support and monitor VHSNCs, support and supervise delivery of community level health programmes such as- Village Health and Nutrition Day (VHND), Nutrition Rehabilitation Centres (NRCs) and functioning of HWCs-Sub Health Centres (SHCs).
- ▶ Implementation of community-based healthcare services are a key component of CPHC and would require roping in additional technical capacities/NGO partnerships that can enthuse, mentor and hand-hold programme managers, primary care providers, ASHAs and her support structures and VHSNCs/MAS to work in coordination. This would be useful in activities for screening, primary prevention and

management of non-communicable diseases, addressing life style issues for substance abuse, addressing gender-based violence, control of endemic/communicable diseases, etc.

- ▶ Role of RKS needs to be better realized as institutional level platforms for community participation through constitutions as per RKS guidelines, planning regular meetings and greater involvement in assessing patient satisfaction, quality of care and resolving issues with respect to delivery of services in addition to present limited function of approving local hospital-based procurements.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ The state has achieved high rates of selection, training and retention of the ASHA workers both in rural as well as urban areas (more than 90%).
- ▶ Regular trainings pertaining to the local diseases are also being conducted for the ASHAs and they are effectively reaching the most marginalized communities.
- ▶ However district health administration should have earmarked training centres in order to further expedite these training sessions.
- ▶ With one-day training, the ASHAs have almost completed the population enumeration and filling of CBAC forms.
- ▶ The overall ASHA support structure in the state is robust. However, it would be beneficial if the state ARC fills remaining positions of DCM and ASHA facilitators in order to maintain the high rates of selection and training.
- ▶ Replenishment of drugs and equipment kit is regular and state has developed a robust support and grievance redressal system for the ASHAs.
- ▶ In order to ensure effective convergence of health with other sectors/ depts a health sub-committee with representations from the education dept, ICDS, water and sanitation, etc. has been formed.

- ▶ Local organizations like Yellamma Mahila Sangham are being leveraged for action on violence against women. Moreover, an ‘Internal Compliance Cell for Female Workers in Workplace’ has been constituted at the district level in order to address complaints of workplace harassment.
- ▶ ASHAs in the states have undergone ANM training but none of them were reported to have received any employment. This needs to be addressed on an urgent basis.
- ▶ Community based interventions like the VHSNCs and RKS are functional and active with regular review meetings. However, in urban areas, the ASHAs are not being involved in the meetings of MAS, as it comes under the jurisdiction of MEPMA.

Arunachal Pradesh

- ▶ The state has achieved more than 90% selection and training of ASHAs up to three rounds of Module 6 and 7.
- ▶ Due to low incentives received by the ASHAs (around 1-1500 per month) drop-out rates are very high (around 20%).
- ▶ An additional fixed incentive of Rs. 1000/month to the ASHAs is provided from state funds.
- ▶ 5-day training in NCDs has been completed and population enumeration has been initiated in 5 sub centres, 2 PHCs and 1 CHC till July, 2018. NCD screening is being done at the community level and the identified cases of NCDs are being sent to the District hospital. Cancer screening has not been initiated.
- ▶ ASHAs (in East Siang) were not provided the basic ASHA kit. ASHA support structures at the block level and below require strengthening.
- ▶ The VHSNCs and RKS committees have been formed as per the guidelines issued by the Govt. of India. However, the meetings were infrequent and set objectives were not achieved.

Assam

- ▶ The state has selected more than 90% ASHAs and training for all ASHAs has been completed up to Round 4. NCD module training has been initiated.
- ▶ The payments for the HBNC visits are given to ASHAs on receiving the vouchers which are handed over to them by the mothers at the time of her household visit.
- ▶ Community reach, especially for the minorities, needs to be strengthened.
- ▶ There were some gaps identified in the knowledge and skills of ASHAs indicating that the refresher trainings need to be conducted on a priority by the state.
- ▶ The VHSNCs and MAS committees have been constituted as per the targets and recommended guidelines. In view of the difficult terrain, to facilitate greater community interactions, an additional of 1278 VHSNCs were sanctioned by the state.
- ▶ Gender issues observed during the field visits stress upon the need to train the front-line workers on management of such issues at the community level.

Bihar

- ▶ State is facing challenges in selection of ASHAs, as per the recommended guidelines, and are covering populations exceeding 1500-2000. Shortfall in selection of urban ASHAs has been noted.
- ▶ The state had engaged four NGO-State Training Agencies (STAs) for implementing ASHA trainings at the state and district, but due to certain issues, their services have been discontinued since March 2016. Challenges with respect to identification of training sites and attrition of trainers thereafter have stalled progress in ASHA trainings in Bihar.
- ▶ ASHAs were functional and performing routine activities but interactions with the ASHAs demonstrated an urgent need of refresher trainings to address the gaps in skills pertaining to identification of danger signs, nutrition

counselling, family planning, safe abortion services, adolescent health and documentation of various activities being conducted.

- ▶ The ASHAs are filling the CBAC forms, without receiving any formal trainings for the same.
- ▶ Vacant positions in the ASHA support systems at various levels has led to lack of supportive supervision by the block as well district level staff on the activities performed by ASHAs.
- ▶ Good levels of convergence with the PRIs/other local bodies have been developed and efforts of the local bodies were directed to strengthening of infrastructures of facilities rather than community outreach and mobilization.

Chhattisgarh

- ▶ The Mitanins demonstrated good levels of motivation and knowledge about Home-Based Newborn Care (HBNC), National Deworming Day, and Intensified Diarrhoea Control Fortnight programme, contraceptive methods, immunization schedule, various immunization campaigns such as Mission Indradhanush, Intensified Mission Indradhanush, etc. This can be attributed to the well-established induction/refresher training structure for the Mitanins.
- ▶ Regular HBNC visits and maintenance of the records of pregnant women, ANCs, institutional deliveries and its outcomes is observed.
- ▶ The State has developed a robust and structured Mitanin programme and VHSNC, with strong support structure at state, district, block and sub-block levels. Regular review meetings are held at all levels.
- ▶ The new Mitanin Training Centres and a range of social welfare measures provided under CM funds is a testimony to the importance they lay on the Mitain programme.
- ▶ The State has also started the ASHA certification programme (through NIOS) for the Mitanins.
- ▶ On community interactions it was learnt that some rural Mitanins in district Korba, were escorting many pregnant mothers to private facilities, leading to high OOPE for USG and

deliveries (especially Caesarean Section costing up to Rs. 50,000).

Gujarat

- ▶ Through continuous efforts, ASHAs have gained respect and social recognition within the community.
- ▶ ASHAs emerged as the backbone of the health programme in rural areas- had good knowledge about their tasks, provision of antenatal services to pregnant women, immunization of children, family planning services, etc.
- ▶ Good level of convergence with the other front-line workers was demonstrated.
- ▶ Districts receive trainings for management of some locally prevalent diseases like sickle cell anaemia in Narmada region by the State.

Himachal Pradesh

- ▶ Although the State has only recently launched the ASHA programme in the State (2014), the progress made by the state in terms of ASHA selection, training, retention and rapport building with the community is commendable.
- ▶ ASHA accounts have been linked for DBT transfers and currently no delay in payment of incentives was noticed.
- ▶ Fixed additional monthly incentive of Rs. 1200/- is being provided to the ASHAs through the state budget.
- ▶ The state has achieved high coverage of immunization, family planning and RNTCP services and have low levels of childhood malnutrition indicating active frontline functionaries.
- ▶ Although ASHAs were carrying out the HBNC visits regularly, the knowledge and skills of the ASHAs for the same needs to be refreshed through refresher trainings / on- job mentoring by the ANMs (there are no ASHA Facilitators in the state).

- ▶ Population enumeration and filling of CBAC forms for NCDs have been started in the state, but the ASHAs have received only one- day training on NCDs.
- ▶ VHSNC and RKS meetings have been formed and are functional with regular meetings being held, but the minutes of the meeting and an Action Taken Report were often either incomplete or missing. RKS funds in many facilities could only be partially used as it was received in the last quarter of the financial year.
- ▶ MAS in the urban areas have not yet been constituted.

Jammu And Kashmir

- ▶ State has addressed the gap in ASHA selection to a large extent, however many ASHAs are still covering a large population (1700-2000).
- ▶ In-spite of difficult terrain and other socio-environmental pressures, ASHAs demonstrate a good rapport and reach, especially of the marginalized community.
- ▶ Most training are conducted in non-residential mode, leading to challenges in ensuring training quality.
- ▶ State has announced insurance based social security schemes for the ASHAs and additional support through ASHA restrooms/ help desks at high case-load referral facilities, timely payment of incentives, setting up a functional grievance redressal system, etc. needs urgent attention.
- ▶ Although the state has established nearly all of their targeted VHSNCs and RKS committees, their functionality remains a grave concern. Trainings of the committees have been stalled since a very long time (last training for VHSNC members were carried out in 2011-12) and needs urgent attention by the state.
- ▶ The demand for training in management of the gender-related issues, by the front-line-workers, hint towards presence of such issues in their communities.

Jharkhand

- ▶ The Sahiyas are highly motivated, show good functionality and are efficiently carrying out various activities like HBNC visits, NCD related activities, Participatory Learning Action (PLA), mobilising community for VHND, VHSNC, PLA, MAS meetings, etc.
- ▶ The quality of training received by the Sahiyas is monitored at each level by presence of state and district trainers, state training co-ordinators, state and district programme management units, etc.
- ▶ The state is also undertaking the ASHA certification programme, wherein, till date, 550Sahiyas have been certified. Moreover, State has effectively rolled out the “10-point Performance monitoring system” for the Sahiyas. The non-performing Sahiyas are closely monitored and assessed for 6 months by support staff and dropped if scores poorly in performance monitoring system.
- ▶ An active grievance redressal system, numerous social security measures and avenues for career progression of the Sahiyas are good motivational mechanisms for ASHAs.
- ▶ Regular monthly review meetings of support staff at both district and block level and cluster meetings of Sahiya Saathis, Sahiya, ANM, AWW, BTT and STT are regularly conducted. Cluster meetings are used a platform to refresh knowledge and practice skills regarding HBNC/ government schemes, submission of HBNC forms, payment vouchers, etc.
- ▶ Sahiya Saathi are playing a dual role of Sahiya and Sahiya Saathi. Thus, in areas where Sahiya Saathis are covering more than 20 Sahiyas, the Sahiya Saathis are overburdened with the task of supervising high number of Sahiyas thus affecting their performance in tasks of both the roles as Sahiyas and that of Sahiya Saathis.
- ▶ There is an urgent need to initiate the refresher trainings for the VHSNC, RKS and MAS committees to revitalise these systems before they become completely redundant.

Karnataka

- ▶ The state has a team of well-trained ASHAs with good knowledge about the various National Health Programmes.
- ▶ There is a practice of appointing nurses as ASHA mentors for a group of ASHA at PHC level for supervision and support, especially for clinical skills.
- ▶ First and third Friday is devoted for source reduction activities for mosquitoes by ASHAs and the anti-larval measures have resulted in reduction of cases of Malaria, Dengue, Japanese Encephalitis (JE) and Chikungunya. This has improved the image of ASHAs amongst the community members.
- ▶ The ASHAs in the state are getting an additional fixed honorarium of Rs.3500, apart from the routine performance-based incentives. Moreover, the state has announced 10% reservation of seats for GNM/ANM training in government nursing institutions.
- ▶ Arogya Raksha Samitis (RKS) have been formed and are actively involved in the activities of public health facilities but some of the recommendations are not implemented for want of release of funds from higher authorities.
- ▶ Similarly, the VHSNCs are functional with good fund utilization rates.

Madhya Pradesh

- ▶ More than 95% ASHAs in rural areas and 90% in urban areas are in position.
- ▶ ASHAs are aware of their roles and responsibilities, are knowledgeable and skilled to perform their activities and act as a bridge between the service delivery mechanism and community especially in rural areas.
- ▶ ASHA support system is well established. Post-graduate ASHA Facilitators are being trained as District Trainers.
- ▶ ASHA software developed in the state has facilitated maintaining the database of all ASHAs and streamlined payment of incentives.

- ▶ State has a policy of 25% reservation in ANM training institutes and 10% in GNM training institutes for ASHAs.
- ▶ In order to provide essential health and nutrition services at the village level, the State has establishment an ‘Anganwadi-cum-Gram Arogya Kendra’ at Anganwadi centre which has 16 types of drugs and perform 5 types of diagnostic tests.
- ▶ Ensuring strong convergence amongst the FLWs is a major challenge for the state.
- ▶ The state will have to ensure continued enthusiasm amongst the ASHAs by focusing on career progression, grievance redressal, timely payment of all due incentives, building ASHA restrooms and ASHA help desks in referral hospitals, etc.
- ▶ Major efforts are needed to re-vitalise the community- based interventions like the VHSNCs, RKS and MAS. Although VHSNCs have been formed, most of the VHSNCs are non-functional and the members are not aware about their roles and responsibilities. RKS and MAS are yet to be made functional in the state.

Maharashtra

- ▶ ASHA were found to be well motivated and trained. HBNC visits and other such assigned tasks are being conducted and supervised.
- ▶ Average per month incentive for ASHA ranges from Rs 2500 – 3000/- including the assured monthly incentive of Rs. 1000.
- ▶ Grievance redressal is through the 104 helpline. All calls are marked to the concerned District Official & THOs for redressal and is monitored by the district level officials.
- ▶ With regard to career progression of ASHAs, the state plan for accreditation for 17 more training centres for carrying out the ASHA certification exam needs to be appreciated.
- ▶ Good linkages for convergence with the departments of Social Welfare, Health, Water and Sanitation and there is a potential of building

stronger links with the Education Department to achieve defined goals.

- ▶ Although the state has launched the Community Action for Health (CAH) programme, there is a need to strengthen the programme to ensure its functionality and involvement to accelerate progress towards action on Comprehensive Primary Health Care.
- ▶ The state can plan to expand the range of services being currently provided by their ASHAs. To ensure this up-scaling of tasks of ASHAs moves smoothly, due emphasis should be laid on the strengthening the support systems for ASHAs.
- ▶ Various committees like Village Health & Nutrition committee, RKS are constituted and meeting regularly.

Punjab

- ▶ With appropriate training and sustained motivation, the ASHAs could win over the trust, faith and confidence of the communities in Punjab.
- ▶ Through continuous support and regular timely payment of incentives, the state has managed to recruit and retain the ASHAs in the system.
- ▶ Schemes for reservation for ASHAs in ANM/ GNM courses have been formulated, but greater awareness about this needs to be created amongst the ASHAs.
- ▶ The state has developed a ‘One- stop centre for Gender & Domestic Violence’ in Gurdaspur District.
- ▶ Focused attention needs to be given to operationalize the established VHSNCs and RKS committees.
- ▶ The convergence with the ICDS is good and should be expanded to the other departments like Education, Water and Sanitation, etc.

Rajasthan

- ▶ More than 90% ASHAs are in position against the target (about 93% in rural and 90% in urban areas).

▶ The pace of ASHA trainings has improved as compared to previous years (about 76% have been trained in Round 4 of Module 6 & 7) but skill attrition is observed and calls for a need for refresher training.

- ▶ PHC supervisors in place of ASHA Facilitators and their role in supportive supervision of ASHA needs to be strengthened.
- ▶ Average incentive earned by ASHA ranges from Rs. 5000-6000/month and incentive payment has been streamlined using ASHA Soft. A monthly fixed remuneration of Rs. 2500/- is received from ICDS. State has ‘ASHA Jyoti’ programme as non-monetary incentive and covers expenses related to their education.
- ▶ AAA convergence known as ‘Rajsangam’, has led to creation of village level maps and identification of focus areas for each frontline health functionary.
- ▶ Around 4,708 Mahila Arogya Samitis (MAS) have been formed in 62 cities of Rajasthan. MAS meetings are conducted by the District NUHM nodal officer or the Public Health Manager on a monthly basis. MAS groups have been connected to the National Urban Livelihoods Mission (NULM). Training of VHSNC has not been conducted since 2011-12.
- ▶ In Baran District, a “Sakhi centre” has been operationalized as a one- stop crisis centre for action on gender-based violence.
- ▶ Duration of ASHA training in NCDs has been reduced to 2-3 days against the five days trainings specified. This has resulted in low skill levels and limited understanding about importance of health promotion amongst ASHAs.

Tamil Nadu

- ▶ ASHAs have been engaged only in tribal areas and role of ASHAs is limited to carrying out only maternal and child activities. Some ASHAs have been engaged under Malaria programme.
- ▶ State has designated the responsibility of carrying out community processes interventions

in both rural and urban areas to the Village Health Nurses (VHNs). Certain activities like HBNC, Home-Based Care for Young Child (HBYC), home-based family planning counselling, etc. which are normally undertaken by the ASHA are being adversely affected as the VHNs are usually busy in organising VHNDs, reporting and attending meetings at the PHCs. Similar issues are also being reported for population enumeration and screening for NCDs.

- ▶ There are significant number of vacant posts of Anganwadi workers both in rural and urban areas adversely affecting the functioning of the AWC.
- ▶ Urban PHCs are all delivery points and generally next or in vicinity to the slum areas. However, the awareness and response for institutional deliveries amongst the slum dwellers is very low.
- ▶ VHSNCs have been formed, fund utilization and record maintenance all need to be improved.

Telangana

- ▶ Telangana has a highly motivated, efficient, knowledgeable and committed team of ASHAs. Thus, there were negligible vacancies of ASHAs in the districts visited and drop-out rates are low.
- ▶ The activities implemented by ASHAs are monitored in the monthly meetings and a thematic discussion is held on a pre-decided theme for the month. This serves as a regular, ongoing capacity building exercise for ASHAs.
- ▶ Linkages with the AWC are good, with beneficiaries like the pregnant and lactating women receiving good quality services from the AWCs.
- ▶ The state needs to develop a performance monitoring system and grievance redressal committees for ASHAs.
- ▶ Greater transparency for the utilization of the RKS / VHSNC funds needs to be ensured.

- ▶ With appropriate handholding, the state can plan service delivery expansion by the ASHAs to include NCDs, gender-related issues, etc.

Tripura

- ▶ The ASHAs selected in the state have good representation from the local communities, including those marginalized.
- ▶ The state has provided ASHA restrooms in high caseloads, referral hospitals and also reserved certain seats for ASHAs in the ANM/GNM courses.
- ▶ Concerns related to training quality has affected ASHAs functionality in the field, as evident from the quality of CBAC forms being filled, family planning services being delivered, etc.
- ▶ The RKS committees have not been formed as per the recommended guidelines. The state should plan for tracking the fund utilization by the RKS to prevent its misutilization.

Uttar Pradesh

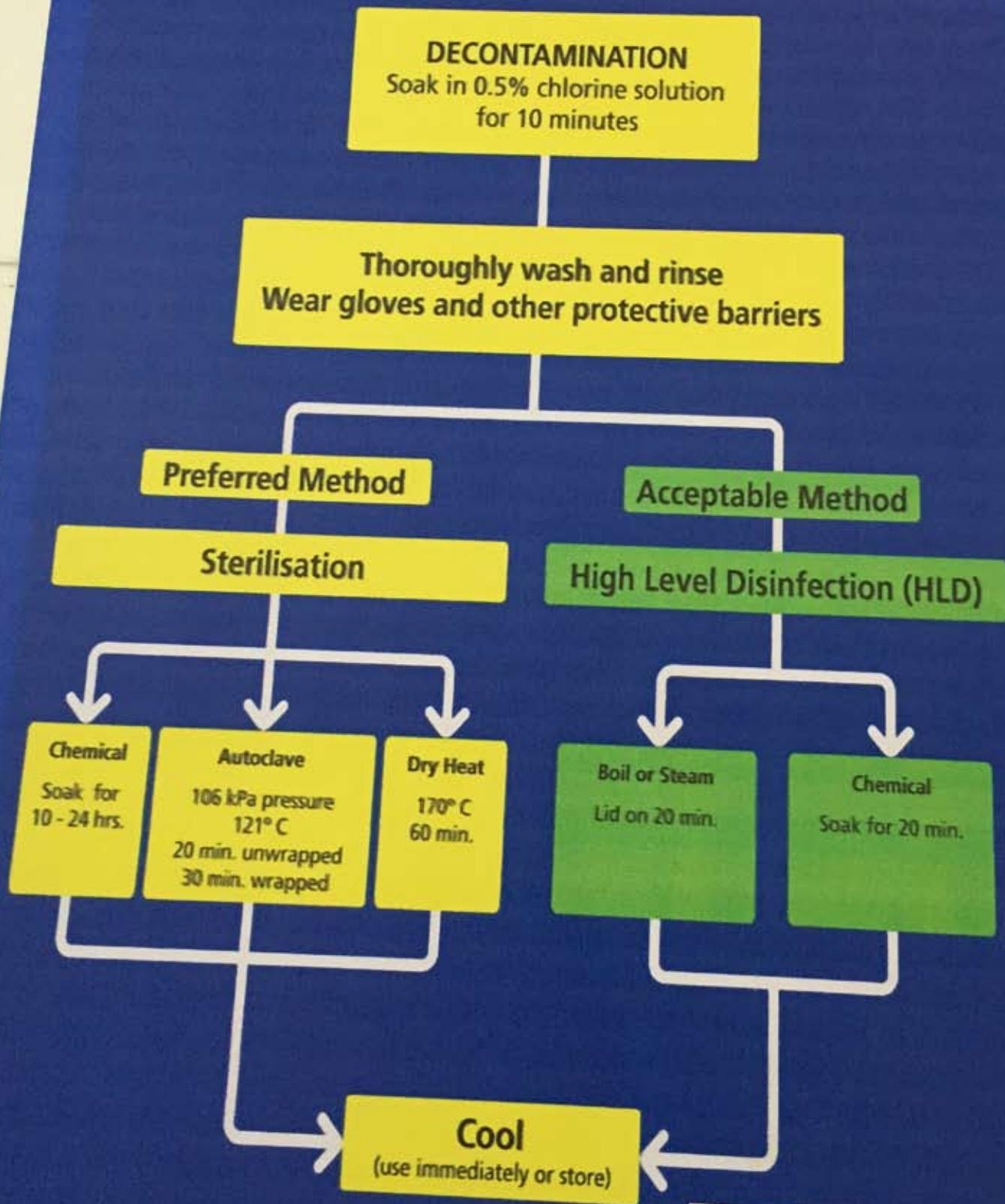
- ▶ 78% of ASHAs in Farrukhabad and 95% in Varanasi have completed Module 6-7 training. All ASHA and ASHA Sanginis are in position.
- ▶ Most of the ASHAs reported receiving incentives on time.
- ▶ The few sections of community in Farrukhabad district continue to prefer home deliveries by the local traditional birth attendant (TBA) and is reported as a challenge by ASHAs.
- ▶ ASHAs grievance boxes have been made available at every health facility. However, the system remains unresponsive towards the grievances.
- ▶ OAs per the state orders, the RKS committee and its funds for all the PHCs will be maintained at the linked CHCs. Findings from the field suggest that the PHC-MOs are unaware regarding the expenditures under this budget.
- ▶ With a primary system of ASHAs being well established, the state should now focus on

hand-holding, training, supervision, expanding the scope of services to address NCDs and gender-related issues and creating avenues for career progression of ASHAs to sustain their motivation.

Uttarakhand

- ▶ The state has announced an additional incentive of Rs. 5000 per year, from the state budget for the ASHAs in addition to the routine and recurrent incentive of Rs. 1000/- from the NHM funds.
- ▶ The state has started training its ASHA Facilitators in Participatory Learning Action modules in order to strengthen its VHSNCs.
- ▶ The Community Action for Health initiative was started in 2016-17 and ToT for the master trainers was also conducted. Since then, 2 rounds of Jan-Samwad have been organised, wherein issues directly related to health as well as non-health issues like water supply and road accessibility were discussed. Actions such as change of place for immunization in hard
- to reach areas has been taken as a follow-up action of the Jan Samwad.
- ▶ State was using NGOs to implement Community Processes interventions. However, the discontinuation of their contract in 2016 has adversely affected the management and training of ASHAs leading to poorly skilled ASHAs. Moreover, the trainings conducted are not as per the recommended guidelines of GoI.
- ▶ The functionality of the ASHAs was sub-optimal as women from the local community mentioned that ASHAs never visited them after delivery or visited only 2-3 times and few women did not know that contraceptives are available with ASHAs.
- ▶ Although ASHA support system has been set-up, they lack clarity in terms of their roles and responsibilities. This indicates an urgent need for refresher trainings.
- ▶ Focussed attention also needs to be given for strengthening the community-based interventions like VHSNCs, RKS, etc.

PROCESSING OF USED ITEMS





QUALITY OF CARE

8.1: NATIONAL QUALITY ASSURANCE STANDARDS

NATIONAL OVERVIEW

National Quality Assurance Standards & accompanying checklists are intended to support the states by addressing requirements of compliance to the standards. In comparison to previous years, this year's experience has seen remarkable progress in terms of efforts and outcomes to provide quality services to the public.

Number of State and National Certifications has increased significantly since the inception of quality journey. The number of National Certification has increased to 179 (as on September 2018) from 59 (2016-17) in one year. There are 503 State Certified facilities in comparison to previous year's 286 facilities.

Andhra Pradesh and Telangana are the two states which have made tremendous progress in comparison to previous year. While states like Arunachal Pradesh, Himachal Pradesh and Jammu and Kashmir are yet to take concrete measures for ensuring Quality in the delivered services.

As per the requirements of the programme's framework, the State Quality Assurance Committees and District Quality Assurance Committees (DQAC) have been formed in all states. Almost all the states have quality consultants (State and district level) and Hospital Managers under the programme. There is also pool of trained

internal and external quality assessors. However, utilization of available HR to their full potential has not yet begun in large number of visited States.

The states need to undertake concerted efforts for disposal of Biomedical waste as per provisions of BMW Rules 2016 & subsequent amendments. Sub-optimal supply of the required consumables or knowledge, attitude & practice exhibited by staff for BMW management are the major bottlenecks. BMW practices were found to be satisfactory in Madhya Pradesh excluding Betul district, while intensive efforts were needed to be taken in the states of Tripura, Andhra Pradesh & Jammu and Kashmir for proper management of BMW.

A similar situation is observed in case of the fulfilment of the statutory requirements. The states need to make concerted efforts for ensuring compliance to the AERB guidelines, fire safety etc.

KEY OBSERVATIONS

- ▶ State Quality Assurance Committee and District Quality Assurance Committee are in place, but regular meetings do not take place.
- ▶ Non-existence of quality team formation at PHC/CHC level currently. Only DH onwards, Quality teams have been formed and found to be functional.
- ▶ Non-utilization of available human resource pool (like internal assessors and empanelled national external assessors) for supporting implementation of the quality standards.



- ▶ Non-availability of comprehensive obstetric services on 24*7 in most of the peripheral health facilities led to overburdening of tertiary level facilities.
- ▶ Non-adherence to the Bio-medical waste management rules 2016 (as amended) in most of the States.
- ▶ Non-compliance to Statutory requirement viz. Authorization for BMW, NOC from fire departments.
- ▶ Lack of implementation of Quality Assurance programmes at urban health facilities.
- ▶ Mera-aspataal Patient feedback system, has not been implemented in many States.
- ▶ Absence of a system of periodic review of the progress of Quality Assurance programmes by State Quality Assurance Unit (SQAU) and District Quality Assurance Unit (DQAU).

RECOMMENDATIONS

- ▶ To improve and increase the range of services in PHC & CHCs by making it functional for 24X7.
- ▶ Conduct of regular bi-annual SQAC and quarterly DQAC meetings.
- ▶ Formation and operationalisation of Quality teams at PHC/CHC level.
- ▶ The States need to accelerate internal assessment under NQAS, LaQshya and Kayakalp.
- ▶ Prioritization: After Internal Assessment, identified gaps should be prioritized to develop time-bound-action-plan.
- ▶ Monitoring of progress on gap closure status at the State level. Efforts should be made to close the gaps and preparing the facilities for State and National level Certification.
- ▶ Districts may require putting a system in place where all healthcare facilities capture, measure and report the Key Performance Indicators (KPI).
- ▶ Training of staff on Bio-medical waste management rules 2016 (as amended) and linkages of peripheral health facilities with the Common bio-medical waste treatment facilities for timely transport, treatment and disposal of waste.
- ▶ Optimal and rational use of empanelled external and internal assessors for mentoring health facilities to enable them in achieving NQAS certification.
- ▶ Strengthening of emergency care services in peripheral area by providing basic life support system training to the medical officers.
- ▶ Implementation of Mera-aspataal initiative at health facilities to measure the patients' satisfaction by capturing patient experience while in health facility.
- ▶ Deployment of robust Grievance Redressal System including dedicated helpline number, resolution of the complaint within a stipulated time-bound manner and provision of feedback.
- ▶ Ensured adherence to regulatory and statutory rules and acts for following:
 - ◆ Bio-medical waste management Authorization.
 - ◆ NOC for fire safety measures at health facilities.

- ◆ License for Blood Bank/ Blood Storage Unit.
- ◆ Electrical Safety Audit.
- ◆ Licence for operating lifts (if installed).
- ◆ AERB Authorisation.
- ◆ Calibration of Measuring equipment (calibration).
- ◆ Laboratories – System of Internal Quality Control, Validation and External Quality Assurance Scheme (EQuAS).
- ▶ Conduct of death audits, medical audits and prescription audit on regular basis.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Progress of the state under National Quality Assurance program is promising as compared to FY 2017-2018. Twenty-one health facilities are certified to the NQAS.
- ▶ The State has a pool of 26 internal assessors and 9 external assessors.
- ▶ District Quality Assurance committees (DQAC) have been constituted and are functional in all districts.
- ▶ Quality teams at district hospital level (DQT) has been constituted, but not constituted at CHC and PHC level.
- ▶ The Government of Andhra Pradesh has signed MoU with Quality council of India for NABH accreditation of 15 teaching hospitals.
- ▶ Majority of people seek treatment from Govt. health facilities. Health facilities are easily accessible by paved roads in villages. Mobile medical units have good access in remote areas.
- ▶ For ANC services, mothers prefer to visit nearest PHC or CHC as doctors are available for routine check-up.
- ▶ The State needs to strengthen Biomedical Waste Management system according to BMW 2016.

Arunachal Pradesh

- ▶ The State has a pool of 19 trained internal assessors and 4 external assessors.
- ▶ District Quality Assurance Committees (DQACs) have been constituted at District Hospital East Siang & Papumpare. District Quality Assurance Committee (DQAC) meetings are not held regularly
- ▶ Quality Circle in Labour room under LaQshya has been formed at Tomo Riba Institute of Health & Medical Sciences (TRIHMS) & General Hospital (GH) Pasighat. LaQshya Baseline Assessment has been conducted in TRIHMS & GH Pasighat.
- ▶ NQAS Internal Assessment was conducted only in GH Pasighat for Six departments.
- ▶ Quality Assurance teams are not formed at CHCs & PHCs level.
- ▶ Internal Assessment of TRIHMS & other CHCs & PHCs was not done.
- ▶ Mera-Aspatal Initiative and Grievance Redressal Mechanism are not there at TRIHMS; GH Pasighat is under the Mera-Aspatal Initiative.
- ▶ Legal & Statutory requirements such as NOC for Fire safety were not available at TRIHMS & GH Pasighat, CHCs & PHCs
- ▶ Non-availability of SOPs & departmental work instructions at the visited health facilities.

Assam

- ▶ The State has constituted SQAC and DQAC at State & District level respectively.
- ▶ The State has a pool of 157 internal assessors and 2 external assessors.
- ▶ Irrational prescription of antibiotics was observed. Prescription audit mechanism needs to be strengthened.
- ▶ Maintenance of Partograph in the labour rooms is variable across both visited districts.

- ▶ Emergency care facilities in the SDH, DH and medical colleges need to be improved. Standardization of OTs needs to be done for quality services.
- ▶ Availability of 24*7 power back-up at the health facilities beyond PHC is an area of concern.
- ▶ To improve the upkeep time of all medical equipment, mapping and tagging of equipment's using an online dashboard have been implemented across the State. Call centre with a toll-free number is also functional. As per State report, 88% equipment are functional.
- ▶ Compliance to Statutory requirement viz. Authorization for BMW, NOC from fire departments need to be strengthened.

Chhattisgarh

- ▶ The state has a pool of 53 internal assessors and 2 external assessors.
- ▶ The state has constituted the SQAC and DQAC, but regular meetings do not take place.
- ▶ In Raipur, Internal Assessment has only been done for CHC Abhanpur and DH Raipur. DH Korba was the public hospital to be certified to ISO 9001 standards. The hospital is also now certified to NQAS.
- ▶ Quality teams at the CHCs and District Hospitals have been constituted, but Infection control committee are yet to be operationalised.
- ▶ Medical and death audits are conducted seldom at the visited District Hospitals.
- ▶ Patient feedback mechanism is in place at DH Korba and a local NGO has been engaged to collect and analysis the feedback. No such mechanism is operational in District Raipur.
- ▶ In DH Korba, e-hospital system having feature of Unique ID and Electronic Health Record system are functional.

Gujarat

- ▶ The State has a pool of 28 internal assessors and 29 external assessors. Currently, four (04) District Hospitals are NQAS certified

- ▶ Blood transfusion facility (Blood Bank/Blood Storage Unit) was better in Narmada than in Porbandar. The availability of blood in many of these centres has been made possible due to the interdepartmental coordination.
- ▶ The state may take necessary steps for development of Common Bio-medical waste treatment facilities, as per norms given in the BMW Rules, so that each health facility has an effective linkage for BMW disposal.
- ▶ Many of the outsourced services (laundry, security, diet, bio-medicate waste etc.) are contracted at local levels with varying clauses/provisions. These contract provisions must be evaluated at the earliest to ensure fair performance.
- ▶ The State needs to implement a comprehensive supportive supervision plan resulting in robust feedback mechanism and action planning.

Himachal Pradesh

- ▶ The State has a pool of 54 internal assessors and 5 external assessors.
- ▶ Labour rooms of the visited facilities have adequate supplies, space and were providing respectful maternity care. DH Chamba is preparing to undergo LaQshya certification while CH Dalhousie was Kayakalp Award winner.
- ▶ Bed occupancy rate (BOR) of secondary care facilities was satisfactory – it ranged from 60-80% in the majority.
- ▶ The wards and indoor areas were generally clean. However, the signages need to be improved.
- ▶ No out of pocket expenditure was reported during the interactions with ANC and PNC patients. However, during ANC, ultrasounds charges were being paid by the beneficiaries as USG facilities were only available only at the district hospitals.
- ▶ On a positive note, almost all the facilities visited had electricity, separate toilets for men and women and running water. The practice of using

colour coded linen to ensure regular change of bed sheets was being practiced across most secondary care facilities.

- ▶ There is a sense of faith/trust of the community in government service provision as the usage of the public health system was more than private health service utilization.
- ▶ Even though diagnostic services are provided free for BPL families, however, often they are not aware of their entitlement and have made payments.
- ▶ RKS have been formed at the health facilities and they have representative of local elected members, PRI (as chairperson), hospital superintendent or facility in-charge (as member secretary), local NGOs and other stakeholders.
- ▶ The GB meetings were reported as being held annually and EC meetings quarterly, though records of meeting minutes, action points and an Action Taken Report are often either incomplete or missing

Jammu & Kashmir

- ▶ The State has a pool of 70 internal assessors and 4 external assessors.
- ▶ Treatment and disposal of Biomedical Waste is not taking place as per recommendations of BMW Rules 2016. Common Waste Treatment Facilities (C WTF) need to be operationalised as early as possible.
- ▶ IEC materials and citizen's charter are not displayed prominently, thereby aggravating the pre-existing information asymmetry.
- ▶ RKS have been constituted in the visited health facilities and its constitution has been revised as per latest guidelines and comprises of a governing body (GB) and an Executive Committee (EC). But their meetings do not take place regularly.

Jharkhand

- ▶ The state has a pool of 87 internal assessors and 2 external assessors.

▶ The state needs to focus on NQAS and LaQshya as state level assessment under NQAS has been done for 2 District Hospitals out of total 23 DH

▶ Colour coded bins are available in some facilities and service providers in these facilities adhere to defined protocol of segregation.

▶ The community is aware about service providers and public health facilities however, they were not aware about entitlements under various NHM schemes like JSSK, Free Drugs and Free Diagnostics etc.

▶ Quality of ANC and HBNC is compromised—large number of home deliveries, failure to capture high-risk pregnancies.

▶ There are inadequate ultra-sonography centres which results in mothers having to get ultra-sonography from private and also do the TSH test. (OOPe – 800-1200/ visit.)

▶ Free drug and diagnostic services have been started in the state, but all the drugs mentioned in EDL are not available in the visited health facilities.

▶ Computerized OPD registration system has been started in District Hospital Ranchi.

▶ High OOPe is observed amongst the community in the villages and especially for those living in the slums, where provision of medical services is poor. OOPe is high even when visiting the public health facilities due to travel costs (mostly go by auto /private vehicle).

▶ Grievance redressal committee formed at all levels- State, District and Block level; last State AMG meeting held in 2017; meetings in 2-3 months held at district and block level.

▶ RKS: - Irregular meetings across health facilities except in DH Bokaro. Proposals pertaining to hospital matters and user charges, etc. are held during meeting and minutes and cash registers are maintained.

▶ No system at place to conduct patient Satisfaction Survey. DH Bokaro and CHC Chas have suggestion cum complaint box for the patients.

- ▶ Operation Theatre in Sadar Hospital Ranchi well maintained; however, it needs additional space for better zoning
- ▶ The State needs to ensure gaps identified under the LaQshya are closed immediately and facilities complete the certification process.
- ▶ The state needs to accelerate internal assessment under the NQAS especially at sub district level hospitals.

Karnataka

- ▶ The State has a pool of 96 internal assessors and 12 external assessors.
- ▶ All the Public Health Institutions have good infrastructure & are well maintained.
- ▶ The facilities at various levels were clean. The health personnel are courteous and dedicated. Most of the facilities are optimally utilized.
- ▶ Signage and protocols are well displayed in most of the facilities. IEC material is displayed at appropriate location facilities in visited facilities
- ▶ The health facilities should focus on standardization of Labour room and OT as per LaQshya guidelines.
- ▶ Bio-medical waste management is being done through selected agencies. The waste is collected in different bins as per the waste collection guidelines. The disposal of sharp objects including needles to be reviewed as per the Bio-Medical Waste (BMW) rules 2016 and its amendments.
- ▶ The Infection control practices need to be improved.

Madhya Pradesh

- ▶ The State has a pool of 176 internal assessors and 5 external assessors. Currently, Two DHs are NQAS certified
- ▶ SQAC & DQACs are functional. However, district quality assurance units need to be operationalised by induction of trained HR. Similarly, for preparing the quality teams.

Hospital manager at district hospital could play a pivotal role.

- ▶ Internal and State Assessments have been done under LaQshya and NQAS for DH Rajgarh.
- ▶ The state has notified antibiotic policy. However, its implementation needs to be ensured.
- ▶ RKS are yet to be formed in urban PHCs in both the districts.
- ▶ Although, X-ray machine was available in DH Rajgarh, but infrastructure of room was not as per the AERB guidelines
- ▶ **BMW:** Colour coded bags and bins are available in all service areas. Most of the service providers are trained in segregation and adhered to defined protocol of segregation. Management of Biomedical Waste takes place as per provision of BMW Rules 2016 only in Rajgarh District. However, management of biomedical waste does not happen as per existing guidelines in Betul district.

Maharashtra

- ▶ Most of the routine and critical care areas in the facilities had good ambience, signage, waiting area and clean surroundings.
- ▶ Digital token system for calling the patient in the consultation room established at facilities (including PHCs)
- ▶ Quality Assurance committees formed in facilities selected for Quality Assurance
- ▶ Color coded bins available in service areas and service providers are adhering to defined protocol of segregation.
- ▶ ETP and liquid waste management and Defined protocols for cleaning critical and non-critical areas, (systemic technical cleaning, particularly for various zones in OT, LR, HDU/ICU, Lab, etc. was lacking) were lacking

Punjab

- ▶ The state has a pool of 259 internal assessors and 6 external assessors.

- ▶ The state has shown good progress in NQAS certification of district hospitals. Currently, Six DHs are NQAS certified.
- ▶ **Cleanliness:** Cleanliness was observed at all level of health facilities. However, cleanliness at DH Moga was compromised.
- ▶ **Parallel hospital management committee** at DH along with RKS, a parallel HMC have been constituted for use of user charges bypassing the RKS. This needs to be examined at appropriate level.
- ▶ State Quality Assurance Committee (SQAC) & District Quality Assurance Committee (DQAC) have been constituted and functional at State & District level respectively.
- ▶ Regular meetings of SQAC have been conducted till date.

Tamil Nadu

- ▶ State Quality Assurance Committee (SQAC) & District Quality Assurance Committee (DQAC) have been constituted and functional at State & District level respectively.
- ▶ Regular meetings of SQAC have been conducted till date.
- ▶ The State has a pool of 339 internal assessors and 13 external assessors.
- ▶ Ramanathapuram DH Labour room has undergone LaQshya certification, while certification of Perambalur DH is under progress.
- ▶ RKS is formed and regular meetings are conducted in many of the visited facilities
- ▶ Signage and branding are not uniform across the state. Citizen Charter at UPHC needs to be all encompassing. Referral channel and destinations of referral are to be mentioned in the Citizen's Charter.

Telangana

- ▶ The state has a pool of 57 internal assessors and 7 external assessors.

- ▶ State Quality Assurance Committee (SQAC) has been constituted and functional at the state level. District Quality Assurance Committee (DQAC) has also been formed in 31 districts.
- ▶ Regular meetings of SQAC have been conducted till date.
- ▶ The State has one State Programme Officer, two State Level Consultants and 31 District Level Consultants
- ▶ 21 PHCs, one Area Hospital, and one District Hospital have been NQAS certified.
- ▶ In Karimnagar, 8 facilities (3-PHCs, 2-CHCs, 1-Area Hospital, 1-District hospital & 1-MCH unit) have been selected for Quality implementation for the FY 2017-18, out of which 06 facilities (3-PHCs, 1-Area Hospital, 1-District hospital & 1-MCH unit) have completed state-level assessment and 04 facilities (3-PHCs, 1-MCH unit) have been nominated for the NQAS certification.

- ▶ The State has demonstrated several good practices, viz. Adoption of liquid waste management technique in hospitals under Quality Assurance.

Tripura

- ▶ The state has a pool of 14 internal assessors and 1 external assessor.
- ▶ The Belonia SDH has got National Level Certification with conditionality in February 2018.
- ▶ In Unakoti district, the QA team is not in a place and SOPs are not available at the facility level. There is a need to strengthen periodical NQAS internal, district and state level assessment.
- ▶ Protocols, SOPs, training, and safety layout and equipment for Disaster management were not available. There is a need to ensure that fire safety measures are in place.
- ▶ Mechanism for conducting patient satisfaction surveys is also not in place.
- ▶ BMW protocols and infection control practices need to be strengthened as it is not being followed

as per BMW rules 2016 recommendations. Practices in South Tripura district were satisfactory. However, management of BMW in Unakoti district was unsatisfactory. Majority of the staffs are not aware of the universal infection control precaution.

- ▶ Integrated call centre for health counselling or grievance redressal is not available in the state.

Uttar Pradesh

- ▶ The state has developed a pool of 195 internal assessors and 13 external assessors
- ▶ Although, at present nearly 150 quality consultants and hospital managers are working under Quality assurance programme still only two (02) District Hospitals are NQAS certified
- ▶ Quality of food provided is good as found during beneficiary interaction and visit to facility kitchen.
- ▶ State Quality Assurance Committee (SQAC) & District Quality Assurance Committee (DQAC) has been constituted and functional at State & District level respectively.

- ▶ Regular meetings of SQAC have been conducted till date.
- ▶ The state has developed a structured register to record minutes of the meeting of RKS. This was one of a unique intervention of the state to streamline accountability of RKS committee.

Uttarakhand

- ▶ The State has a pool of 92 internal assessors and 3 external assessors. The State has 2 consultants and 1 programme assistant at state level i.e. Quality Monitoring, Quality assurance & Programme management coordinator.
- ▶ The State has constituted their SQAC and DQAC. All the 13 districts have operationalised District Quality Assurance committees
- ▶ National level Assessment of CRW Hospital, Haridwar has been completed and its result is awaited.
- ▶ State needs to implement Bio Medical waste management Rule 2016 and as per the recent amendments.

S.No.	State	NQAS Status
1	Andhra Pradesh	Green
2	Arunachal Pradesh	Red
3	Assam	Red
4	Chhattisgarh	Yellow
5	Gujarat	Green
6	Himachal Pradesh	Red
7	Jammu and Kashmir	Red
8	Jharkhand	Red
9	Karnataka	Yellow
10	Madhya Pradesh	Yellow
11	Punjab	Green
12	Tamil Nadu	Yellow
13	Telangana	Green
14	Tripura	Yellow
15	Uttar Pradesh	Yellow
16	Uttarakhand	Red

Red-Poor; Yellow-Moderate; Green-Satisfactory

8.2: KAYAKALP

NATIONAL OVERVIEW

This scheme was initiated on 15th May 2015 to promote a culture of ongoing assessment and peer review of performance to promote hygiene, cleanliness and sanitation. Started with DHs level facilities in the year 2015-16, Kayakalp has been extended to all SDHs/ CHCs, PHCs and urban health facilities in year 2017-18. There is significant increase in level of cleanliness, hygiene and infection control practices in public healthcare facilities. Kayakalp has also provided opportunities and incentives to bolstering inter sectoral coordination for the improvement of health systems.

In year 2017-18, total award-winning facilities were 2959, including 289 DHs, 109 SDHs, 658 CHCs, 1729 PHCs and 181 Urban health facilities.

KEY OBSERVATIONS

- ▶ Although, the states are participating in Kayakalp every year from DH to PHC level, it is observed that all UPHC/PHCs are still not participating and achieving in minimum 70% Kayakalp score.
- ▶ The states of Arunachal Pradesh & Jharkhand should undertake more efforts to have more health facilities, scoring 70% or above.
- ▶ State of Gujarat has proactively included all State medical colleges under Kayakalp.

RECOMMENDATIONS

- ▶ Inclusion of urban health facilities under Kayakalp for next fiscal year
- ▶ Kayakalp winner facilities in 2017-18 may be targeted for NQAS certification
- ▶ Sustenance of gains of convergent action by periodic monitoring and supportive supervision.



STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ In the year 2017-18, Hindupur DH has got the best District Hospital award under Kayakalp.
- ▶ All the facilities visited were found to have good IEC display, hand washing and infection control practices.

Arunachal Pradesh

- ▶ Out of 18 DHs, 63 CHCs and 143 PHCs under Kayakalp scheme in the state only 1 DH, 2 CHCs and 6 PHCs have achieved 70% Kayakalp score and were awarded in the FY 2017-18.
- ▶ Visited facilities were found neat and clean and scored good under Kayakalp initiative.

Assam

- ▶ In the State, 12 DHs, 9CHCs, 2 PHCs and 3UPHCs achieved 70% Kayakalp score from 25 DHs, 3 SDHs, 93 CHCs and 165 PHCs under Kayakalp scheme, and were awarded in FY 2017-18.

Chhattisgarh

- ▶ In the State 23 DHs, 17 SDHs, 155 CHCs, 795 PHCs and 38UPHCs were assessed for Kayakalp scheme, of which only 4 DHs, 1 SDH, 21 CHCs, 62 PHCs and 6 UPHCs met the Kayakalp criteria and were awarded in FY 2017-18.
- ▶ Kayakalp awarded facilities has received award money for FY 2016-17, and it has become a very valuable resource for the facility upgradation

Gujarat

- The state has included medical college hospitals and specialty hospitals under the Kayakalp Initiative. In the year 2016-17, 16 District Hospitals, 120 CHCs/SDHs, 361 PHCs got more than 70% of the Kayakalp score. In the year 2017-18, 13 DHs, 146 CHCs/SDHs, 440 PHCs and 37 UPHCs scored more than 70% on Kayakalp external assessment.

Himachal Pradesh

- State included 9 DHs, 63 SDHs, 90 CHCs, 515 PHCs and 14 UPHCs under Kayakalp scheme out of which only 4 DHs, 10 SDH, 4 CHCs, 26 PHCs and 1 UPHCs have achieved Kayakalp criteria and awarded in FY 2017-18

Jammu and Kashmir

- In the State 3 DHs, 2CHCs and 6 PHCs have scored more than 70% under Kayakalp scheme in the year 2017-18. From last three year only DH Leh, Baramula and Udhampur are the Kayakalp award winner under District Hospital category

Jharkhand

- Out of 23 DHs, 200 CHCs and 330 PHCs under Kayakalp scheme in the state, only 2 DHs, 4 CHCs and 9 PHCs met the Kayakalp criteria and awarded in FY 2017-18.

Karnataka

- The National Quality Assurance Programme is at a very nascent stage in the State. Only few facilities have undergone accreditation. District Hospital Udupi has undergone State Assessment and is planning for National.
- State has assessed 39 DHs, 330 CHCs and 2190 PHCs under Kayakalp scheme however, only 18 DHs, 60 CHCs and 212 PHCs have scored more than 70% Kayakalp score and awarded in FY 2017-18.
- The state did not include urban health facilities in this year.

Madhya Pradesh

- State included 51 DHs, 66 SDHs, 334 CHCs and 1170 PHCs under Kayakalp scheme, out of which 13 DHs, 1 SDH, 9 CHCs and 40 PHCs scored 70% in the external assessment and awarded in FY 2017-18.
- The state did not include urban health facilities in this year.
- The state should undertake proactive approach to target more facilities under Kayakalp scheme to achieve a score of 70%.

Punjab

- The state has made substantial efforts under Kayakalp and has included all urban health facilities under the scheme.
- State has taken 22 DHs, 41 SDHs, 150 CHCs, 496 PHCs and 118 UPHCs under Kayakalp scheme, only 9 DHs, 7 SDHs, 10CHCs, 22 PHCs and 20 UPHCs achieved 70% score under Kayakalp and have been awarded in FY 2017-18.

Tamil Nadu

- In the state of Tamil Nadu, 17 DHs, 21 SDH/ CHCs, 59 PHCs had scored more than 70% of the score in the year 2016-17. While in the year 2017-18, this number increased to 23 DH level facilities, 168 SDHs/CHCs, 186 PHCs and 24 Urban Health Facilities getting more than 70% Kayakalp score.

Telangana

- State included 36 DHs, 118 CHCs and 681 PHCs under Kayakalp scheme out of which only 7 DHs, 9 CHCs, and 117 PHCs have achieved Kayakalp score of 70% and awarded in FY 2017-18
- Low cost innovation for liquid waste management technique was found in the hospitals
- Under Swachh Swasth Sarvatra (SSS) funds have been distributed to 32 CHCs for bridging the gaps identified during the internal assessment

Tripura

- ▶ State assessed 7 DHs, 11 SDHs, 21 CHCs and 94 PHCs under Kayakalp scheme, out of which only 2 DHs, 6 CHCs, and 14 PHCs has scored 70% or more in Kayakalp external assessment and awarded in FY 2017-18.
- ▶ Urban health facilities were not included under the Kayakalp in FY 2017-18.
- ▶ Adherence with the Biomedical Waste Management protocols was seen in the visited facilities of South Tripura District. However, in Unakoti District biomedical waste was dumped in open spaces without its prior treatment. Staff was unaware of the universal precautions and non-adhered with the standard infection control protocols and practices

Uttar Pradesh

- ▶ State has taken 155 DHs, 225 CHCs and 269 PHCs under Kayakalp scheme and only 37 DHs, 25 CHCs, and 54 PHCs met Kayakalp criteria and awarded in FY 2017-18.
- ▶ Few urban health facilities were also included under the Kayakalp scheme

Uttarakhand

- ▶ In the State only 7DHs, 4 CHCs and 5 PHCs scored equal to or more than 70% Kayakalp score out of 20 DHs, 70 CHCs and 255 PHCs taken under Kayakalp scheme
- ▶ Urban health facilities were not included under Kayakalp scheme in FY 2017-18.

S. No.	State	Kayakalp Status
1	Andhra Pradesh	Green
2	Arunachal Pradesh	Yellow
3	Assam	Yellow
4	Chhattisgarh	Green
5	Gujarat	Green
6	Himachal Pradesh	Green
7	Jammu and Kashmir	Yellow
8	Jharkhand	Yellow
9	Karnataka	Yellow
10	Madhya Pradesh	Yellow
11	Punjab	Green
12	Tamil Nadu	Green
13	Telangana	Green
14	Tripura	Yellow
15	Uttar Pradesh	Yellow
16	Uttarakhand	Yellow

Red-Poor; Yellow-Moderate; Green-Satisfactory

पुण्यमहान् | कर्मकर्ता है हंडमार् ॥

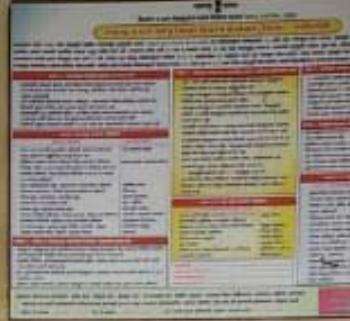
त्व अनुदान योजना ।

सी मागातील गणेदू मातांची नियमित
गी होउन त्याना सूक्ष्म आहार प्रिकारासाठी
गाना शब्दविण्यात चेते.
गमार्या: अनुभूचित जमातीतील अर्थवती
सदूर योजनचा लाभ तिसऱ्यांपत्य-
दिला जातो.
गारे एकूण अनुदान: रुपये 100/- आण्ये
रुपये 400/- योजीवेवरुपये 800/-
यांच्या स्वरूपात

जननी सुरक्षा योजना ।

योजन्यात उक्त सुरक्षा योजनात लाभावधार्यांना
जेव्हानेत मातांचा छारावून
लाभावधार्यांनी तेचव्या प्रसारात करावीलानांना केला भजा
उपयोग.
सदूर योजनेचा लाभ केवळ दोन तिसऱ्यांपत्यांपासून
द्यावत्यात प्रसारात द्यावत्यात प्रसारात द्यावत्यात
ग्रामीण माझा 1000/- योजीवेवरुपये 800/-
800/- योये उन्हाला एकूण अनुदान दिला जातो.

PPUCD



HUMAN RESOURCE FOR HEALTH



NATIONAL OVERVIEW

Health workforce is one of the fundamental elements required for accelerating, achieving and sustaining the progress of any health programme. The National Health Mission (NHM), over the last 14 years have added approximately 4 lakhs of additional human resources in the country with the aim of providing quality healthcare services to the community. Though, mere availability of health workforce is not enough, it is essential that they are equitably distributed and are accessed by the population. Also, it is important to ensure that our health workforce possess the required skill and competency and are motivated and empowered to deliver quality healthcare. In the present situation, each of the 36 states and UTs are at various level of epidemiological transition. However, the issues pertaining to health workforce such as difficulty in deployment and retention, measuring performance, availability of skilled workforce are common across the country.

As a key intervention towards addressing the existing HR issues, it is essential for the states to have special focus on management of health workforce. Besides, it is also necessary that the states plan for human resource keeping the current and future healthcare demand for healthcare services in mind. The planning must ensure assessment based on population, demography, current and emerging healthcare needs and morbidity pattern, time to care approach, existing and change in the fertility rate and expected growth in health spending by government. HRH planning and management



would also have to take into account the availability of skilled human resources and their capacity building

KEY OBSERVATIONS

Availability of HR

- ▶ Despite of heightened measures to attract and retain Health Workforce, critical shortages particularly of Specialists were observed. However, salary wasn't cited in any report as the reason of this shortage. Lack of adequate Specialists was reported across many states including Andhra Pradesh, Arunachal Pradesh, Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Punjab, Telangana, Tripura and Uttar Pradesh. In some States shortages of medical officers/MBBS doctors and staff nurses were also observed. Management functions esp. monitoring, reporting and supportive supervision are disrupted in some states (Andhra Pradesh, Bihar and Uttar Pradesh) due to long pending

vacancies at state, district and block level of programme management staff.

- ▶ Some states have streamlined the recruitment processes for Medical Officers (MOs) through constituting separate Health and Medical Recruitment board for recruitment of MOs (in Assam), and decentralizing hiring process up to district level and conducting walk-in interviews (in Chhattisgarh). In view of low availability of PG Doctors, Jharkhand is setting up new Medical Colleges but admissions have not yet taken off due to pending approvals from authorities. In a bid to attract Specialists, Jharkhand has adopted competitive bidding strategy “our post-your quote” and also reached out to other states for campus interviews. However there still remains a big gap to be filled.
- ▶ In Arunachal Pradesh, number of sanctioned posts were not revised in line with upgraded facilities while in Tripura sanctioned posts of Frontline workers were in excess of requirements and Specialist posts were not sanctioned even at CHCs. States like Telangana are giving preference to in-service staff under NHM in recruitment for regular positions through assigning additional weightage.
- ▶ Issues of availability of Health workforce are further compounded by their irrational distribution. Issues related to irrational deployment was observed in states like Arunachal Pradesh, Himachal Pradesh, Madhya Pradesh, Telangana, and Uttar Pradesh. Programmatic HR i.e. HR dedicated to single programme especially where there is low case load is leading to overall low service delivery and under-utilization of HR.

Work Force Management

- ▶ Due to lack of robust HR policies in States there have been long standing issues in workforce management. Most states (including Arunachal Pradesh, Punjab, Telangana and Tripura), do not have Specialist cadre and thus all Undergraduate and Post Graduate MOs join at the same rank irrespective of

their credentials. As there is no laid down transfer policy, frequent transfers at critical administrative posts were observed which affected administrative functions in Andhra Pradesh. In Arunachal Pradesh, irrational deployment of Specialists was observed at PHCs while in Telangana and Tripura, HR deployed was not commensurate with the existing caseloads at facilities.

- ▶ Many states have implemented HRIS for management and retrieval of HR information. Interestingly in Assam, HRIS was also linked to salary disbursement of staff while in Madhya Pradesh, it is also utilized for appraisal of staff. In some states, issues pertaining to implementation of HRIS were also observed such as in Telangana, where contractual and regular HR information was captured separately with no intercommunication; in Bihar, HRIS was not covering all facilities and cadres; while in Chhattisgarh and Telangana, training details were not integrated in HRIS.
- ▶ Lack of integration is an area of concern. Lack of integration between Health Directorate and NHM Programme Management Units was observed in Tripura where Directorate officials had limited understanding of NHM. Similarly, integration between service delivery staff hired under different programme was also reported. Services of common cadres such as LTs, Counsellors have not yet integrated in many states including Arunachal Pradesh and Telangana which is leading to their inefficient utilization.
- ▶ Punjab and Chhattisgarh have incorporated skill-based competency tests for recruitments of clinical staff while in many states (including Arunachal Pradesh, Telangana) it is yet to be done. Structured mechanisms of Performance appraisal were reported in Chhattisgarh and Madhya Pradesh while the appraisal system was not objectively linked with performance in Arunachal Pradesh, Jharkhand and Punjab. Lack of structured Programme Management Units at state and district level was reported as a bottleneck in achieving effective programem implementation in Himachal Pradesh.

- ▶ Some States have adopted several measures to improve retention of doctors, viz: Compulsory service bond of one year after completion of MBBS from State Medical College (Assam), and building MO Transit hostels from district corpus funds (Chhattisgarh). However such measures were limited to few States.

CAPACITY BUILDING

- ▶ In the state of Punjab there was no district or regional level training institute to conduct trainings. Training Plan and Calendar were found in place only in Uttarakhand and Chhattisgarh. In most states including Andhra Pradesh, Arunachal Pradesh, Jharkhand and Tripura, systems of Training planning were observed to be weak. However, Lack of Master Trainers was reported as a deterrent in achieving training targets in Andhra Pradesh. In Himachal Pradesh, LSAS and EmOC trainings have got discontinued because of lack of master trainers. Physical achievement of training was poor in Jharkhand while in Arunachal Pradesh, no regular trainings have been conducted in the last two years.
- ▶ As a welcome step, Telangana state has started a Nine-day induction programme for orientation of newly joined programme management staff under NHM.

RECOMMENDATIONS

- ▶ States must develop robust HR policies which should cover the entire gamut of HR. It should cover the entire HR life cycle starting from attracting skilled and motivated HR. It should also ensure rational posting and equitable distribution of HR.
- ▶ States must revise sanctioned number of HR based on the existing number of facilities as per the latest IPHS norms and make an intensive effort to fill in the vacancies. There is an urgent need to adapt the measures which have been implemented successfully elsewhere (like differential monetary incentives, building transit hostels, campus interviews in neighbouring

states) to fill vacancies of critical HR especially for Specialists, Medical Officers, and Nurses particularly in the tribal and difficult areas.

- ▶ States where there is no separate specialist cadre must create a specialist cadre and ensure that the PG doctors gain entry in system at higher rank and are given more emoluments than their UG counterparts. Strategy of inviting competitive bids from Specialists under “our post-your quote” initiative may be helpful in attracting specialists in states. However the States must also work on surrounding issues to ensure retention like timely payment of salary, availability of team, availability of drugs and equipment etc. In order to scale up generation of specialists, alternate measures such as launching CPS (College of Physicians and Surgeons) courses and increasing DNB seats in key specialties may be adopted.
- ▶ Health Systems Approach must be adopted in states through merging ToR of HR with similar roles across programmes. Multiskilling/ orientation trainings must be conducted to equip the HR with requisite skills and knowledge as per their new roles. In order to undertake programme management functions effectively, states must ensure that they have structured Programme management units with key staff at all levels in place.
- ▶ Skill based competency assessment must be an essential part of the process of recruitment of clinical and skilled HR in all states. Structured performance appraisal mechanisms must be in place that are objectively linked to job-specific indicators, and contract renewals should be strictly based on performance review.
- ▶ HRMIS should be scaled up and strengthened in all states for efficient management and retrieval of HR information to facilitate administration in taking informed management decisions. HR information of regular and contractual HR must be integrated and smooth interoperability with other information systems must also be ensured. Training management system should be a sub-system of HRIS

- States need to strengthen planning mechanisms of Training and ensure that actual needs at facility and community level are reflected in Training Need Assessment. Comprehensive Training Calendar must be developed considering Training resources available in states must periodically conduct mapping of Training infrastructure and HR for training and take remedial measures promptly if required so that essential trainings are never stalled. States may introduce Induction Programme for newly recruited HR to orient them on the requisite skills and knowledge required at their respective roles.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- Critical shortages of health workforce observed in health facilities. Gap was the highest for Specialists (56% vacancies) followed by Nurses (30%) in Hospitals under Andhra Pradesh Vaidya Vidhana Parishad (APVVP) which was affecting service delivery primarily at CEmOC centres and in tribal areas.
- Vacancies of management staff also observed in the state and districts. Post of Director vacant at state level Training Centre for many years and vacancies of District Accounts Officer and District MIS officer observed in one of the districts visited (Godavari).
- Due to lack of robust transfer policies, frequent transfers at administrative posts (such as DM&HO) were observed which affected administrative functions.
- No Training Plan or detailed Training Calendar was in place.
- Trainings under RNTCP were conducted regularly while there were programmes such as IDSP where there was no training conducted in the last two years.
- Lack of trained faculty to work as Master Trainers reported as a bottleneck in achieving targets.

Arunachal Pradesh

- Issues of low availability and irrational deployment of Specialists are affecting the service delivery. Specialists were found posted at PHCs
- Sanctioned posts of HR have not been revised in line with upgradation of facilities.
- Lack of transparent transfer and posting policies is posing difficulty in achieving rational deployment of HR..
- There is no centralized system like HRMIS (Human Resources Management Information System) to maintain and retrieve HR data for carrying out administrative/ managerial functions.
- The state does not have a Public Health or Specialist cadre.
- No multiskilling training of the skilled HR has taken place and services of common HR cadres (such as LTs, Counselors, etc.) have not been integrated across vertical programmes which is leading to their inefficient utilization.
- Skill based competency assessment tests are not used for recruitment of skilled HR.
- The state does not have robust system of performance linked appraisal of HR.
- Training plan and Training Calendar was not found in place in the state. Training Need Assessment was not properly done to assess skill gaps.
- No regular trainings have been conducted in the State in last two years.

Assam

- In a bid to avoid inordinate delays by Public Service Commission and to fast-track recruitment processes, the state has constituted a separate Health and Medical Recruitment board for recruitment of Health HR.
- Shortage of Staff Nurses (34%) and MOs (29%) observed in the state. State doesn't have a separate specialist cadre. Most specialists deployed are from the regular cadre and there is low availability (50% gap) of Pediatricians.

- ▶ There is a Compulsory service bond of one year after completion of MBBS from all Medical Colleges in the state.
- ▶ The state has HRMIS system to manage HR information and the salary disbursement of NHM staff is centralized at state level. However its integration with regular HRH system is yet to be completed.
- ▶ Training of frontline workers in Routine Immunization including entry in MCP card, microplan preparation, head count survey etc.) and Cold Chain Handlers in basic logistics management needs strengthening. Health providers in the HFs visited need training in biomedical waste management and facility based SAM management.
- ▶ Accounts and finance staff have not been trained for a long time.

Bihar

- ▶ The state has made efforts to clear long pending reservation rosters of clinical HR through recent rounds of recruitments but gaps still remain for Medical Officers (including Specialists) and Nursing staff.
- ▶ There was lack of Biomedical engineers to look after maintenance and upkeep of equipment in the districts visited.
- ▶ Huge vacancies of management staff: observed. 5 District Account Manager (DAM) and 88 Block Accounts Manager (BAM) positions are vacant.
- ▶ Most positions in RNTCP are vacant which is adversely affecting the programme.
- ▶ HRIS has been developed but does not covering all facilities and cadres.
- ▶ There is no defined HR policy for attraction and retention of HR.
- ▶ Lack of clarity was observed among staff regarding their job responsibilities. There is no system of inducting new staff after fresh recruitment.

Chhattisgarh

- ▶ The state has decentralized recruitment processes up to district level and also initiated walk-in interviews for Medical Officers (MOs) and Specialists. But still there is acute shortage of Specialists with more than 80% vacancies in both the districts visited (Raipur and Korba).
- ▶ Initiatives such as building transit hostels through District Mineral Development funds have been helpful in improving retention of doctors in the state.
- ▶ Skill tests are used for recruitment of Clinical staff.
- ▶ HRIS system has been developed but its utilization in decision making and managing transfer and posting is limited.
- ▶ There is a structured mechanism for conducting performance appraisal.
- ▶ The state has multitude of training institutes and infrastructure at state and district level.
- ▶ Training Calendar was found in place and training coverage was also found satisfactory.

Gujarat

- ▶ There was no vacancy observed under RNTCP and NPCDCS programme.
- ▶ Skills lab at Vadodara is well equipped with necessary staff and skills stations. They provide training in 32 predefined skills to SN, MO and ANM of nearby 6 districts..
- ▶ Vacancy was reported in DEIC Porbandar. There was no audiologist and Speech therapist. Also, the dentist and dental technician were underutilized due to unavailability of dental chair.
- ▶ The state has initiated partnership with private paediatricians in PPP mode to provide services to children up to one year of age.
- ▶ It was observed that the Multi-Purpose Workers Male (MPW) has limited interaction with the community in terms of home visits, record keeping etc.

- ▶ All eligible couples were registered and were counselled on family planning. However, there was lack of follow up between the couple and the frontline workers (ASHA/ FHW). The second contact was majorly when any pregnancy was suspected.
- ▶ Many of High-risk pregnancies, identified at DH, were not back tracked at peripheral level by the Female Health Workers (FHWs)
- ▶ 2 out of 4 CHC in Porbandar and majority of CHC in Narmada did not have functional X-Ray machine because of unavailability of HR, issues related to logistic and infrastructure.
- ▶ Training and knowledge of Health Staff (MO, MPHW-Male and Female) on RNTCP was adequate.
- ▶ Trained HR was available as per level of MCH Care in Narmada, but not so in Porbandar.
- ▶ The MO training module for prescription of antipsychotic drugs has been prepared.

Himachal Pradesh

- ▶ Issues of acute shortage of doctors and specialists and their irrational deployment are affecting service delivery.
- ▶ There are no dedicated SPMUs or DPMUs with State/District Programme Manager to look after programme management functions.
- ▶ The state has discontinued LSAS and EmOC training due to unavailability of Master Trainers.
- ▶ None of the Staff Nurses and ANMs in the facilities visited were found trained in SBA.

Jammu & Kashmir

- ▶ Shortage of specialists at secondary and tertiary levels was found in Kupwara district due to it being a difficult area.
- ▶ HR shortfall was reported mainly for staff nurses and counsellors across the NCD clinics. This is mainly due to lack of rational deployment and integration of vertical programs of NHM.

- ▶ Line listing of High-risk pregnant women was not available with ANM as well as at the facilities; Staff were aware of open vial policy under UIP but not practicing uniformly.
- ▶ The ANM and Staff nurse are posted in rotation basis in all departments. As a result, staff who have undergone SBA, NSSK and PPIUCD training were unavailable in the labour room. Staff nurses/ANM posted in labour room were not aware about the Antenatal corticosteroid administration (ANCS) guidelines in preterm labour. Also, they were unaware about the kangaroo mother care and care of low birth weight babies. Knowledge of Staff nurse on NSSK was also not satisfactory.
- ▶ AH counsellors are underutilized the monthly average client load is low at 50 to 100 clients. Only old counselors were found trained in AFHS. Knowledge about counseling and thematic areas of RKSK was not up to the mark.
- ▶ State has initiated Save Heart Initiative programme which is an integrated social network of a pool of more than 500 doctors for better cardiac care across Kashmir Valley. The cardiac services provided are free to the patient.
- ▶ There is a need for state to focus on Capacity building of HR at all levels. For instance, Staff didn't get training/ orientation on F.P./ contraceptive updates since last year. The ANMs were found to be lacking knowledge and skills on how to measure haemoglobin. The RMNCHA Counsellor was not trained/ skilled for counselling skills on Modern contraceptives.

Jharkhand

- ▶ The state has undertaken large-scale recruitments lately to fill huge number vacancies (1596) at state and district level.
- ▶ To fill specialists' vacancies, the state has also reached out to southern states like Karnataka and have adopted alternate measures such as competitive bidding. But huge vacancies of Specialists still remain.

- ▶ The state has only three Medical Colleges but PG seats are largely available in RIMS Ranchi only. In addition, there are three new Government Medical Colleges being set up in the state, but due to pending approvals, admissions have not yet taken off.
- ▶ The system of appraisal of Clinical and Programme HR is not objectively linked to performance.
- ▶ Training Calendar was not found in place. Physical achievement of various NHM training was found poor. Skills of labor room staff were found to be inadequate and there was apparently a need for refresher training.
- ▶ There is one skill lab in the state but the same has not been properly utilized for refresher skill training of the staff. More skill labs also need to be established.

Karnataka

- ▶ The health personnel were found to be courteous and dedicated
- ▶ High Vacancy has been reported in regular cadre. Lack of a full time doctor in NUHM facilities remains a concern.
- ▶ CHC and PHCs in the State are more than the norm and hence posts of Medical officers sanctioned are less. State needs to conduct health facility and services mapping on the basis of time to care approach to decide functionality of the facilities and depute MOs accordingly. It will also take care of reallocation of staff from under-utilized facilities.
- ▶ In RNTCP there is 26% vacancy at state level and 16% at district level. In Chikmagalur 33% key HR positions were found to be vacant leading to compromise in programme supervision and monitoring.
- ▶ There is inequitable distribution of pharmacists in stores for dispensing, leading to increased waiting time for patients
- ▶ In District Udupi there are training issues in facilities on PPP mode. State needs ensure that Skilled Birth Attendant (SBA) training is imparted to Staff Nurses and ANMs of these facilities as well
- ▶ Trainings on newer contraceptives (Antara and Chhaya) need to be strengthened

Madhya Pradesh

- ▶ There is acute shortage of Specialists and Staff Nurses in the state. In Rajgarh district, 74 out of 88 Specialist posts were vacant.
- ▶ HR including Medical Officers (MOs) was not rationally distributed in the state, which led to uneven caseloads.
- ▶ The state has HRMIS that manages HR information of contractual and regular staff however integration hasn't been complete. HRMIS is also utilized for appraisals of NHM staff.
- ▶ Inadequate utilization of trained Human Resources was observed. Only 29 out of 86 LSAS trained doctors were posted at MCH Level 1 and Level 2 facilities. Services of 25 EmOC trained doctors have not been engaged for conducting complicated deliveries.
- ▶ Revision of curriculum of GNM Training needs to be carried out to include all programme guidelines and skills development.
- ▶ DTC is functional in Rajgarh, although no training batch was going on; while DTC in Betul is partially functional. The DTC is occupied by CMHO office. The approved position of DTO is vacant since many years. There was no annual training plan, only RMNCH+A training is done. The capacity building among peripheral staffs is lacking due to partial functioning of DTC.
- ▶ There was well established ANMTC in Betul with 4 out of 7 knowledgeable teaching staffs. 60 trainees present,
- ▶ ANMs, do conduct VHNDs regularly, but they do not visit the villages in their jurisdiction as per their fixed tour schedule.
- ▶ HWC have been named as Arogyam and have 1 MO and 1 SN each per HWC. They have been

trained for 3 days on prevention, screening and management of common NCDs. Training on NCDs has not been provided to MPW

- ▶ Training and certification of all frontline workers for malaria diagnosis and treatment on priority basis is required for which NVBDCP staff/ trainers should be engaged. Training and benchmarking of LTs for microscopy as per GOI guidelines also needs to be done.

Maharashtra

- ▶ District and Block Level administration and management of health programmes are done by Public Health professionals.
- ▶ Provisions of hiring Specialists available for operationalizing FRUs.
- ▶ Points being given for PG on rural posting.
- ▶ CEOs are empowered to transfer Nursing and Para Medical staff working at RH/PHCs/HSCs within the district.
- ▶ Biometric attendance system is in place in higher facilities and salary of NHM staff is disbursed on the basis of biometric attendance report.
- ▶ No major irrationality observed in posting in both districts.
- ▶ No performance appraisals / monitoring in visited districts
- ▶ Specialists/ GDMOs and Public Health cadres are not clearly defined along with career path, transfer, posting, convergence at apex, etc.
- ▶ CPS courses are being conducted at Satara.
- ▶ Good coverage of NCD training in Satara district.
- ▶ Adequate progress in BEmOC (42% & 71%) & PPIUCD -SNs (61% & 39%) trainings in both districts.

Punjab

- ▶ HR Cell is existing and functional in the state.

- ▶ Skill based competency tests are conducted for recruitment of technical staff.
- ▶ The state has acute shortage of Specialists (29% vacancies), Staff Nurses (23% vacancies) and ANMs (19%). Vacancies were found to be more severe in Moga district.
- ▶ Annual performance appraisal is not objectively linked to performance. All existing positions get continued every year.
- ▶ There is no Public Health or Specialist cadre in the state.
- ▶ There is a state level training institute, i.e. SIHFW Mohali for planning and coordination of trainings but there are no regional or district training institutes to take up that role at regional and district level.

Rajasthan

- ▶ High vacancies have been reported for RNTCP in medical colleges. Some have been vacant for more than 2 years. There is also very high vacancy in all NUHM facilities.
- ▶ In NVBDCP, posts of epidemiologists and entomologists are vacant. Looking at the prevalence of vector borne disease these posts are essential and should be filled up urgently.
- ▶ Filling up of vacant position or manning of a new facility needs to be fast tracked. A mobile medical unit having CBNAAT facility could not be made functional in 5 months due to want of a driver.
- ▶ While training was found to be good in NCD, leprosy, and NPHCE it needs to be improved for NVBDCP, NUHM and for finance staff.
- ▶ Orientation of HR in HWC is not satisfactory. ANMs knowledge of immunization was found to be inadequate. RI micro-plans and ANM roster was not available.
- ▶ Supportive supervision was found to be weak. Immunization sessions/VHNDs are not being monitored. Non availability of vehicles for supportive supervision cited as a reason by a DTO for not conducting regular visits.

Tamil Nadu

- ▶ Most of the initiatives in TN are being undertaken by using the existing regular employees which is worth emulating by other States.
- ▶ The HSCs in the State are single VHN (Village Health Nurse) HSCs so the HSC remains open only one day in the week as the VHN goes for outreach to anganwadis 4 days in week and one day she goes to the PHC for meetings and reporting etc.
- ▶ Medical Officers do not have adequate information and knowledge about community level initiatives and programmes. This is one of the reasons for gap in the monitoring. CRM team felt that there is need for random checks to monitor the effectiveness of programmes. E.g. there is a huge drop out among people identified in the community with NCDs
- ▶ The district has MDR TB ward for MDR TB cases with separate rooms for each patient at district hospital. The district is using Hospital on Wheels/ MMU for awareness generation on TB and also for sputum collection; which shows that the State is trying to adapt as per the requirements of the patients and disease.
- ▶ TB All the contractual posts have been filled and trained.
- ▶ Malaria slides are not being taken in fever cases. In spite of the fact that the urban slums are cauldron of all the endemic disease, especially Dengue, Leprosy and other neglected tropical diseases, no reliable and systemic case detection and reporting are in place. No Special Outreach Camps are organized. However, under CPHC scheme, community based NCD screening has been initiated through deploying SHG members as Women Health Volunteers in identified areas.

Telangana

- ▶ Highest vacancies are among Specialists (53%), LTs (52%) followed by Pharmacists (36%) and Staff Nurses (35%).

- ▶ The state does not have a dedicated HR policy for contractual staff and management decisions are executed through department orders on need basis.
- ▶ There is no Public Health or Specialist cadre in the state and all Undergraduate and Postgraduate MOs are hired at the same rank irrespective of their credentials.
- ▶ HRMIS is operational in the state but contractual and regular HR information is captured separately in two different systems which do not communicate with each other. Moreover, issues of interoperability also observed between TMIS and HRMIS.
- ▶ Skill based competency tests are not conducted for selection of clinical staff.
- ▶ While recruiting into regular services, the state gives additional weightage to contractual candidates having completed minimum service of five years.
- ▶ Instances of irrational deployment of HR were observed-staff numbers were not commensurate with the caseloads at some facilities.
- ▶ Services of common cadres like LTs, Counselors were not integrated across the programmes.
- ▶ The state has uniquely started a 9-day induction training programme for newly joined programme management staff under NHM.

Tripura

- ▶ Around half of the posts of Medical Officers (including Specialists) and 38% LT posts are vacant in the state. Shortage of Specialists was also observed in DH, SDH and CHCs in the districts visited (South Tripura and Unakoti).
- ▶ Uneven HR distribution leaves tribal areas most deprived. Vacancies of MPW(F) and MPS(F) were 50% and 98% in tribal areas in comparison to 40% and 34% in overall state respectively.
- ▶ The state has more than required number of Subcentres (RHS) and thus sanctioned posts

of Frontline workers are also higher than required.

- ▶ The state does not have district-wise or facility-wise number of sanctioned positions, and there is no bifurcation of HR strength between Medical College Hospitals and level of District Hospital and below. With these details missing, it is difficult to undertake HR planning and exercise rational postings of staff.
- ▶ Instances of irrational postings of HR were observed. Most blood banks had 4 LTs without adequate workload and at DH, 3 Physiotherapists were posted without any equipment and only one bed.
- ▶ The state does not have a specialist cadre. CHCs had no sanctioned posts for Specialists and entire load of patients is handled by SDH and DHs.
- ▶ Government doctors are given a meagre NPA (Non-Practicing Allowance) of Rs 1500 per month and instances of private practice were found quite rampant in the state.
- ▶ Lack of integration was observed between Health Directorate and NHM Programme Management Unit. Directorate officials reported to have limited understanding of NHM.
- ▶ Encouraging efforts were seen at local level for building morale and team spirit among employees. SDMHO at SDH South Tripura has initiated free health check-ups of all facility employees and organized celebration events in the past to promote team building among staff.
- ▶ Overall Training system observed to be weak and there is no system of conducting post training follow-up in the state.

Uttarakhand

- ▶ Unavailability of District Epidemiologist, microbiologist and lab technician is hindering the implementation of IDSP programme at district/ block level. State to multi-skill and rationally deploy the existing staff in order to ensure services.
- ▶ Both the districts provide mental health services: through psychiatrists or MO trained at NIMHANS.
- ▶ Lack of supportive supervision of service providers as well as programme managers observed at all levels.
- ▶ There is need for strengthening the training for the MOs, ANMs and ASHAs by plugging the gaps noticed in programme implementation for RNTCP/IYCF/RBSK/IMNCI etc.
- ▶ The counsellors at facility level are poorly utilised. AH counsellors need to monitor outreach sessions in the community along with the schools. State has clinical psychologists/ Counsellors in various facilities but are underutilized.
- ▶ Awareness among FLWs related to elderly care was poor. There is a need for training the FLWs on NPHCE programme to ensure home-based care to those in need.
- ▶ Most of the Medical Officers were not trained in IDSP and whosoever trained have not undergone refresher training in recent past.
- ▶ There was lack of clarity among frontline workers regarding filling of CBAC forms as it was observed that the forms were not being filled properly. There was also lack of awareness on NIDDCP among the FLWs.
- ▶ SBA training of ANM/SN are not being carried out regularly.
- ▶ State TB Training & Demonstration Centre (STDC) is non-functional. Owing to this, a huge training gap was observed.
- ▶ Training of Nodal officers of District DR TB Centre is not done in both the districts.
- ▶ Issue related to rude behavior of the staff during delivery was shared with the team.
- ▶ Lack of communication between pharmacists and prescribing physicians regarding medicines available was noticed.

- ▶ Training Plan and Training Calendar was found. HR at the facilities visited was observed to be trained in Family Planning (Injectable Contraceptives), Dakshata, SBA, NSSK, FBNC, CAC and EmOC.

Uttar Pradesh

- ▶ Irrational deployment has led to inadequate functionalization of facilities especially FRUs. State needs to carry out a comprehensive HR audit and rationalize the HR as per actual requirement and caseload.
- ▶ Shortage of HR particularly of Nurses (Grade A) was observed at District Hospital.
- ▶ At a non 24*7 lab in DH Farrukhabad, 20 LTs were found posted against the IPHS norm of 12 LTs for DH, and the workload of lab was also quite minimal, i.e. 20 tests per day.
- ▶ DWH Varanasi has 11 gynec (against a sanction of 18) with a load of only 15 deliveries a day (conducted by SN) whereas almost none are

available in the periphery. DWH Varanasi has 5 paediatricians for a 4 bed SNCU whereas BHU SNCU not well staffed.

- ▶ Considerable vacancies of management staff observed largely at district and block level with 6 District Accounts Manager (DAM) and 71 Block Accounts Manager (BAM) positions vacant.
- ▶ Fever rate is high but slide examination rate is very low and needs to be monitored. Male MPWs need to be deployed for the malaria activities in each sub centre.
- ▶ In Varanasi although NPPCF has been launched but none of the activities has commenced. Fluorosis lab not available, training to MOs and health staff has not been conducted.
- ▶ Service providers should be trained in all the essential trainings such as SBA, NSSK etc. Trainings on Newer contraceptives, PPIUCD, FP-LMIS etc. to be fast tracked. Quality of trainings needs to be improved.



MEDICINE, DIAGNOSTICS & BIO MEDICAL EQUIPMENT MAINTENANCE & MANAGEMENT PROGRAM (BMMP)

TOR 10



10.1: FREE DRUG SERVICE INITIATIVE

NATIONAL OVERVIEW

Ensuring availability of free essential quality medicine is expected to result into significant reduction in out of pocket expenditure (OOPE). The States have undertaken substantial efforts to ensure availability of free drugs at healthcare seekers at health facilities.

Free drug scheme covers all dimensions of drug supply, starting from procurement to distribution. Although, the scheme was implemented in most of the States, its percolation down below in district level has been found to be weak. Irregular supply from the State level to district level was observed, and it led to out of pocket expenditures among the service users. Apparently, the drug distribution has not been rational and demand based.

KEY OBSERVATIONS

- ▶ Jammu and Kashmir and Uttar Pradesh haven't initiated the FDSI formally while rest of the other visited States have implemented the scheme
- ▶ Central Procurement Board is present in all States except Arunachal Pradesh, Tripura and Uttar Pradesh
- ▶ EDL are available in all State except Jammu and Kashmir. However, in Andhra Pradesh & Arunachal Pradesh EDL was not displayed at facilities while in Assam, Chhattisgarh, Gujarat, Jharkhand drugs were not available as per EDL

- ▶ IT enabled inventory management and procurement system was available up to facility level in Andhra Pradesh, Chhattisgarh, Gujarat, J&K, Himachal Pradesh, Jharkhand, Karnataka, Punjab and Telangana. However, states like Arunachal Pradesh and Uttar Pradesh have yet to initiate IT enabled system up to facility level
- ▶ High Out of Pocket Expenditure and frequent stock outs complaints were found in states viz. Arunachal Pradesh, Jammu and Kashmir, Jharkhand and in urban pockets of Punjab, Uttar Pradesh and Uttarakhand.
- ▶ Standard Treatment Guidelines (STGs) were not available in most of the facilities and if present the clinician were not aware of it and were not using it either
- ▶ System for prescription audits and grievance redressal were missing in almost all visited states except in States of Andhra Pradesh and Karnataka

RECOMMENDATIONS

- ▶ Implementation of DVDMs at all levels to ensure transparency in procurement and distribution of drugs.
- ▶ Enhanced monitoring of availability of essential drugs at all level of facilities including Health and Wellness Centres (HWCs).
- ▶ Quality testing of the procured drugs.
- ▶ Improvement in storage condition of drugs by strengthening the drug warehouses.

- ▶ Utilization of Prescription Audit and Standard Treatment Guidelines for generalized usage of generic drugs and rational usage of antibiotics.
- ▶ Ensure availability of all essential drugs, especially under non-communicable disease spectrum to reduce out of pocket expenditure.
- ▶ Capacity building of pharmacist and storekeeper on inventory management techniques to avoid stock-out of essential drugs.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Andhra Pradesh has its own central procurement body, A. P. Medical Services and Infrastructure Development Corporation. State has notified Free Drug Policy and developed Essential Drug Lists (EDL) for all level of health facilities.
- ▶ The state has IT enabled strong procurement and distribution system. A system is at place to keep three-month stock for all medicines at facility level and quarterly indenting and procurement is done.
- ▶ There was very minimal out of pocket expenditure on purchasing the medicines and consumables.
- ▶ The state has 6 accredited labs to assure quality of supplied drugs.
- ▶ Prescription audits and usage of Standard Treatment Guidelines were not practised in all facilities.

Arunachal Pradesh

- ▶ The state undertakes the procurement of drugs through Directorate of Health Services
- ▶ Although the state has notified free drug policy but huge OoPE is incurred by population to buy medicines due to non-availability of drugs in hospital pharmacy.
- ▶ Non-Availability of drugs at health camps and SC or PHC level forces the patients to seek care at DH level

- ▶ Since indenting is manual, the state has yet to make the procurement and distribution process IT enabled for which efforts have been initiated to engage for linking with DVDMS portal through CDAC.
- ▶ The drug procurement and distribution mechanism are not done using scientific mechanism, neither it is demand based nor case load wise and hence there is irrational distribution of drugs.
- ▶ The state has not notified policy regarding prescription audit, usage of STG etc.

Assam

- ▶ Assam has a centralised procurement agency, Assam Medical Services Corporation Limited through which drugs and consumables for the state are procured.
- ▶ The state has notified free drug policy and has also developed and notified its EDL for all level of public health systems.
- ▶ The State also emphasises upon prescription with generic name only. However irrational prescription of the antibiotics was observed and hence the state is recommended to strengthen the prescription audit mechanism and usage of STGs.
- ▶ The procurement procedure is IT enabled to some extent. At the facility level, the disparity was observed pertaining to the stock maintenance as the records are being maintained manually.
- ▶ Overall, Health care seekers were satisfied with availability of free drugs at public health facilities. Few patients raised their suspicion on the quality of drugs supplied. The state needs to make efforts to ensure supply of drugs only after quality testing by empanelled labs.

Chhattisgarh

- ▶ Good stock of drugs was found at visited HWC and DH. Free drugs were available for pregnant women and the mothers under JSSK although it was found few of the prescribed drugs by the gynaecologists were not the part of the EDL.

- ▶ The challenge of stock out was observed for drugs under the RNTCP, probably due to non-integration of procurement of drugs covered under the RNTCP with the Medical Service Corporation. This has led to out of pocket expenditure for TB patients. Similarly, stock out was reported for anti-malarial drugs.
- ▶ Although, mechanism of indenting, procurement and distribution was IT enabled but it was observed that there is still the lead time of 15 days. In such scenario, local purchase was done.

Gujarat

- ▶ Procurement of medicines & equipment had been streamlined by Gujarat Medical Services Corporation Limited (GMSCL); all procurements were found to be as per notified tender procedure.
- ▶ The state has notified its free drug policy and list of essential drugs across all levels and the EDLs had been revised in 2017.
- ▶ There are around 556 drugs in EDL of Medical College/DH/SDH, 369 for CHC and 249 for PHC/SC.
- ▶ The drug procurement and distribution are IT enabled with DVDMs.
- ▶ The corporation ensures quality check of drugs before distribution. However, concrete step needs to be taken to strengthen the system by incorporating Prescription audit mechanism and setting up of the grievance redressal mechanism.

Himachal Pradesh

- ▶ A central Procurement Agency, Drug Regulatory Authority and a Procurement Committee is in place, though no state laboratory has yet been empanelled for quality testing of drugs.
- ▶ There was adequate availability of the commonly prescribed drugs. However, all the drugs were not available at some facility as per EDL.
- ▶ Due to shortage of storage space, patient/relatives have to make repeated visits for the refilling of drugs. Cold chain was maintained adequately in most facilities.

- ▶ Distribution system seems to vary across the state. Despite training been provided, the use of DVDMs was restricted to few facilities. Jan Aushidhi Centre was functional at the District Hospital Chamba.

Jammu and Kashmir

- ▶ The state has a central procurement agency, Jammu & Kashmir Medical Supplies Corporation Ltd. The procurement is done by open tendering process. The procurement and distribution process are IT enabled.
- ▶ The state is yet to implement the Free Drug Service Initiative. Due to non-availability of free drugs, huge out of pocket expenditure is incurred.
- ▶ At HWC/SC drugs were unavailable as per the essential medicine list including antihypertensive, anti-diabetics and antiepileptic. If the drugs are available, they are being given for 5-7 days due to shortage and patients due to rough terrain prefer to buy medicines instead of going back for refilling or are forced to directly go to the higher level of facilities.
- ▶ Oxytocin (Lifesaving drug), IFA, emergency drugs, Albendazole, etc. were unavailable at almost all other facility level. Similarly stock out of vaccines was also observed.
- ▶ Another glaring observation was prescription of drugs by brand names in many of the facilities and that also for pregnant women. PW are thus forced to buy these medicines leading to increased OOPE. On an average, an individual spends Rs. 500/- to Rs. 3000/- on drug purchase.
- ▶ It was observed many times due to non-availability of refrigerator; drugs were found stored in ILR which possibly will affect the efficiency.
- ▶ Community also expressed their concern of non-availability of drugs especially related to cardiac emergency management during winter (heavy snowfall) season when transportation of drugs by road becomes tough. Hence the state is recommended to have buffer stock mechanism in place.

Jharkhand

- ▶ Majority of interacted beneficiaries were unaware about provision of free drugs.
- ▶ Due to non-availability of drugs including Ayush drugs, there is high OOPE.
- ▶ IT platforms like e-AUSHADHI and eVIN portals have been started.
- ▶ No essential drug list was available at many facilities and no records pertaining to logistics or drug inventory are being maintained.

Karnataka

- ▶ Drug supplies and availability are good- State supply as well as Jan-Aushadhi Kendras.
- ▶ Drugs are dispensed to all patients in adequate quantity and their quality is also monitored
- ▶ Procurement of drugs for Paediatric AIDS, Vitamin-A and Iron Folic Acid tablets at rates fixed by NPPA remains an issue
- ▶ Storage of drug is key issue which needs to be fixed
- ▶ There is no set system of inventory management or buffer stocks available in the facilities, leading to risk of stock outs of vital drugs. The IT initiatives for drug supply management are not being observed in the stores.

Madhya Pradesh

- ▶ Madhya Pradesh has its central procurement agency- Madhya Pradesh Public Health Services Corporation Limited Bhopal and has notified free drug policy
- ▶ The Drugs procurement and the distribution system is IT enabled through e-Aushadhi. Drug stores in each facility were well maintained and all drugs were available
- ▶ The pharmacist/ dispensers followed the FEFO (First Expiry First Out).
- ▶ The state has also developed the toll-free helpline to capture the grievances pertaining to drugs availability, quality etc.

- ▶ Since there is no prescription audit mechanism currently reported in the state. It is recommended to initiate the audit process.
- ▶ Few of the supplied medicines had the label, which also mentioned its price. This may give opportunities for misappropriation of drugs. Hence it is recommended to put the label of “Government Supply” on the back of the strips.

Maharashtra

- ▶ Out of 429 EDL, 80 drugs are being monitored by the state. However, 45 drugs at DH, 129 at SDH and 17 at UPHC were available. The same was adequately available at Gadhchiroli.

Punjab

- ▶ The State has made significant investments in terms of centralized procurement system. However, it was found despite all the efforts, only 40% to 60% drugs were available at the visited facilities
- ▶ Although the EDL have been made for the state for all level of health facilities, the same have not been displayed at any health facilities.
- ▶ It was observed that medical officers have preference for branded drugs especially for non-communicable diseases, and drugs listed under EDL are not prescribed
- ▶ Due to the Non-availability/ partial availability of essential drugs at all level of healthcare facilities, there is high OOPE and dissatisfaction among health seekers
- ▶ PUSH system rather than PULL system is in practice for supply of drugs; i.e. facilities are not indenting what and how much they require, and as a result only drugs that are available at warehouses are being supplied.

Tamil Nadu

- ▶ Tamil Nadu Medical Services Corporation Ltd (TNMSC) is the central procurement agency for the purchase of drugs, equipment, consumables etc.

- ▶ Automation and use of IT system are observed at every step of its functionality. However, present software does not allow the health facilities to indent online or remotely. Nor does a facility has access to know about availability of the required drugs at the district warehouse. The State is recommended to make the indenting and access from facility the IT enabled.
- ▶ The District Drug Warehouses in both the districts are found to be well maintained, ventilated and well managed by a very small group of staff.
- ▶ Community is satisfied with the availability of free drugs at all level of health facilities
- ▶ The State has issued the guidance note to prescribe drugs with generic name only. It is recommended to initiate the prescription audit mechanism.

Telangana

- ▶ The state has Telangana State Medical Services Infrastructure Development Corporation as the central procurement agency which ensures uninterrupted supply of the drugs across all level of health care facilities via IT enabled platform e-Aushadhi.
- ▶ However, different facilities displayed different list of drugs despite the notification of free drug policy and EDL.
- ▶ The state has NABL accredited labs which ensure the supply of quality tested drugs.
- ▶ The state has notified the guideline for prescription audit but it's important to ensure its implementation as well.

Tripura

- ▶ The state doesn't have a central procurement agency. Drugs & consumables are procured by different agencies for different level of healthcare services. Directorate of Family Welfare & Preventive Medicine procures for Primary Health Care level (SC/ PHC /CHC) and Directorate of Health Services/ Respective Hospital Authority / RKS Body procures for Secondary Health Care level (SDH/DH/ State Hospital/ Medical College).

- ▶ All drugs are distributed to the facilities through geographically well-dispersed nine drug warehouses.
- ▶ The State has IT based Supply Chain Management Information System (SCMIS) for indenting, monitoring and tracking the utilization of drugs as per Essential Drugs List (EDL), vaccines and FP logistics up to PHC level.
- ▶ However, it was found despite the EDL, availability of drugs and supplies in the facilities is highly inadequate leading to unacceptably high OOP expenditures (ranging from Rs.600 for fever and cough to Rs.5000 for other serious ailments). Even basic drugs like paracetamol and supplies like syringes were not available.
- ▶ There were also cases in Unakoti district, where patients including children are prescribed Injectable antibiotics and are discharged after a day without any continuation dose of the antibiotic. Prescription audit was not conducted.
- ▶ None of the ASHA kits were found to be complete. Community also reported High out of pocket expenditure for institutional deliveries in public facilities, on an average, Rs 3000/- to Rs. 4000/- mainly for purchase of medicines.

Uttar Pradesh

- ▶ The state procures through three different sources- directorate, ESI and local purchase and supplies are kept in separate drug store demarcated as NHM, NCD and UP Government Supply. There are instances of stock outs generally related to lack of proper indenting mechanisms and lack of integration of above three.
- ▶ The pharmacists were unclear about stock management and indent process.
- ▶ Drugs seem to be largely available at CHC and DH, though in community discussions, community reported shortages and reported that they need to purchase drugs from shops. Gaps were observed in the supply of medicines for diabetes at the visited H&WC,

despite of the fact that state has provided Rs. 30,000/year/H&WC to address shortfall of NCD drugs.

Uttarakhand

- ▶ Central Medical Store Department in Directorate of Medical, HFW, Uttarakhand is a centralized procurement agency. The management of drugs procurement and distribution is being done through e-Aushadhi portal currently managed by C-DAC. All procurement of medicine is done through e-tendering process via Uttarakhand web portal.
- ▶ The State has three drug warehouses in Dehradun, Roorkee and US Nagar. The warehouse at Dehradun serves as the main warehouse from where Vaccines and Drugs are distributed to the

districts. There are 13 CMO-CMSD warehouses, one in each of the 13 districts.

- ▶ It was observed that mapping of state's EDL has not been done on DVDMs dashboard and moreover, rate contracts for 576 medicines were not available. Across the state there is limited availability of medicines and it is incurring OOPE.
- ▶ One of the major issues is that supply of medicines is based on the availability at district store and not as per the demand.
- ▶ There is lack of communication between pharmacists and prescribing physicians regarding medicines available. One of the other serious concerns was Quality of drugs, reportedly NSQ (Not of Standard Quality) percentage of drugs in government Supply Chain is high at 12.1%.

S. No.	State	Status Free Drugs Service Initiative
1	Andhra Pradesh	Yellow
2	Arunachal Pradesh	Red
3	Assam	Yellow
4	Chhattisgarh	Yellow
5	Gujarat	Green
6	Himachal Pradesh	Red
7	Jammu and Kashmir	Red
8	Jharkhand	Red
9	Karnataka	Yellow
10	Madhya Pradesh	Green
11	Punjab	Yellow
12	Tamil Nadu	Green
13	Telangana	Yellow
14	Tripura	Red
15	Uttar Pradesh	Red
16	Uttarakhand	Yellow

Red-Poor; Yellow-Moderate; Green-Satisfactory

10.2: FREE DIAGNOSITC SERVICE INITIATIVE NATIONAL OVERVIEW

- ▶ National free diagnostic initiative guidelines were designed to ensure the availability of comprehensive healthcare in public health facilities by providing quality diagnostic and imaging services.
- ▶ The following CRM States namely Maharashtra, Assam, Andhra Pradesh has executed the services delivery in public private partnership mode. List of 53 tests at District level and Sub-district level, 36 tests at Community health Centers and 17 tests at Primary healthcentre level are available for all beneficiaries.
- ▶ State of Assam has outsources labs services, X-ray reporting services using Tele-radiology mode and CT scan services as per NHM guidelines.
- ▶ State of Rajasthan, Tamil Nadu, Telangana and Gujarat are having in house model to provide diagnostic services.
- ▶ The state of Uttar Pradesh has notified Free Diagnostics for only 52 district hospitals under Uttar Pradesh Health System Strengthening project (UPHSSP). The state has outsourced their CT scan services to M/s HLL Life care Ltd, however the services are yet to commence.
- ▶ State of Jharkhand has notified free diagnostic for BPL patients at all level of health facilities in public private partnership. The reimbursement to the service provider is done on CGHS rate per test.
- ▶ State of Bihar is providing radiology (X-ray and Ultrasound) services from PHC up to DH level in public private partnership. None of the facilities arecomplied to statutory requirements.

KEY OBSERVATIONS

- ▶ The implementation of free diagnostic initiative has ensured greater confidence in the public health facilities and reduction in out of pocket expenditure.

- ▶ States which have not rolled out the the programme, varying user charges across facilities was observed. The rates for the tests are decided by RKS. Services were mostly free for BPL and JSSK beneficiaries except in some cases where even BPL are charged.
- ▶ The list of drugs and diagnostics available at different facilities were different.
- ▶ Many states have formulated IEC mechanism for community awareness. The programmes are envisaged to be monitored through the dash board provided by the service provider by the nominated nodal officers at the state and district level.
- ▶ The use of quality assurance mechanisms to validate the quality of tests being performed was lacking across many facilities. In some facilities, radiology equipment such as X-ray machines were lying idle due to lack of trained technicians to operate them.

RECOMMENDATIONS

- ▶ It is recommended to state to notify the list of 53 diagnostics tests at District level and Sub-district level, 36 diagnostics tests at Community health centres and 17 diagnostics tests at Primary health centre level that are available for all beneficiaries as per NHM guidelines in all the government facilities to lower the out of pocket expenditure.
- ▶ It is suggested that the Government develops a clear strategy and institute monitoring mechanisms to avoid unwarranted fluctuations in utilisation of services and Utilisation of 'individual/single tests' should be monitored closely by the State Government.
- ▶ The grievance redressal mechanism at health facilities should be strengthened.
- ▶ A regular and structured inter-laboratory comparison of in-house laboratories and service provider's laboratories should be instituted for relevant tests to allay any quality-related concerns of the doctors. These comparisons would also enable identification of discrepancies in test outcomes of the two laboratories.

- ▶ Adequate oversight is required for tests which are being done in-house and through the service provider at individual facilities. Although it may appear prudent to use services of the service provider, it is important not to lose the focus on cost-efficiency of in-house laboratory services and maintain the capacity of public health facilities to provide services in the long run.
- ▶ It is recommended that the administrators at health facilities and district health officials take up a larger role in monitoring of services at the health facility level.
- ▶ They should assess monthly analytical reports on availability and utilisation of service provider's services at individual Government health facilities; and quality assurance at service provider's laboratories.
- ▶ The district officials should provide feedback to the State officials based on an in-depth and closer monitoring of the services and its uptake. All information from the health facilities and laboratories should be validated before it is presented.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ The state of Andhra Pradesh has notified Free Diagnostics all the citizens. It includes package of essential diagnostic tests at each level of health facilities.
- ▶ Free Diagnostic services are outsourced in the state and are under implementation. The state has outsourced its lab services from 2016 with sample rate of Rs.235 for all tests at District & Sub-district level, CHC and PHC level.
- ▶ Free diagnostic services are running in hub & spoke model in PPP mode. PHC is conducting 19 tests out of which 7 are outsourced. Similarly in CHC, UPHC and DH are providing 21, 29 and 57 tests respectively.
- ▶ Currently, there are 105 Labs operating that include 7 Mother Labs & 98 Processing Labs across all the 13 districts.

- ▶ CT Scan services are provided via 4 district hospitals in PPP mode. A total of 114 thousand patients availed the service till date. The CT scan of the DH is doing 15-20 CT per day with same day reporting.
- ▶ Tele-radiology services in terms of x-ray reporting are present in the CHC & DH visited. This programme is operated through a “hub and spoke” model where radiology services are provided remotely.

Arunachal Pradesh

- ▶ State of Arunachal Pradesh is in the process of implementing Free Diagnostic Services.
- ▶ Tenders are in progress for Free Lab Services and Free CT scan Services.
- ▶ All diagnostic tests(except for JSSK beneficiaries) are charged a user fee which is displayed in the facilities.
- ▶ The minimum number of diagnostics at the PHC/ CHC levels is not notified.
- ▶ State was suggested to expedite the tendering process. State may seek support from Healthcare division of NHSRC to finalize the tender at the earliest.

Assam

- ▶ The state of Assam has recently notified Free Diagnostics for all the citizens. This includes various diagnostic services upto Sub centre level. X-Rays up to the level of CHCs and CT Scan services at District level.
- ▶ Free Diagnostic services are outsourced in the state and are under implementation. The state has outsourced its lab services to HLL Life care Ltd. On 14/02/2017 with sample rate of Rs. 320 at District level, Rs.224 per sample at CHC level and Rs. 128 per sample at PHC level.
- ▶ Tele radiology services for X ray reporting in the state are outsourced to Krisna Diagnostics since 31/12/2016 at Rs. 150 per X-ray reporting. CT scan services in the state are outsourced to Spandan Diagnostic Centre since 24/01/2017 at Rs. 1423

per CT Scan. The financial criteria for bidding were single rate system. However the X-ray and CT scan services commenced from 11/05/2017.

- ▶ Diagnostics services are available in both the CRM districts. Diagnostic facility for hypertension and diabetes is available in the H & WCs.
- ▶ Follow up mechanisms for suspected and diagnosed cases of NCDs need to be established in the HFIs in the district.
- ▶ In NCD clinics suspected cases of hypertension and diabetes need to be followed up for the diagnostic results and the diagnosed cases are to be followed up using existing community process set up for treatment compliance.

Chhattisgarh

- ▶ The state of Chhattisgarh is in the process to roll out Free Diagnostics Initiative. Tenders are in progress for Free lab services, CT scan services and Tele radiology services.
- ▶ The state is procuring reagents and consumables at Centralized Mechanism through state fund.
- ▶ State is suggested to expedite the tendering process. State may seek support from Healthcare division of NHSRC to finalize the tender at the earliest.

Gujarat

- ▶ State of Gujarat is having in house system to provide lab services, CT scan services and X ray services free of cost to the patients. The diagnostic services are being provided free of cost to all beneficiaries through in house mechanism from the level of Sub-centre up to the level of District hospitals.
- ▶ The number of test available at Sub centre, Primary Health Centre, Community Health Centre, Sub-District hospital and District hospital are 5, 19, 33, 33 and 68 respectively. Under radiological services, CT scan services are available in 4 district hospital.
- ▶ The procurement and supply chain management of equipment, reagents and consumables

is executed by Gujarat Medical Service Corporation Limited.

- ▶ State has developed various training modules including sample collection, Biomedical waste management etc for end users for each level of facility.

Himachal Pradesh

- ▶ State of Himachal Pradesh is having in house system to provide lab services, CT scan services and X ray services are run under PPP mode.
- ▶ Lab tests were being offered for majority of the tests on the facility diagnostic list, though a few were not being performed due to shortage of reagents, lack of equipment or demand from clinicians.
- ▶ In Bilaspur, Lab technicians were in place and often providing integrated services – covering general lab tests and also those on national programmes (e.g. ZN staining on sputum samples for TB). The latter were being regularly sent for sensitivity testing to CBNAAT centres, but the results often not followed-up.
- ▶ However, in Chamba there was a shortage of Lab technicians. Further, the positioned ones need to be sensitized on providing comprehensive lab services. At Chamba, Red Cross was providing lab services on reimbursement basis at one civil hospital. However, at the periphery few institutions with vacant LT position had equipments lying unutilized and vice versa. In Chamba, the SRL diagnostic lab services were present at the District Hospital level. The collection time for the DH internal lab was 9.00 am to 12.00 noon, post which the patients use the SRL lab services which runs 12.00 noon to 9.00 am.
- ▶ Apart from the DH and larger facilities, zoning was often not visible due to cramped spaces. The use of quality assurance mechanisms to validate the quality of tests being performed was lacking across facilities. In some facilities, radiology equipment such as X-ray machines were lying idle due to lack of trained technicians to operate them. User charges were applied to the APL population and often formed the main-

stay for RKS earnings. In Chamba, there was no CT scan service available.

- ▶ Many BPL patients are often charged for diagnostic tests – either due to lack of awareness or lack of proper documentation. This can significantly add to out-of-pocket expenditure. Greater awareness of free diagnostics (like the free drug scheme) will ensure there is less financial hardship on poorer patients.
- ▶ Consideration needs to be given to an infrastructure upgrade, especially for smaller labs, so that adequate zoning for infection control can take place. There is often unused space available at some of these facilities, which can be utilized for this.
- ▶ In Chamba, PPP mode of SRL Diagnostics is a good initiative to decongest the facility load. However, DH services should run for at least 8hrs for collection of the samples, which is currently only for 4 hrs. Lab technician have been hired with third party engagements, their quality needs to be ensured.

Jammu and Kashmir

- ▶ The State of Jammu and Kashmir is yet to roll out the Free Diagnostic Initiative programme. The programme was not implemented in state and no Observations were listed by CRM team regarding FDI programme.
- ▶ State was suggested to expedite the process to roll out the programme. State may seek support from Healthcare division of NHSRC to finalize the tender at the earliest.

Jharkhand

- ▶ The state of Jharkhand has notified free diagnostics services only for BPL population at all level of health facilities.
- ▶ It is free for all at Sub-centres and Primary Health centres only. The State has outsourced the pathology services from District hospitals up to Community Health centre level to M/s Medal Healthcare Pvt. Ltd and M/s SRL Diagnostic Pvt. Ltd at the CGHS Ranchi test rate.

- ▶ X-ray, Ultrasound and CT scan services have been outsourced to M/s Health Map Pvt. Ltd.
- ▶ The PPP model is based on revenue sharing and reimbursement of tests are done at CGHS rate. No Observations were listed by CRM team regarding Free Diagnostics programme.

Karnataka

- ▶ Lab services are being provided through facilities, while CT & MRI services are running in PPP mode.
- ▶ The state of Karnataka has recently notified Free Diagnostics for all the citizens. This includes a set of laboratory test up to the level of PHC, X-Rays up to the level of CHC and CT Scan & MRI Services at District level.
- ▶ CT Scan & MRI services are provided in PPP mode whereas diagnostic lab services are primarily provided in-house except for low volume-high cost test
- ▶ The programme is proposed to be monitored at the states level by an in-house software called E-hospital. At the district level, District TB Officer (DTO) is the nodal officer nominated for this programme.
- ▶ The state is planning for central procurement of equipment and reagents through the process of demand generation. There is an existing grievance mechanism in place for non-availability of services.
- ▶ For CT scan and MRI services, the state has signed a contract with Krssna diagnostics on 24/05/17 and is valid for 10 years. Financial Criteria for award of contract was single rate CGHS discount – MRI Scan Rs. 3000 per scan and CT Scan Rs. 1550 per Scan with or without contrast.

Madhya Pradesh

- ▶ Free diagnostic services are available at all levels through in house model. State is planning to strengthen their in house lab services by procuring equipment in rental reagent model.

- ▶ The CT scan tests will be provided free of cost to below poverty line patients and test will be provided to APL patients at the discounted rates @ Rs.933/- Out of 19 CT scan units total 7 CT scan units were established.
- ▶ It was observed that in the fees are collected from the APL in patients for diagnostic services at Biaora CH. It was also found that DH Rajgarh charges Rs. 200/- per x-ray.
- ▶ Though state has defined number of diagnostic services in different health facilities – DH 48, CH, 32, CHC, 28, PHC 16 and SHC 5 but at visited facilities it is different at same level of facilities. List of 18 tests in Machalpur PHC (H&WC), 23 tests in Kurawar PHC (H&WC), 28 tests in CHC Jirapur and 32 tests in DH Rajgarh are displayed.
- ▶ All visited facility has Lab Technician, Lab infrastructures with equipment's are available. More tests could be done if equipment are provided to the lab. CBC could not be done for many days due to non availability of reagents in Machalpur PHC.
- ▶ The DH Rajgarh is running in old building where most of the services are in separate locations e.g. Diagnostic services are in nearly 200 meter distances separate building. ETAT and ICU - are functional at DH Rajgarh. Cancer therapy service is available in the DH.
- ▶ It is recommended to state to notify the list of 53 diagnostics tests at District level and Sub-district level, 36 diagnostics tests at Community health centres and 17 diagnostics tests at Primary health centre level are available for all beneficiaries free of cost as per NHM guidelines in all the government facilities to lower the out of pocket expenditure
- ▶ It is suggested that the Government develops a clear strategy and institute monitoring mechanisms to avoid unwarranted fluctuations in utilisation of services and Utilisation of 'individual/single tests' should be monitored closely by the State Government.
- ▶ The grievance redressal mechanism at health facilities should be strengthened.

Maharashtra

- ▶ State has defined number and type of tests to be conducted in house or through outsourcing. All the labs visited were clean and properly maintained. Delayed reporting observed in outsourced tests at some places. Facilities visited had capacity to conduct about 30-40% tests outsourced. No defined protocols for calibration, inQAS and eQAS
- ▶ None of the hospital staff is involved in monitoring and quality checks of out-sourced lab reporting.
- ▶ Round the clock lab services are not available even at DH & SDH.

Tamil Nadu

- ▶ State of Tamil Nadu is having in house system to provide lab services, CT scan services and X ray services free of cost to the patients. MRI, CT scan, Cath labs in tertiary care are being done under PPP mode on user charge collection under the aegis of TNMSC.
- ▶ Minor Diagnostic facilities are free of cost to the patient at every level of facility and are available 24x7 in higher centers.
- ▶ NHM Free Drug and Diagnostic policy has been adopted by the state although this is run by TNMSC.
- ▶ Certain high end investigations are covered by CMCHIS and this information has been percolated down the system up to the PHC level.
- ▶ CT/MRI tests are chargeable.

Telangana

- ▶ The state of Telangana plans to deliver free diagnosis using in house facilities and human resource.
- ▶ Free Diagnostic pathology services is provided with available in house mechanism at PHC, CHC and DH level. State plans to add more diagnostics tests under free diagnosis via strengthening in house facilities.

- ▶ Tele radiology services are not provided in state. In- house radiologists are used to deliver the X ray reporting.
- ▶ Apart from general grievance mechanism no specific emphasis is given on diagnosis by the state.

Tripura

- ▶ Free Diagnostic Services are yet to be implemented fully in the state. Tender is in progress for Free lab services.
- ▶ Free CT scan Services and Tele radiology services are rolled out in state PPP model.
- ▶ State has initiated Tele radiology services across 23 Health Facilities for free X-Ray reporting as well as free CT Scan reporting at three district hospitals including Dhalai DH, Gomati DH and North Tripura DH.
- ▶ In SDH Kailasahar, CHC Kumharghat and PHC Machmara even after availability of compound microscope, adequate HR and minimal workload, complete blood biochemistry was not being carried out, only Hb estimation using sahli's method was being done.
- ▶ Facility in-charges were also reluctant and ignorant.

Uttarakhand

- ▶ The state of Uttarakhand has notified Free Diagnostics for MSBY card holders only. This includes a total of 30 tests at District & sub district level and 28 at CHC level. The state has recently outsourced their Teleradiology services to M/s Vital Pvt. Ltd. CT scan services are provided through in-house mechanism at select facilities, however for both Teleradiology and CT scan services a nominal fees is charged from the patient, other than MSBY beneficiaries.
- ▶ The programme is monitored at the district level by ACMOs, however there is no dedicated software for monitoring. The in-house Pathology services are operationalised by 51 lab technicians and 13 Lab specialist doctors.

▶ The reagents are procured at state as well as facility level, the demand generation is through a paper based mechanism. The samples are collected from 9am until 11 am and dispatched at 2pm. 24 by 7 Emergency diagnostic services are also available in the state.

- ▶ CT scan unit was established in September 2017. Radiologist is available and 952 CT scans have been done so far. Machine is under AMC for 5 years.
- ▶ Digital X-Ray not functional except in Trauma Centre of SDH Roorkee. Monsoon season sees the X-ray machines not serviced.
- ▶ Of the 2 X-Ray machines are available at DH Uttarkashi, only one is functional. The other is old and the staff is unaware of the process of condemnation.
- ▶ Ultrasound is available and functional. Reporting done by Radiologist of the Hospital.
- ▶ Tele radiology is available at DH Uttarkashi in partnership with a Pvt firm based in Noida since Nov 2017 and 1413 patients have benefitted. However same service at CHC is poorly utilized, barely 1-2 patients a month.
- ▶ 28 and 14 free Pathology tests are available at DH and CHC in Uttarkashi respectively. 70 tests done daily on an average on the autoanalyser.
- ▶ At CHC level X ray is done once a week and Ultrasound done twice a week by visiting radiologist.

Uttar Pradesh

- ▶ The state of Uttar Pradesh has notified Free Diagnostics for only 52 district hospitals under UP Health System Strengthening Project. The state has recently outsourced their CT scan services to M/s HLL LifecareLtd, however the services are yet to commence.
- ▶ For laboratory services, various service providers namely, Gian Pathology, Dr Khanna Pathcare, Medilab Diagnostic Centre, RMLIMS, Chandan Healthcare and SRL Ltd. are selected for their respective clusters. These services

commenced from November 2015 at some of the facilities.

- ▶ The programme is monitored by UPHSSP, and they have an in-house developed software for monitoring the programme. There is a provision for one lab technician at each collection centre.
- ▶ External Quality Assurance System (EQAS) is mandatory for each lab. Monthly EQAS results are linked to the payment of Service Provider for accuracy of the result, which ensures calibration and control.
- ▶ There are no grievance redressal mechanism in place.

10.3: BIOMEDICAL EQUIPMENT MAINTENANCE & MANAGEMENT PROGRAM (BMMP)

NATIONAL OVERVIEW

- ▶ Biomedical Equipment Maintenance and Management programme has been implemented in most of the CRM States.
- ▶ The following CRM states namely Chhattisgarh, Jharkhand, Madhya Pradesh, Uttrakhand, Uttar Pradesh, Rajasthan, Telangana, Maharashtra, Punjab, Andhra Pradesh, Arunachal Pradesh, Assam and Tripura have implemented this programme in PPP model.
- ▶ State of Tamil Nadu and Gujarat are having in house system for biomedical equipment maintenance and management. There is no progress in Bihar on programme implementation.
- ▶ The centralized toll free numbers and real time dashboard are available where programme has already been implemented. Monitoring of programme was highlighted as one of the key challenges in prior CRM reports. Consultative meetings at national level have been done with all the focal persons of States to develop the Standard operating protocol for maintenance monitoring. Deliverables tools have been developed to boost the monitoring

process and already disseminated to all States where programmes have been implemented and these are part of tender where tender is in progress. More than 10000 historical dysfunctional equipment have been rectified in States under CRM where programme has been rolled out.

KEY OBSERVATIONS

- ▶ Prior to this programme it had been taking 3 to 4 months to repair medical equipment in the state public health facilities because of long protocols followed by the facilities. This programme has shortened the turnaround time to repair the equipment.
- ▶ The Programme has improved the upkeep time of medical equipment in health facilities substantially and converted the pending historical dysfunctional equipment to functional.
- ▶ Corrective maintenance, preventive maintenance, calibration, user training, Toll free number based complaint booking, website based summary on all the medical equipment till the level of district hospital were made available after the initiation of programme.
- ▶ However technical competency of the service provider staff needs to be improved to deal with higher end medical devices.

RECOMMENDATIONS

- ▶ State may assign 2-3 nodal persons at each facility apart from facility in-charge for call closure/signing of service reports etc.
- ▶ Employ Biomedical Engineer in each district hospital. They may verify technical activity like preventive maintenance as per checklist of manufacturer / use of genuine spare parts/ reporting of adverse events / calibration as per recommendation of manufacturer in all the facilities in the districts.
- ▶ DPMU & below should also be involved in the BEMMP. The SPMU / DPMU can also

- monitor the programme and use the same for planning.
- ▶ State nodal officer may be asked to conduct monitoring and evaluation (via field visit) of the programme on all districts (till level of PHC) at least once in a year.
 - ▶ Service provider may be advised to synchronize calibration schedules with NQAS assessment, renewal of license for blood bank or renewal of AERB registration etc.
 - ▶ Apart from availing corrective maintenance, ensure availing services like calibration, preventive maintenance, use of dashboard/ website, user training and availing stand by equipment (in case critical equipment) are being provided.
 - ▶ State nodal officer should cross verify and remove any equipment having valid AMC/CMC/ warranty, counted under the total asset value of service provider. This is to avoid any possibility in duplication of payment for maintenance service.
 - ▶ Every month service provider should get consolidated report on services, PM, calibration or user training activity conducted in every district.
 - ▶ The service provider should employ biomedical engineer certified in advanced skill for the equipment being maintained and certified medical equipment technical either by OEM or by HSCC in basis clinical equipment skills.
- ▶ The Programme has improved the upkeep time of medical equipment in health facilities substantially and converted the pending historical dysfunctional equipment to functional. Current non-functional assets are at 2.1%.
 - ▶ For any breakdown of critical equipment like ventilators/defibrillators has been addressed by the service provider with response time of 24 hours.
 - ▶ For Non-critical equipment response time is 3-5 days.
 - ▶ The service provider has established the Dashboard to provide transparent information about status of medical equipment's under NHM. The website was envisaged to ease the decision makers or state nodal officers and different programme managers for procurement or planning.
 - ▶ Process of condemnation is followed in various level of certification starting with the service provider and ends with certification by CSIR.
 - ▶ Some of the challenges faced were difficulty to provide stand by equipment for non-functional instruments/ equipment.
 - ▶ Some of the critical equipment are not covered in programme.
 - ▶ State is suggested to recheck the equipment mapping data and include the missing critical equipment in BMMP programme.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Biomedical Equipment Maintenance and Management Programme were implemented in the state in PPP mode from 2016. Rs.250 Crores worth of Equipment are covered in this programme. The tender was awarded to TBS India Private Limited at the rate 7.45% of the asset value. State of Andhra Pradesh has run the BMMP programme successfully for the last two years.

Arunachal Pradesh

- ▶ The State of Arunachal Pradesh has rolled out the programme in Public Private Partnership model. The state is having an Asset Base of Rs. 19.24 Cr. The service provider is M/s Medicity Pvt. Ltd rendering the services @ 10.8% of the Asset Value.
- ▶ The state didn't seem to have any mechanism to monitor for the annual maintenance of the biomedical equipments.
- ▶ The critical equipments like radiant warmer weren't functioning properly in DH East Siang.

- ▶ There is no mapping of the biomedical equipments at all facilities. State may assign 2-3 nodal persons at each facility apart from facility in- charge for call closure/signing of service reports etc.
- ▶ The state nodal officer periodically interacts with the service provider and monitors the activities and the records of periodic maintenance are kept.
- ▶ Apart from availing corrective maintenance, ensure availing services like calibration, preventive maintenance, use of dashboard/ website, user training and availing stand by equipment (in case critical equipment) are being provided.
- ▶ The detailed deliverables and SOPs for Preventive Maintenance, Calibration and month wise with district wise availability of technical manpower should be available with the facility.
- ▶ State is suggested to recheck the equipment mapping data and include the missing equipment in BMMP programme.
- ▶ The service provider should employ Biomedical engineers certified by OEM/HSCC for advanced skills and medical equipment technology certified by HSCC for skills in medical equipment repair maintenance of clinical equipment.

Assam

- ▶ The State of Assam has rolled out the programme in outsourcing model since 2017. The state is having total asset value of Rs 307 Crore. The service provider is M/S TBS India Telematic services rendering the services @7.85% of the asset value.
- ▶ The Asset mapped is disclosed on the NHM website/Central Dashboard.
- ▶ As per State report 88% equipments are functional.
- ▶ Call centre with a toll free number is also functional.
- ▶ The Operating Manual consisting of SOP and Preventive maintenance check lists are not available.

- ▶ The detailed deliverables and SOPs for Preventive Maintenance, Calibration month wise and district wise availability of technical manpower should be available with the facility.

Chhattisgarh

- ▶ The State of Chhattisgarh rolled out the programme in outsourcing mode very recently. The state was completed mapping for equipment and having an Asset Base of Rs. 90.8 Crore. The service provider is M/s Medicity Pvt. Ltd rendering the services @ 6.9% of the Asset Value. Technical manpower is available with the state with 13 numbers of Biomedical Engineers.
- ▶ The programme implemented in state very recently and no challenges were listed by CRM team regarding BMMP programme.

Gujarat

- ▶ State of Gujarat procures equipment for health facilities through Gujarat Medical Service Corporation. There is a provision to enter into maintenance activities through AMC and CMC at the time of procurement. Monitoring of AMC and CMC are being done by GMSCL. State of Gujarat floated tender for Biomedical Equipment Maintenance Program thrice to enter into an agreement with third party but could not be concluded due to additional state terms and conditions.
- ▶ Since the programme is not implemented in the state and no challenges were listed by CRM team regarding BMMP programme.

Himachal Pradesh

- ▶ The State of Himachal Pradesh is planning to roll out the program in outsourcing mode. The state is having an Asset Base of Rs 98 Crore. The Asset mapped is disclosed on the NHM website. The mapping is complete in 100% of the facilities.
- ▶ The program is in implementation stage in state and no challenges were listed by CRM team regarding BMMP programme.

Jammu and Kashmir

- ▶ The State of Jammu and Kashmir is planning to roll out the programme in outsourcing mode. The programme is in implementation stage in state and no challenges were listed by CRM team regarding BMMP programme.

Jharkhand

- ▶ The State of Jharkhand has rolled out the programme in outsourcing mode on August, 2017. The state is having an Asset Base of Rs 113 Crore. The service provider is M/s Mediciti Healthcare Pvt Ltd rendering the services @ 6.78%. The Asset mapped is disclosed on the Central Dash Board.
- ▶ The State has Rs 25 Cr worth of functional equipment and the value of equipment suggested for condemnation by service provider to NHM is still under verification. Out of 5188 historical dysfunctional equipment a total of 360 equipment have been rectified by the service provider.
- ▶ The services are being provided in 100% of the total facilities. No challenges were listed by CRM team regarding BMMP programme.

Karnataka

- ▶ The Radiological equipment need AERB approval (Registration) under the Atomic Energy Act.
- ▶ The State of Karnataka is planning to roll out the programme in outsourcing mode. The state is having an Asset Base of Rs 300 Crore. The Asset mapped is disclosed on the NHM website. The mapping is complete in 100% of the facilities. The programme is not implemented in the state and no challenges were listed by CRM team regarding BMMP programme.

Madhya Pradesh

- ▶ BMMP has been rolled out in the state through PPP model in 2017. The state is having an Asset Base of Rs 185 Crore. The service provider is M/S AOV services rendering the services @6.4% of the asset value.

- ▶ All the health facilities visited are covered under the BMMP.
- ▶ End users of the equipment are reported that the equipment maintenance and management services are prompt.
- ▶ Repeated breakdown reported on the most of the repaired equipment.
- ▶ It was found by CRM team that the Preventive Maintenance of the equipment is not as per protocol. Service provider place the PM sticker based on functionality of the machine as reported by the end users.

Maharashtra

- ▶ BMMP was being implemented. Terms & conditions/ provisions for the MoU were not known to the clinicians. Log books of equipment indicating down time were not maintained. Double AMCs for single equipment (BMMP & maintenance under concerned national programme) was also noted.

Tamil Nadu

- ▶ State of Tamil Nadu procures equipment for health facilities through Tamil Nadu Medical Service Corporation. There is a provision to enter into maintenance activities through AMC and CMC at the time of procurement. Monitoring of AMC and CMC are being done by TNMSCL. Bio-medical equipment management- Inventory management software is a state initiative (Inventory-Equipment System).
- ▶ Mapping of all the health facilities in the state has been undertaken. Pharmacists are trained and guided by the bio-medical engineers to maintain the inventory up to date. Costly Equipments are maintained by TNMSC which are in Tertiary Care Institutions.
- ▶ AMC has been fixed for 7 years after the warranty is over by TNMSC for other less costly items. However centralized monitoring system is not yet operational. District wise Biomedical Engineers are deployed under TNMSC.

Telangana

- ▶ The State of Telangana has rolled out the programme in outsourcing mode on June 2017. The state is having an Asset Base of Rs 209 Cr. The service provider is M/s Faber Sindoori Pvt Ltd rendering the services @ 5.74% of the Asset Value. The Asset mapped is disclosed on the Central Dash Board. However BMMP was restricted to DH level only.
- ▶ Non-functional equipment (e.g. radiant warmers, deep freezers, etc.) were found in peripheral facilities.
- ▶ As per agreement, all the facilities up to PHC were covered in BMMP. State has to ensure that the services are being provided in 100% of the total facilities.
- ▶ State may assign 2-3 nodal persons at each facility apart from facility in- charge for call closure/signing of service reports etc.
- ▶ Apart from availing corrective maintenance, ensure availing services like calibration, preventive maintenance, use of dashboard/ website, user training and availing stand by equipment (in case critical equipment) are being provided.
- ▶ Adequate staff as per the licensing requirement should be sanctioned for the District Blood Bank and equipments should be covered under the biomedical equipments maintenance programme

Tripura

- ▶ State of Tripura has done a state-wide rollout of Biomedical Equipment Maintenance and Management Program (BEMMP). This programme has been contracted out under Public Private Partnership (PPP) model and started implementation from September 2016. The asset value of medical equipment

was estimated by inventory mapping prior to tender as 31 Crore. The tender was awarded to L1 bidder, Mediciti Healthcare Services Private Limited at the rate 10.77% of the asset value. State of Tripura has run the BMMP programme successfully for the last two years.

- ▶ CRM Team found that regular maintenance and timely intervention is not done by outsourced agency.
- ▶ Lack of monitoring of programme by NHM Tripura and shortage of technical staff under NHM to appraise the activities of service provider.
- ▶ It was recommended that technical competency of the service provider staff needs to be improved to deal with higher end medical devices.

Uttarakhand

- ▶ The State of Uttarakhand is planning to roll out the programme in outsourcing mode. The state is having an Asset Base of Rs 108 Crore. The Asset mapped is disclosed on the NHM website/Central Dash Board. The State has 21% of dysfunctional equipment. The mapping is complete in 100% facilities. The program is in implementation stage in state and no challenges were listed by CRM team regarding BMMP program.

Uttar Pradesh

- ▶ The State of Uttar Pradesh rolled out the programme in outsourcing mode very recently. The state is having an Asset Base of Rs 508 Crore. The Asset mapped is disclosed on the NHM website/Central Dash Board. The State has 34% of dysfunctional equipment. Since the programme implemented in state very recently and no challenges were listed by CRM team regarding BMMP programme.



GOVERNANCE, ACCOUNTABILITY & HEALTHCARE FINANCING



11.1: GOVERNANCE & ACCOUNTABILITY

NATIONAL OVERVIEW

▶ Institutional arrangements (State & District Health Missions, Programme Management Units and City Level Committees) are by and large in place. However, in most of the places regular meetings of the State and District Missions is not taking place. Planning process is still top down and convergence restricted to WCD and Education department. Involvement of Urban Local Bodies is largely limited to disease control programmes and in specific activities like source reduction, fogging etc. There is a requirement to bring in more accountability to PPP arrangements.

▶ The Clinical Establishments (Registration and Regulation) Act, 2010 continues to receive unsatisfactory response from the States. So far only 12 States –Sikkim, Mizoram, Arunachal Pradesh, Himachal Pradesh, Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Uttarakhand, Assam, Haryana and Karnataka and all Union Territories except Delhi, have adopted the Act. Even in states where the Act has been adopted, the enforcement is rather weak. The primary impediment in its adoption and implementation is the stiff resistance from ‘interested stakeholders’. Concerted efforts and steps must be taken to enforce the provisions of the Pre Conception and Pre Natal Diagnostics Techniques Act, 1994 [carry on registration, inspections and



covert operations, file complaints and secure convictions], along with broader awareness and gender equality advocacy in the community.

KEY OBSERVATIONS

PROGRAMME MANAGEMENT

▶ Most states have strengthened their institutional arrangements such as, State and District Health Mission Programme Management Units and city level committees. However, regular meeting of state and district health missions are not being held in the states of Bihar and Jharkhand. While meetings of the Governing Board of Programme Management Unit are being regularly conducted,

the Block Level Programme Management Unit has not been strengthened in most of the states.

- ▶ In NHM, decentralized planning process has been conceived as a core system strengthening instrument of public health service delivery mechanism, and has been initiated in a few states such as Bihar, Chhattisgarh, Nagaland, Odisha and Maharashtra. However, during the CRM visits it was observed that most of the states are practicing top to bottom planning and the planning itself is mostly limited to budgeting of ongoing activities. Almost no State uses HMIS data, supervisory feedback or grievance related data for preparation of District Health Action Plan. Current process of planning, therefore, has not been able to incorporate community perspective in planning. There is no institutional mechanism available in the state and even the role of SIHFW in planning process is largely undefined and limited to in-service capacity building, which is also not happening at full pace due to lack of adequate and competent faculty, in most of the states.

CONVERGENCE

- ▶ Intra-sectoral convergence is limited to WCD and Education department for RBSK and WIFS programme in states like Assam, Bihar, Chhattisgarh, Karnataka, Odisha, Nagaland, Uttarakhand and Punjab. In Andhra Pradesh, Inter-sectoral coordination has been established with Udyana Vanam Shakha (Horticulture) for sapling plantation to provide green leafy vegetable to pregnant and lactating women. In Maharashtra, Panchayati Raj Institution has been instrumental in converging all line departments. In most of the States, NUHM-SBM-NULM convergence has been initiated and trainings have been planned for concerned stakeholders. Involvement of ULB is limited to source reduction, fogging etc. MAS members were involved in SBM activities at ward in some of the states. DISHA committee should be formed for better inter-sectoral and inter-departmental convergence with different departments and elected representatives of district like MPs and MLAs.
- ▶ All the visited states reported functional 104 health helplines, except Meghalaya and Haryana. Notably, Bihar is the only state where state government has introduced legislation on grievance redressal, namely "Lok Shikayat Nirvaran Adhiniyam 2016" in the Bihar Assembly. CRM States are providing services through 104 health helplines, such as medical advice, counselling, health service information and grievance redress. A few states like MP, Chhattisgarh, Rajasthan and Karnataka are providing additional services such as basic information on RMNCHA+ related schemes, advice on first aid, ASHA soft helpline, health insurance help line, malnutrition information etc.
- ▶ PPP arrangements in the States exist for a variety of services like radiology, diagnostics, laundry, fair price shops etc. In a few States UPHCs were also found to be running on PPP mode, for instance Uttarakhand. A common cause of concern found under these PPP arrangements is that the MoUs did not clearly lay down the responsibility of private partners or defined time bound deliverables and measurable outcomes. There is a need to review the MoUs and the PPP models to assess the impact on the public health systems.
- ▶ In most of the hospitals, the display of 'Citizen Charter' was considered as a sufficient and complete engagement for ensuring patients' rights. There is also no uniformity in the Citizen Charters seen across facilities/states in terms of content or structure. Some facilities only displayed Essential Drug List and yet others displayed the names of service providers under the heading of Citizen Charter.
- ▶ Implementation of Maternal Death Surveillance and Response (MDSR), Maternal Near Miss (MNM), and Child Death Review (CDR) is uneven. There is limited focus on review and feedback to periphery for ensuring action, by District Collector. Daily Zero reporting of deaths and engagement of Panchayati Raj Institutions in Maharashtra has helped that State use MDSR/ CDR data for Health System improvements.

ACCOUNTABILITY

REGULATIONS

Pre-Conception and Pre Natal-Diagnostics Techniques Act, 1994 [PCPNDT]

- ▶ The enforcement of PCPNDT Act is poor in most states. Many states have not been able to complete registration of all facilities, have not been able to carry out inspections and have been found to be totally lacking in filing cases, let alone obtain convictions. There is also a lack of proper documentation and record keeping. Some states ascribe the poor implementation to lack of funds for enforcement measures. However, during the visits it was observed that in many states there is under utilisation of funds already sanctioned.
- ▶ The States visited this year that have not secured a single conviction under the PCPNDT Act, since 1994 are - Arunachal Pradesh, Tripura, Andhra Pradesh, Jharkhand, Karnataka, Tamil Nadu and Uttarakhand. Out of these, Arunachal Pradesh and Tripura have not even registered a single case under the PCPNDT Act in the same time period. The States visited this year, which are relatively better in terms of enforcement of the Act, are Maharashtra, Rajasthan, Punjab, Gujarat, Tamil Nadu and Telangana.
- ▶ Key identified problems in the implementation of the PCPNDT Act include - lack of dedicated team for inspections and general implementation of the act, lack of funds, delay in judicial process, lack of witnesses, exclusion of practitioners of Indian medicine (Registered Medical Practitioners) from the ambit of the act, absence of regular inspection of Ultrasonography (USG) centres, lack of documentation of inspection report, lack of tracking facility in USG machines, seized USG machines go missing, inadequate number of decoy operations, non-imposition of penalties, lack of regular meetings by authorities etc.

Clinical Establishment (Registration and Regulation) Act, 2010 [CEA]

- ▶ Different states are at different stages of implementation of the Act. Out of the states

visited, following states have adopted the CEA – Arunachal Pradesh, Assam, Bihar, Himachal Pradesh, Jharkhand, Uttarakhand, Uttar Pradesh and Karnataka. The following have not yet adopted the CEA – Chhattisgarh, Gujarat, Jammu & Kashmir, Maharashtra, Punjab, Rajasthan, Tamil Nadu, Telangana and Tripura.

- ▶ Some states that have adopted the CEA have made some modifications that may dilute some of the provisions of the central act and compromise nation-wide uniformity. The modifications made may also depend on the stakeholders engaged with. The drafts developed in Kerala, Tamil Nadu, Karnataka and Maharashtra are examples of this.
- ▶ Some states have been implementing pre-existing state legislation to regulate the clinical establishments, such as Andhra Pradesh, Madhya Pradesh and Tamil Nadu.

RECOMMENDATIONS

- ▶ States need to ensure that the planning process follows the bottom-up approach and community engagement. States need to fix accountability at all levels of programmatic and administrative set-up. HMIS data should be used for planning, programmatic review and mid-course correction
- ▶ State-specific comprehensive and transparent HR Policy needs to be developed with special attention to recruitment, selection, training, transfer, Incentives, appraisal and increment
- ▶ Ensure timely transfer of NHM Funds from State Treasury to State Health Society
- ▶ Minimize time taken for decision-making and procurement of goods & services
- ▶ Focus on vertical expansion and convergence of departments for holistic implementation of health action plan
- ▶ Build facility & community linkage through community meetings, PRI interactions, facility visits etc.
- ▶ District Health Action Plans should be based on disease burden and priorities of the respective

- districts. Subsequently these plans / priorities reflected in DHAPs must become part of State plan.
- ▶ GB and EC meetings should also monitor programme performance and not be limited to financial transactions.
 - ▶ PPP in any area should follow structured principles, processes, standards and KPIs for monitoring.
 - ▶ Prescription, Medical, Death and Near Miss reviews and audits to be conducted and linked with systemic gaps.
 - ▶ Enforce the PCPNDT Act by removing gaps related to HR and adequate budget for enforcing provisions of the act. Sex selective abortions/determination however, can't be prevented by just prosecuting doctors and healthcare institutions. Apart from implementing the law, there is a need to deploy a sustained and continuous campaign on gender equality and the importance of protecting the girl child. Changing societal norms and biases on gender issues requires continuous and concerted engagement with the community.
 - ▶ Continuous engagement for adaption/adoption/ inspired State legislations required to ensure enactment of Clinical Establishments regulation in all the States.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ At the community level, member of Panchayat and VHSNC members are being involved in and have been associated with planning. ASHA is nominated as member secretary. Women belonging to SC/ST have been made the chairpersons.
- ▶ Gram Darshini is a Grievance Redressal mechanism in rural areas organized by the Revenue Dept. where every Monday, community get together and discuss their problems including issues related to health.

- ▶ Andhra Pradesh is implementing its own legislation for regulating clinical establishments-the A.P. Allopathic Private Medical Care Establishment Act. Meetings have been conducted with professional organizations for advocacy and currently professional unions are cooperative as per state officials.
- ▶ The district and block administrations should be encouraged to participate in health care planning in order to increase the efficiency in subsequent implementation of various programmes.

Arunachal Pradesh

- ▶ Lack of comprehensive supportive supervision mechanism for monitoring the functioning and implementation of various programmes.
- ▶ Lack of accountability amongst the administration authorities, which is hampering the programme outcomes.
- ▶ NHM follows top bottom planning as it does not involve the community, LDC in decision-making and hardly engages with NGOs and civil society.
- ▶ The State does not utilize the HMIS data for planning and mid-course correction.
- ▶ There is lack of integrated rural and urban health planning. Poor convergence of departments of DWS, RD, MoTA, WCD, PHED etc. that has adversely affected holistic public health planning and subsequent action.

Assam

- ▶ State level NUHM-SBM-NULM convergence initiated and trainings have been planned for concerned stakeholders. Involvement of ULB is limited to source reduction, fogging etc. MAS members were involved in SBM activities at ward and UPHC level but documentary evidence of the same was not provided.
- ▶ Monitoring is poor and follow up of DHS meeting decisions is almost negligible.
- ▶ The Directorate and the NHM continue to function as parallel structures. The problem

persists at the district level and below. NHM PMUs concentrate more on RCH and health systems issues, and are not well informed about the DCPs and NCDs. The Medical Officers and other staff still see the programmes as verticals and integration efforts at the level of implementation in the facilities are absent.

- ▶ Role of Urban Local Bodies in implementation of NUHM is restricted, largely due to the fact that the state has not by legislation, devolved powers and functions related to public health to the ULB. The State is currently not conducting any Social audits or Jan Sunwais.
- ▶ State has adopted the Clinical establishment Act and has notified its rules

Chhattisgarh

- ▶ Regular coordination meetings with ULBs are being held. Nagar Nigam provides free water and electricity to UPHCs. Jeevan Deep Samiti (JDS) meetings in visited districts were held regularly. Things like proper record keeping, assets, funds and overall governance seems to be in order. Though it was mentioned that RSBY-MSBY funds are merged with JDS, the books of records did not reflect the same. Delay in transfer of funds from State treasury to State Health Societies (SHS) continues to be a major problem.
- ▶ NHM has good coordination with Directorate, Health services, SIHFW and Chhattisgarh State Medical Supply Corporation.

Gujarat

- ▶ At the state level, the director level officers (designated Additional Directors) report to the PS (Health) / Commissioner through the MD (NHM). The regional level structure, as reported, has representation only from Department of Health. This administrative level may be comprehensively planned with convergent departments reporting under a Divisional Commissioner.
- ▶ Among the institutional structures, activity of the District Health Mission is valuable and the working

of District Health Society in close coordination with District Panchayat is appreciated.

- ▶ State has picked up on the reporting and review of MDSR and CDR. An area of improvement would be to focus on the 'output of DC review'. This would be possible only if the review under the district health team identifies those areas where the intervention of district collector is required. For instance, interdepartmental coordination, additional fund requirement from sources other than health etc.

Jharkhand

- ▶ The VHSNC meetings are held regularly and untied funds are being used optimally. However, in Bokaro, untied funds have not been received since 2015-16. Training of VHSNC members and PRI members have been completed.
- ▶ The Mission Director and PS Health chaired meetings related to the Maternal Death reviews and have issued necessary directives to improve reporting and reviews and also delineated the actions to be taken.
- ▶ The services delivered in PPP mode are not functioning well, particularly the outsourcing of diagnostic services to Medall.

Karnataka

- ▶ There is a good mechanism to ensure supportive supervision (Nodal officers from State). They are regularly visiting the districts.
- ▶ Programme management units under NHM at different levels are good. More frequent review of District Health Officers is required.
- ▶ Internal review missions for monitoring of health system are held with State officials and experts.
- ▶ There are several Public Private Partnership models functional in state.g. Mental (Tele-psychiatry), Dialysis, CT scan, MRI, Biomedical Waste Management, etc.
- ▶ The Karnataka Private Medical Establishments (Amendment) (KPME) Bill, 2017 was passed

with some modifications, under pressure from the private medical establishments. The proposed law originally prescribed stringent punishment, including six months to three years of imprisonment and a fine of Rs 25,000 to Rs 5 lakh for officials of hospitals charging fees in excess of costs fixed by the state. The final version of the Bill dropped the imprisonment clause. It has also provided for private sector representation on the district-level public grievance redress committees.

Madhya Pradesh

- ▶ No systemic and comprehensive orientation on various critical programme issues and check points for PMUs working at various levels.
- ▶ Performance monitoring, systemic appraisal and comprehensive assessment of staff is in place.
- ▶ There is a need for better coordination between NHM/ SPMU and Health Directorates and rationalization of staff is not yet attempted.
- ▶ Madhya Pradesh has been implementing the M.P. Nursing Home Act 1973

Maharashtra

- ▶ Zila parishads and PRIs are empowered and well functional for implementation and monitoring of various programme activities. Chairman and CEOs of various committees at different levels actively participate and contribute in programmes.
- ▶ Village / Block level Plan for Health were not available and no convergence between District and State Plan was observed.
- ▶ State is developing a Bill for regulation of Clinical Establishments

Punjab

- ▶ No meeting of District Health Mission has been conducted during last year.
- ▶ VHSNC committee has been formed but meetings are not regularly held and minutes are not maintained. AAA convergence mechanism

is informally active at the community level. However, there is no integrated approach for nutritional issues in the community.

- ▶ There is poor convergence and integration of health department and Panchayati Raj institution and Inter-sectoral convergence meetings are not being conducted regularly at the Panchayat level in the villages visited.

Tamil Nadu

- ▶ Very good integration between State Health Directorates and NHM was observed. System of programme review at regular interval at State and district level is in place.
- ▶ Engagement of Urban Local Bodies is appreciated.
- ▶ The cadre structure in the state is facilitating smooth functioning.

Telangana

- ▶ State facing some procedural delays due to division of State (Telangana, Andhra Pradesh) and creation of new districts (10 to 31 districts).
- ▶ District level convergence committee is formed and held one meeting in the month of October along with Department of Women and Child Development (DWCD) and representatives from Water and Sanitation department.
- ▶ Health department works in coordination and collaboration with various line departments to conduct VHNDs, VHNCS, UHNDs, Gramasabha, General body Meetings, Parent Teacher Meet at schools and RKS meetings.

Tripura

- ▶ Directorate and NHM PMU seem to work independently. While directors have the technical know-how, they do not know about NHM in detail leading to complete lack of supervision and monitoring.
- ▶ The team was made to understand that drug procurement has been delayed due to delay in tendering process. Most medicines and

supplies were found to be purchased by patients (including paracetamol, antibiotics, cough syrup, syringes etc.) leading to high OOPE. As per GOI, in case of unavailability of drugs, it is purchased at facility level using RKS fund. However, no such case was observed during the visit.

- ▶ Free Diagnostic Services are yet to be implemented fully in the state. Varying user charges across facilities was observed. The rates for the tests are decided by RKS. Services were mostly free for BPL and JSSK beneficiaries, except in some cases where even persons BPL are charged.

Uttarakhand

- ▶ No meeting has been held at State level for convergence with SBM and NULM. No comprehensive state plan was in place to ensure convergence. Hence, coordination between ULBs, WCD, Water and Sanitation and State/District Health Department at grass root was found poor.
- ▶ The SHM is chaired by the Chief Minister, while the DHM is chaired by the Chairman of Zila Parishad/Zila Panchayat. SHM carries out Video Conference with CMOs of the Districts on 2nd Thursday of each month.
- ▶ District level plans are discussed at State level during annual meetings prior to finalizing State PIP, but active use of HMIS/MCTS data for planning at various levels has not been in place.
- ▶ Supportive supervision mechanism is not institutionalized at any level. However at the district level, programme review is held on 1st day of every month by the CMO and minutes are recorded.

11.2: HEALTH CARE FINANCING

NATIONAL OVERVIEW

The National Health Mission (NHM), under the Ministry of Health and Family Welfare has, since its inception in 2005- 06 till March 2018, released about Rs. 1.7 Lakh Crore¹. NHM is one of the most important centrally

sponsored schemes in the health ministry with a share of more than 50 percent of the overall health budgets over the years. Utilisation of NHM funds have remained a challenge at the state level and depend to a great extent upon the absorption capacity of the health system present in the state. Among all the CRM states, utilisation of NHM funds have reduced between 2014-15 and 2016-17, only exceptions being Telangana and Jharkhand. As per 2016-17 estimates, states with very high utilisation includes Telangana, Jharkhand and Andhra Pradesh where the utilisation exceeds 100%. On the other hand, Arunachal Pradesh, Maharashtra and Bihar have relatively lower utilisation with utilisation rate less than 50%.

One of the goals of NHM is to reduce OOPE and numerous initiatives have been taken by the Government towards this such as the provision of free essential drugs and diagnostics, free ambulance services and JSSK entitlements which include free blood services besides free diet, drugs and transportation. In most of the CRM states, OOPE exceeds 50 % of total health expenditure. Gujarat, Karnataka and Himachal Pradesh are the only states with OOPE under 50 percent. In Andhra Pradesh, Bihar, Punjab and Telangana, share of OOPE exceed 70 percent of total health expenditure.

Table: Out of Pocket expenditure across the States in 2015-16.*

Out of Pocket Expenditure (OOPE)				
	In Rs. Crore	Per capita in Rs.	% GSDP	% THE
Share of OOPE IN Total Health Expenditure 40%-50%				
Himachal Pradesh	1706	2437	1.5	49.5
Karnataka	15908	2447	1.6	49.6
Gujarat	10589	1681	1	50.4
Share of OOPE IN Total Health Expenditure 50%-60%				
Assam	4339	1315	1.9	55.1
Jammu & Kashmir	2780	2138	2.3	56
Rajasthan	13455	1818	2	56.4
Uttarakhand	7941	3054	1.4	57.9
Chhattisgarh	5322	1971	2	58.4
Maharashtra	33459	2788	1.7	58.9

1. 11th Common Review Mission, NHSRC, MoHFW and Press Information Bureau Government of India MoHFW.

Out of Pocket Expenditure (OOPE)				
	In Rs. Crore	Per capita in Rs.	% GSDP	% THE
Share of OOPE IN Total Health Expenditure 60%-70%				
Uttar Pradesh	2630	2391	1.5	61.2
Tamil Nadu	21500	2829	1.9	65.2
Jharkhand	5228	1494	2.3	66.3
Madhya Pradesh	14283	1879	2.7	70.1
Share of OOPE IN Total Health Expenditure 70%-80%				
Andhra Pradesh	19512	3097	3.2	74.7
Telangana	52841	2469	4.7	76.5
Punjab	12563	4332	3.2	77.4
Bihar	19890	1776	5.2	79.9
India Average	3,20,211	2,494	2.3	60.6

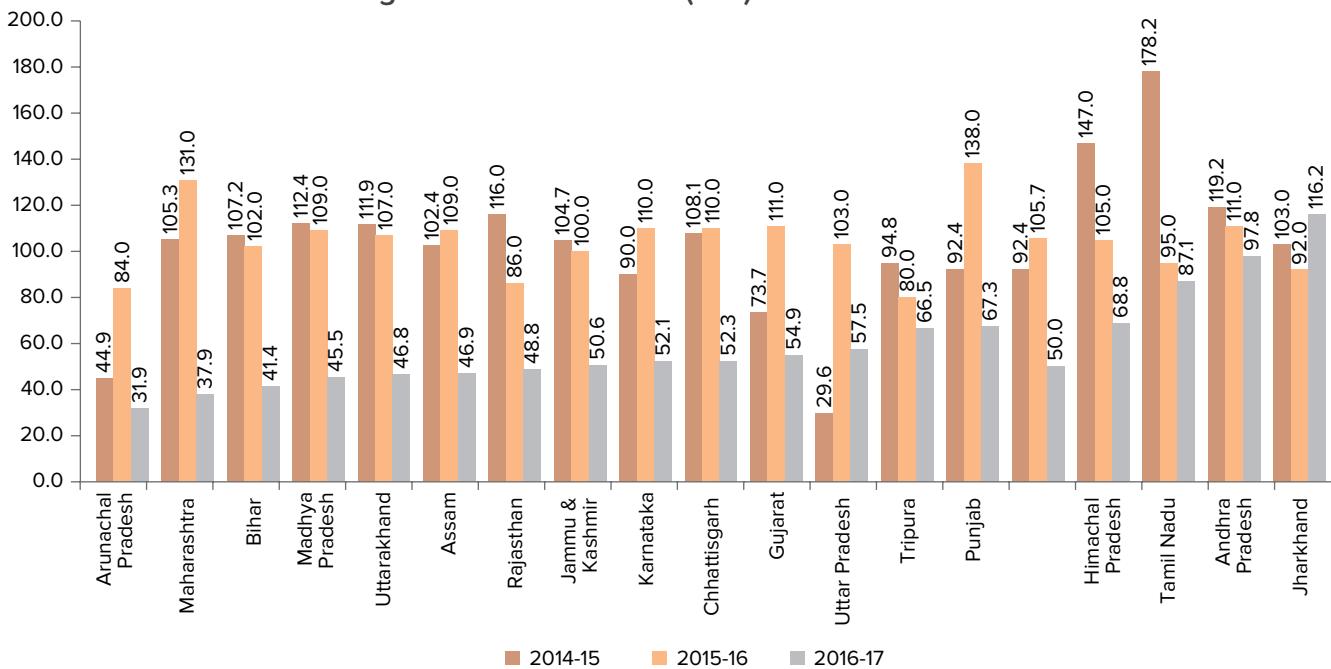
Source: National Health Systems Resource Centre (2018). National Health Accounts Estimates for India (2015-16), New Delhi, Ministry of Health and Family Welfare, Government of India

*Estimates for two North-eastern states namely Tripura and Arunachal Pradesh is not reported due to small sample size of household at the state level.

KEY OBSERVATIONS

- ▶ The issue of shortage in finance and accounts staff seems to be resolved in most of the states visited. However, it is still a challenge for Uttar Pradesh, Uttrakhand and Tripura. Arunachal Pradesh, Bihar and Himachal Pradesh reported that the training imparted to the financial personnel at different levels of health care is not adequate.
- ▶ CRM team identified certain good practices which could be implemented in other states such as: Availability of a single agency (PIU) for construction related to health and all related procurements, initiatives like e-vittaprapah in Madhya Pradesh—a financial application developed by the state for the smooth arrangement and optimum utilization of the NHM fund and use of ASHA Performing Monitoring System (APMS) and Inventory Management System (IMS) in Assam.

Fig. 1: NHM Utilisation* (In%) across the States



Source: FMG, National Health Mission, Ministry of Health and Family Welfare, Government of India; accessed from http://nhm.gov.in/images/pdf/FMG/FMG_RTI/Central_Release_State_Share_Credited_and_Expenditure_undr_NHM.pdf

1. *Utilisation of NHM = Expenditure ÷ Centre Release+State Share
2. Release for the F.Y. 2016-17 is updated upto 15.12.2016 and is provisional.
3. Expenditure (as per FMR reported by the State/UTs) includes expenditure against Central Release, State release & unspent balances at the beginning of the year and it is updated upto 30.09.2016.

- ▶ Most of the states visited have successfully implemented Public Financial Management System (PFMS) leading to a better financial management system. In states such as Andhra Pradesh, Gujarat, Madhya Pradesh, Punjab, Tamil Nadu, Telangana PFMS coverage was 100 %. Maharashtra and Uttar Pradesh have registered coverage of 94% and 93%.
- ▶ Internet connectivity has been a problem in implementing PFMS in all the North-eastern states under the CRM i.e. Arunachal Pradesh, Assam and Tripura. In Arunachal Pradesh, proper orientation of PFMS was lacking at the facility level. In Jammu and Kashmir the transfer of funds from Block Head Quarter to CHCs/ PHCs is not being done through PFMS.
- ▶ There is still room for improvement in accounting practices in terms of bookkeeping, accounts maintenance and better management of funds especially at the facility level in states like Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jammu and Kashmir, Punjab and Tripura. Some of the common problems cited related to statement of bank reconciliation, financial reporting, maintenance of register with proper accounting and financial transactions.
- ▶ Non-compliance with statutory obligations also seems to be a prominent issue in many states already identified in previous CRM reports. Only a few states, namely Chhattisgarh and Maharashtra reported of completing the statutory audits for 2017-18. Compliance with concurrent audit was found to be poor across all the states barring Maharashtra.
- ▶ Delay in transfer of funds from State treasury to State Health Societies (SHS) continues to be a major problem for most states visited. Delay of 30-45 days in Bihar, 18-86 days in Chhattisgarh, 36 to 215 days in Jammu and Kashmir, 53-124 days in Maharashtra, 25 days in Punjab, 10 to 144 days in Rajasthan, 25 days in Tripura and 60-70 days in Uttrakhand were noted. Delay was also reported from state health society to district level in Andhra Pradesh, Bihar, Himachal Pradesh and Telangana. This delay in disbursal had a direct effect on utilisation of these funds for different health programmes.
- ▶ Timing of fund disbursal under JSY programme has been a problem in a few states. In Assam, payments to JSY beneficiaries were pending in all the health facilities visited. In Himachal Pradesh there was no listing/systematic identification of the eligible beneficiaries who hadn't received the JSY benefits. In Uttar Pradesh, there was delay in payment of JSY beneficiaries at all level. In Maharashtra delay ranging from 10-40 days was observed in transfer of benefits under JSY as the payments were processed at different levels of care/ service. A major portion of delays were also attributed to absence of PFMS validation for bank accounts with co-operative banks. States like Madhya Pradesh, Rajasthan and Telangana have reported positive results as there was no delay in payment to JSY beneficiary as well as incentive amount paid to ASHA.
- ▶ The dissemination of 'district RoPs' was reported only in few states such as Rajasthan, Uttrakhand and Karnataka. In the absence of district RoPs fund allocation to the lower facilities becomes difficult and leads to delay in fund transfers, which ultimately leads to lower utilization of funds by CHCs and PHCs.
- ▶ Utilisation of untied funds under VHSCN remained an issue in states of Bihar, Assam, and Uttar Pradesh. Numerous factors such as management of funds, transfer of funds, community involvement and role played by PRI have all been instrumental in under utilisation of untied funds in these states.
- ▶ Majority of the states visited during CRM, reported of OOPE incurred by households due to purchase of medicines and diagnostic services or utilization of services from private sources. Not much information was collected on implementation of insurance programme to reduce OOPE in the states. Only states like Maharashtra, Tamil Nadu, Gujarat, Jharkhand and Rajasthan have mentioned name of health insurance scheme functional in the state.
- ▶ Utilisation of funds at the district level varied across the states for the year FY 2017-18. In Bihar utilization ranged from 51% to 57% for NHM funds and 28% to 9% for NUHM. In Karnataka,

utilization ranged from 65% to 85%. Utilisation of funds in Maharashtra was low and it ranged from 19% to 26%. Similarly in Uttar Pradesh, it ranged from 35.5 % to 43% in two districts for the FY 2017-18.

- ▶ Role of RKS as well as management of RKS funds needs further attention. The present study identifies issues pertaining to non-utilisation of RKS funds to improper fund management. In Bihar, Chhattisgarh and Himachal Pradesh, user charges of RKS are kept in cash and there is no register maintained for accounting RKS funds.

RECOMMENDATIONS

- ▶ States should ensure timely release of funds from the Treasury to the SHS accounts along with the State share for effective utilization of funds. Similarly, the SHS should also release funds to District Health Societies (DHS) in a timely manner.
- ▶ There should be timely dissemination of RoPs and District Health Action Plans for better planning, rational allocation and timely release of funds.
- ▶ Steps must be taken for improvement in accounting practices in terms of bookkeeping, accounts maintenance and better management of funds especially at the facility level. States have to address the issue of bank integration and ensure synchronization to avoid transaction delays.
- ▶ More efforts required for improving the RKS programme. The state needs to utilize the RKS funds for patient welfare or for any urgent medical needs at the facility level. The RKS requires to be strengthened as an accountability structure for quality of care and should be developed as a mechanism to sustain the quality standards.
- ▶ The States facing problems in implementation of PFMS due to internet connectivity should also liaise with the concerned Government departments to address the issue.
- ▶ It is pertinent to implement programmes to reduce OOPE due to expenses on medicine

and diagnostic tests. States should strengthen the implementation of programmes such as free Drugs and Diagnostic Schemes and the JSSK scheme. States should also take steps in implementing the health insurance programme for the poor such as PMJAY.

- ▶ Other recommendations including those that were made in the previous CRM and have not been addressed by most States and require immediate attention are:
 - ◆ The recruitments of finance personnel and accountants positions need to be completed at the district level on a priority basis to ensure bookkeeping and better management of funds.
 - ◆ Capacity building on PFMS training is essential for accounts staff at the district and block levels for reporting and managing expenditure in a more efficient way.
 - ◆ States need to address delays in the transfer of funds under JSY, JSSK such that the benefits reach target groups on time and also make timely payments to staff and ASHA incentives.

STATE SPECIFIC FINDINGS

Andhra Pradesh

- ▶ Delay in fund transfer from SHS to DHS. Utilisation rate at the facility level in the last three years was 59%, 53% and 63% respectively.
- ▶ All the health facilities were covered under Public Financial Management System (PFMS) in both the Districts visited.
- ▶ Fund distribution from state to the districts is uneven and not based on the actual utilization rates.

Arunachal Pradesh

- ▶ The financial management system was followed properly in terms of maintenance of Books of Accounts and other records at District Hospital level. But at lower facility-levels accounts maintenance is still a challenge.

- ▶ Utilization of JSSK, JSY, RKS funds & Untied Funds needs further improvement.
- ▶ Re-fresher training on PFMS implementation is required at State level for concerned employee of DHS, CHCs and PHCs. The problem of Internet connectivity to implement the PFMS system at CHCs and PHCs was rampant in the state.
- ▶ OOPE on diagnostics and medicine is a common grievance of all the patients visiting the hospitals.

Assam

- ▶ PFMS have been implemented in entire State up to facility level. State has developed software like FMS, HRMIS, ASHA Performing Monitoring System (APMS) and Inventory Management System (IMS).
- ▶ JSY beneficiaries payments were pending in all the health facilities. Moreover, around 20 percent of payment to JSY beneficiaries were made without proper cross verifications.
- ▶ Under-utilization of Untied funds for VHSNCs due to lack of training among ANMs and ASHAs.
- ▶ Absence of training of accounts and finance staffs for long time. There are vacant positions of account department both at block and facility level.
- ▶ Facility level accounts are maintained manually. Stock register (other than medicine) are not maintained at the facilities visited.

Bihar

- ▶ It takes around 30-45 days to transfer funds from State Treasury to SHS and one month for transfer from SHS to DHS. Lastly, from DHS it takes another one month for transferring the funds to concern peripherals.
- ▶ In the study area utilization ranged from 51 % to 57% for NHM funds and for NUHM funds it was 28% to 9%.
- ▶ All operational accounts have been mapped on PFMS. Payments for ASHA and beneficiaries

are being made through PFMS. But there is difficulty in the management of PFMS due to changing of FMR Code and inter locution of new FMR code. PFMS is also affected by poor internet connection.

- ▶ There is shortage of Accounts and Finance personnel at facility level which affects the quality of work. Accounting practices were not upto mark as ledger or bank reconciliation statement was either absent or not prepared properly at the health facilities.
- ▶ The statutory auditor has been appointed at State level for all districts. TDS is not deducted on due date.
- ▶ All essential drugs/diagnostic facilities are not available at PHCs/Districts hospitals and thus the patient purchases the medicine from the private medical store which leads to high OOPE.

Chhattisgarh

- ▶ Delay in the transfer of funds from State Treasury to SHS with average delay of 30-60 days for the FY 2018-19 was seen. These delays have its impact on utilization of funds.
- ▶ The PFMS has been implemented upto the District level and the funds are transferred through PFMS.
- ▶ Accounting practices were no up to mark as manual cash book in all the facilities was not updated. The Bank Reconciliation statement was not prepared by all the facilities.
- ▶ Delay in finalisation of the audit report as statuary audit report for the F.Y. 2017-18, is not yet submitted by the State to the Ministry. Concurrent audit is held on monthly basis but irregularities were observed in the account.
- ▶ Different formats of FMR / SoE are being used for reporting at different facility levels creates confusion in the compilation of expenditure data.
- ▶ Management of RKS funds is an area of concern as user charges collected at all the facilities are per the prescribed rates under RKS, is not

deposited in any facility on a daily or weekly basis. There is no prescribed accounting practices followed for RKS funds.

- ▶ The financing staffs have not been provided any training resulting to lack of clarity regarding the financial management practices under NHM.

Gujarat

- ▶ Facilities didn't face any problem in utilization of NHM funds.
- ▶ Statutory audit report for the financial year 2017-18 has not submitted to the concerned authorities.
- ▶ PFMS system is fully operational in the state as it has registered 100% of the agencies in PFMS. The State has started expenditure filing (including DBT and non-DBT payments) on PFMS
- ▶ Books of accounts are maintained for user charges and utilization of user charges after approval of the concerned authority.
- ▶ Availability of a single agency (PIU) for the construction related to health and all related procurements on a rate contracted basis have prevented procedural delays, informal payments, poor quality work etc.
- ▶ Health Insurance Scheme for BPL Cardholder has been implemented in the State.

Himachal Pradesh

- ▶ Delays in the distribution of funds to district level due to parking of funds at the state health society level.
- ▶ Funds were transferred from districts to blocks on a lump-sum basis under the flexible pools, not activity-wise as desired.
- ▶ Statutory Audit for the year FY 2017-18 had not been done and State had submitted the Statutory Audit Report along with Audited UCs for the F.Y. 2016-17 to the Ministry. The concurrent audit was also not held on regular interval.

- ▶ Most of the positions in the State under finance have been filled. But it was observed that the capacity of finance personnel at various levels needed improvement and there was hardly any training.
- ▶ There was no listing/systematic identification of the eligible beneficiaries who hadn't received the JSY benefits. Payments were made to beneficiaries of JSY only on demand and effort was missing to ensure that JSY eligible women get their benefits before leaving the hospital.
- ▶ User charge was collected under RKS scheme at the facility level but not much was reflected when it comes to spending this money.
- ▶ OOP expenditure incurred in buying drugs and diagnostic facilities. The state is yet to implement 3Ds- Free Drug, Diagnostics and Diet Services initiative comprehensively and upto PHCs & SC level.

Jammu and Kashmir

- ▶ Delays in fund transfer from State Treasury to SHS by 36 to 215 days in the year FY 2017-18 and for the year FY 2018-19 delay was 62 to 78 days.
- ▶ The untied funds for the current financial year have not yet been released by the SHS.
- ▶ The submission of the Statutory Audit Report by the State for the FY 17-18 is pending.
- ▶ The Audit of Rogi Kalyan Samithi (RKS) covered only untied funds and not the user charges collected by the facilities.
- ▶ The provisions of Tax Deducted at Source (TDS) are not being properly complied within most of the facilities.
- ▶ Expenditure filing (payments to vendors) is not being done through PFMS in most of the facilities.
- ▶ In most of the facilities, only cashbooks are being maintained and no ledgers being maintained at CHC/SDH, PHC, SC levels.
- ▶ There are long standing vacancies of Block Accounts Manager.

- ▶ The pick-up facility to the mothers though available but most of the mothers could not utilize such facility due to unreachable helpline numbers.
- ▶ Out of pocket expenses were reported due to different diagnostic tests and medicines from private providers.

Karnataka

- ▶ Only 65% expenditure was done in FY 2017-18 out of the sanctioned ROP in district Udupi. Only 85 % budget is utilised out of sanctioned ROP in Chikmagalur; The utilization of available funds needs to be improved.
- ▶ Activities of regular programmes (e.g. financial assistance to TB patients through Nikshay) should continue without waiting for ROP sanction.
- ▶ There is a need for monitoring sub-district level release of funds after getting ROP.

Madhya Pradesh

- ▶ PFMS has 100 % coverage in the state. Most of the payment practices are Aadhar linked in both the Districts. Regular Finance Review meeting (Once a month) are conducted at sub-district level.
- ▶ The state government has taken initiative to improve the financing system with e-vittaprawaha – a financial application which is developed by the state for the smooth arrangement and optimum utilization of the fund. This system is linked with the PFMS.
- ▶ There was no delay in payment to JSY beneficiary as well as incentive amount paid to ASHAs.
- ▶ State's share of NHM fund was released on time. The utilization rate at the district level was more than 70 % of the total budgeted amount.
- ▶ RKS meeting were held once in a month at the district. RKS account was kept in a separate account in the facility.

Maharashtra

- ▶ Delays in fund transfer from State Treasury to State health society in the range of 53 days to 124 days.
- ▶ Funds were transferred from State treasury to Director Health Services and further to the account of State Health Society through RTGS, through a cumbersome 12-step process.
- ▶ Utilisation of funds was low and it ranged from 19% to 26% in 2017-18. Further, in 2018-19 even after passing of 4 months, maximum utilization reported in different pools was 5.78 % only.
- ▶ PFMS coverage in the state was more than 90%. The State has effectively implemented EAT (Expenditure, Advance and Transfer) module.
- ▶ Books of Accounts were maintained at all levels but more capacity building is required at periphery levels like at PHC, Rural Health (RH) Centre and Sub Divisional Hospital (SDH) for both account maintenance and updation.
- ▶ The statutory audit was being conducted in the state. Concurrent Auditors for the FY 2018-19 were appointed in both districts visited and audit has been undertaken in most of the visiting facilities. Separate Audit of RKS for 2017-18 was also conducted.
- ▶ Delays ranging from 10-40 days were observed in the transfer of benefits under JSY and Family planning as the payments were processed at different levels than point of care/service.
- ▶ Health insurance scheme for poor named Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) has been operational in the state since 2017.

Punjab

- ▶ Delay in fund disbursement as it takes around 285 days for the funds to move from State Treasury to SHS. In SHS, 72 bank accounts are operational which is not as per the norm given in national guidelines.
- ▶ Numerous measures to reduce OOPE has been initiated in the state and it includes free

drugs, diagnostics, blood and transport but significant OOPE is still there.

- ▶ PFMS coverage is 100 % and all the transactions are made through PFMS system.
- ▶ Bank reconciliation statements are updated.
- ▶ No Unique Transaction Receipt number mentioned leading to difficulty in tracking the payment to the beneficiary.
- ▶ High OOPE is mostly driven by very high reliance on private services in the state.

Rajasthan

- ▶ There has been delay in the transfer of funds from State Treasury to SHS. In 2017-18 it took 10 to 144 days for transfer of funds. In the year FY 2018-19 there was some improvement still it took 31 to 47 days for the transfer.
- ▶ All the funds are being transferred from the State to the Districts via PFMS. RTGS/cheques have been used to transfer funds from Primary Health Centre to lower peripheries as like Sub Centre and VHSNCs. State has effectively implemented EAT (Expenditure, Advance and Transfer) module.
- ▶ Books of Accounts are maintained very well. Cash books, Ledgers and Bank Reconciliation statements are in order.
- ▶ ASHAs payments are regular, accurate and satisfactory. ASHAs were satisfied in terms of timely settlement of their incentives.
- ▶ Bhamashah Health Insurance Scheme is operational in the state since 2015. The purpose of this scheme is to reduce the burden of high OOPE.

Tamil Nadu

- ▶ Utilization of funds out of total allotted money in both the studied districts exceeds 60% in most of the items under NHM for the year 2017-18.
- ▶ Books of Accounts are maintained properly. However, at the community level the VHSNC untied funds need to be managed and

documented properly. All the fund transfer take place through PFMS.

- ▶ ASHA benefits, as well as JSY payments, are being done through DBT.
- ▶ Payment to the WHVs is being transferred as a corpus to the concerned corporations.
- ▶ No user fee at the facilities whatsoever as a result OOPE at the facility level is almost nil.
- ▶ Health insurance scheme run by the government also known as Chief Ministers Comprehensive insurance scheme is operational in the state.

Telangana

- ▶ There was a delay in the release of the approvals for districts from the state. One common concern was these funds were released to districts activity-wise instead of pool wise disbursement.
- ▶ All JSY, ASHA incentives, and vendor payments are processed through PFMS in both Districts and there was no delay in payments of JSY beneficiaries and ASHA incentives.
- ▶ Non-adherence to auditing practice has affected the fund flow from centre to state.
- ▶ Funds were not released to the State during the FY 2017-18 and 2018-19 under NUHM due to high unspent balance under this programme.
- ▶ TDS is not deducted for all applicable payments at the district level and bank reconciliation is not maintained at health facilities below District level.
- ▶ Physical progress against the financial achievement is not reported in FMR at District level and differential financing mechanism is not used at District level for disbursing RKS/ Untied/ AMG funds

Tripura

- ▶ There was a delay of around 25 days in releasing NHM funds from State Treasuries to SHS.

- ▶ PFMS coverage in the state has reached 100%. However at the District Hospital, internet facility is not continuous. DBT has also been implemented and the payment is done accordingly.
- ▶ Untied funds are being utilised appropriately at all the levels from SC to District hospitals. At the SC level, the stock registers are not complete.
- ▶ There was a lack of coordination and communication between the State and the districts in financial reporting.
- ▶ The accounting staff at DH was overburdened with extra work. This has led to delays in the regular accounting work and needs to be remedied urgently.
- ▶ There is a delay in the audit process. Auditors were not appointed in time leading to delay in overall process.
- ▶ High OOPE was reported by those utilising the public facilities. Medicine constituted a major chunk of OOPE for the households going for these treatment.

Uttar Pradesh

- ▶ Delay in disbursement of funds as the substantial amount was parked with the state government. Around Rs. 204 crore of 2017-18 was parked with the government treasury.
- ▶ Utilizations of funds range from 35.5 % to 43% in two districts for the FY 2017-18.
- ▶ Unspent Balance was available in the bank account at all VHNSC and Sub Centre. There is a need to monitor these funds for timely utilization at all level. Delay in payment of JSY beneficiaries was also observed.
- ▶ The state has implemented PFMS up to PHC level and has registered 93% agencies much higher than the national average of 89%.
- ▶ Books of account are maintained both manually as well as in computerized format. These accounts were authenticated by DDO.
- ▶ Bank Reconciliation Statements are prepared at all levels. RKS book of Accounts maintained at

Varanasi District Hospital but it didn't follow proper tender/quotation system for utilization of funds.

- ▶ Statutory Audit Report for the FY 2014-15, 2015-16 and 2016-17 are not yet to be put up in GB meeting. The concurrent auditors were not provided the detailed financial observations in the report.
- ▶ Many of the finance posts in the state are vacant and it includes positions such as Senior Manager, District Account Managers and Block Account managers. Apart from vacant position it was observed that there is a strong need for reorientation programme for the existing staffs.
- ▶ High OOPE was reported mostly due to reliance on costly private health facilities. People preferred going to private services as it was physically more accessible as compared to government facility also people felt that private services were safe.

Uttarakhand

- ▶ Delay in release of funds by State Treasury by almost 60-70 days before it reaches the SHS.
- ▶ PFMS is implemented up to Block level. Bank Reconciliation statement prepared at all levels and funds transferred from state to district to blocks as Flexi pool.
- ▶ Books of accounts are being maintained at all levels both manually as well as computerized overseen by MO I/C and CMO.
- ▶ High unspent balances at the district level is hardly followed by any kind of internal reviews. Many times, funds remain unutilised as Grants are sent to districts without any prior intimation or directions on how to use it.
- ▶ ASHA Payments in both districts was made mostly in March 2018 and very few payments thereafter. JSY payments are prompt at Blocks (3-4 days), but it took longer time in District Hospital (cross 15-20 days).
- ▶ Significant OOPE noticed in both districts visited due to expenses on Drugs- even those available in District Hospital, Diagnostics, and Informal expenses.



Team Composition and Facilities Visited



Mahindra
Mitsubishi
Fuso

TEAM COMPOSITION ANDHRA PRADESH

Team members – Ananthapuramu	Team Members – East Godavari
Dr. Dinesh Baswal, DC(MH), MoHFW, Team Leader	Dr. Rajesh Kumar, Asso. Prof, NIHFW
Dr. Praveen Davuluri, Consultant, NHSRC	Dr. Shanta Achanta, WHO
Dr. Surajit Choudhury, Consultant, RRC-NE, NHSRC	Mr. Rajnish Ranjan Prasad, SPO Rajasthan, UNFPA
Dr. Mahesh Gorla, WHO	Mr. Rudra Prasad Pradhan, Technical Specialist, PSI
Mr. Hari Krishnan K, Consultant, Finance	

FACILITIES VISITED ANDHRA PRADESH

Types of Facilities & Activity	Ananthapuramu	East Godavari
Community interaction	Ramachandra puram village Kotipi village; Lakshmiapuram Urban slum, MMU services.	Dhumalpeta, Narsapuram, Andrapalli, Antarvedi devsathanam, urban area Amalapuram, Ramarao peta
SC	Kotipi SC	Nandrada, Tamarapalli, Narsapuram, Antarvedi devsathanam,
PHC	Chowluru PHC, Lepakshi PHC	Maredumalli, Lakkavaram
CHC	CHC Penukonda	
Area Hospital (AH)		Amalapuram, Rampachodavaram
DH	Hindupur	Rajmundry
Teaching Hospital	GGH Medical college	Kakinada

TEAM COMPOSITION ARUNACHAL PRADESH

District - Papumpare	District – East Siang
Dr. J N Srivastava (TL)	Dr. Shahab Ali Siddiqui
Dr. Aboli Gore	Dr. Anil Kumar Gupta
Dr. Jagjeet Singh	Dr. Kapil Singh
Dr. Palash Talukdar	Dr. Prairna Koul
Finance Consultant - Sumit Kumar	

FACILITIES VISITED ARUNACHAL PRADESH

District Hospital	TRIHMS Medical College	District Hospital, Pasighat
Mission Hospital	R K Mission Hospital	—
CHC	Kimin, Doimukh, Sagalee	CHC (FRU) Ruksin
PHC	Poma, Jote, Chiputa	PHC Bilat
UPHC	Itafort	UPHC Baskata
Sub Centres/ Anganwadi Centre	SC Khamir, AWC Lekhi – I & II, Bokring	Niglok, Mirem, Miglung
Villages	Poma, Relo	Ayang, Mirem

District Hospital	TRIHMS Medical College	District Hospital, Pasighat
Urban Slum	Harekmaal Colony	Ward 12, Ward 11
FGD with	WRA, Adolescents, mixed group >30 yrs, ASHAs (5), ANMs, PRI/local leaders,	WRA, Adolescents, mixed group >30 yrs, ASHAs (2), ANMs, PRI/local leaders

TEAM COMPOSITION ASSAM

District – Kamrup Rural	District – Barpeta
Dr. Sila Deb (team leader)	Mr. Padam Khanna
Dr. Sandra Alber	Dr. Ashalata Pati
Dr. Vandana Mishra	Dr. Sanjiv Trehan
Dr. S Singh	Ms. Indu Kapoor
Mr. Sumanta Kar	

FACILITIES VISITED ASSAM

	Barpeta	Kamrup Rural
Villages	Bilasipara, Hazipara, Pather, Satra Kinara – (4)	Futuri 1, Futuri 2, Futuri 3, Naitor Khola Reserve, Halogaon, Singarpara (6)
Schools and AWC	Nabajyoti higher secondary schools (1)	Singarpara AWC, Baredola AWC No. 22,
Boat Clinic/ MMU	Boat clinic 2 in Mandia block (1)	MMU (at Baredola) (1)
Health and Wellness Centre and SCs	Hazipara HWC and Bilasipara HWC, Gomura SC (3)	Futuri H & WC, Singarpara SC (2)
PHC/MPHC	Roha PHC, Gomura PHC (2)	Halogaon MPHC, Nitor Kalyan pur MPHC, (2)
SDH/ BPHC/CHC	Pathsala SDH (FRU) and Howly CHC (2)	BPHC Nagarbera, Rangia SDH / BPHC (FRU), Bihdia BPHC, Boko CHC (FRU) (4)
DH	Barpeta Civil Hospital, Kalagachia (1)	T B K Civil Hospital (1)
Medical colleges	Barpeta Medical college (1)	Guwahati Medical College (1)

TEAM COMPOSITION BIHAR

Rohtas District	Muzaffarpur District
Dr. KL Sahu, DHS MP (Rtd.)	Dr. Naresh Goel, DDG NACO
Dr. Ameet Babre, Lead Consultant, Family planning division, MoHFW, Gol	Dr. Shailey Gokhale, Consultant, NHSRC
Dr. Disha Agrawal, Consultant, NHSRC	Dr. Brijesh, UNICEF
Dr. Shazia, WHO RNTCP Consultant	Dr. Rupinder Sahota, Consultant, NHM Haryana
Mr. Mahtab Alam, Consultant, JSK	Dr. Kumar Gaurav, WHO RNTCP consultant
	Mr. Mahtab Alam, Consultant, JSK

FACILITIES VISITED BIHAR

Facility	Rohtas District	Muzaffarpur District
District Hospital	DH Sasaram	DH Muzaffarpur
Medical College	Skill lab PMCH, Patna	SKMC
Referral hospital	SDH Dehri, New Gardener Hospital (MIC)	Sakra
PHC	Kochas, Rohtas, Nokha, Nauhatta, APHC Chakanwah,	APHC Sihoh, CHC Sakra
HWC	UPHC Takiya, APHC Barauah	APHC Sihoh
Sub centre	Kathrayin, Kapasiyan, Barauah	Sihoh, Pigambarpur
Villages/ Community interaction	Kathrayin, Kapasia, Sweeper colony	Musahri block, Rajwada, Sihoh, Paigambarpur
Schools	Rajkiya Madhyakrit Vidyalaya, Utkramit Madhya Vidyalaya	
AWCs	Barauah 1, 2	Sihoh, Pigambarpur

TEAM COMPOSITION CHHATTISGARH

Team Raipur	Team Korba
Dr. P.K. Prabhakar, Deputy Commissioner - Child Health, MOHFW	Dr. Santosh K. Gupta State TB Officer, Uttar Pradesh
Dr. Vishal Kataria Lead Consultant - Child Health, MOHFW	Mr. Arun Srivastava Sr. Consultant, NHSRC, MOHFW
Dr. Honey Arora Consultant - NUHM, MOHFW	Dr. Aishwarya Sodhi Consultant - Maternal Health, MOHFW
Dr. Ravindra Sharma CARE, BIHAR	Dr. Neeta Rao - Sr. Advisor, Health USAID
Ms. Isha, Finance Consultant, MOHF	Dr. Mangesh Gadhari, Health Officer UNICEF, Mumbai
Dr. Kshitij Khaparde, WHO RNTCP Representative	Dr. Nishchit Rajashekaran, WHO RNTCP Representative
Dr. Chinayee Dash, State Consultant, NVBDCP Chhattisgarh	

FACILITIES VISITED CHHATTISGARH

	District Raipur	District Korba
Community	Hasda Village, Manikchori village, Shivpara urban slum, Durga nagar Bhatagaon, urban slum Chandrashekher, urban slum & AWC Dhaneli, Government Primary School, Hasda Government Primary, Middle School Dhaneli	Singhali village, Kadamjharia village Parsabhatta urban slum, Madhai village, Abhaypur village
Sub Center/ SSKs	Dhaneli HWC (SCs), SSK Bhatagaon, SSK Mandigate	Dhelwadih HWC (SC), Madhai SC, Gadhuproda SCs, SSK 15 Block,
PHC / UPHC	Manikchori HWC (PHC), Bhatagaon UPHC, Mova HWC (UPHC)	Lehmaru HWC (PHC), PHC Korba Rani Dhanraj Kunwar Devi UPHC, Dhelwadih HWC (PHC), HWC Dolipara & Gopalpur, Nursing Home Navjeevan
CHC / UCHC	CHC Tilda (FRU), UCHC Birgaon	CHC Katghora
DH	District Hospital Raipur, District Hospital MCH Wing	District Hospital Korba
Medical College	Dr. Bhim Rao Ambedkar Memorial Hospital, Raipur	

TEAM COMPOSITION GUJARAT

Dr. Alok Mathur (Team Leader) MoHFW New Delhi	Dr. Jyoti Baghel Singh, MoHFW New Delhi
Prasanth Subrahmanian, NHSRC New Delhi	Mantu Kumar, FMG NHM MoHFW New Delhi
Dr. Leela Visaria, GIDR Ahmedabad	Dr. Hiren Thanki, WHO India
Dr. Hariprakash Hadial, MoHFW New Delhi	

FACILITIES VISITED GUJARAT

Narmada	Porbandar
Anganwadi- kakarpada FGD Discussions – ANC, PNC Adolescent	Community Walk – slum area of Subhashnagar and ZararaNes FGD Discussions – ANC, PNC women, Adolescent Girls and Boys, Elderly (women and men), School children (age 7-12), ASHA at PHC Mahila Arogya Saminti (MAS) members – Shitla Chowk UHC
Narmada	Porbandar
Sub Center – Savali and Kakrapada	Subcentre – Zarara Nesh (PHC Bileshwar), Kuchdi (Visavada)
PHC – Bujetha, Gangapur UPHC – Narmada	PHC Mahiyari, PHC Garej, PHC Visavada, UHC Subhashnagar, Shitla Chowk
CHC Garudeshwar & Sagbara	CHC Advana
District Hospital Narmada	District Hospital Porbandar
DPMU, DHS, RDD Vadodara	DPMU and DHS, GVK EMRI boat ambulance
SSG Medical College, Vadodara, SIHFW, DTT – Vadodara	Collector cum District Magistrate, DDO

TEAM COMPOSITION HIMACHAL PRADESH

Bilaspur	Chamba
Dr. Bina Sawaney	Dr. Raman
Dr. Vinay Bothra	Dr. Ravinder Kaur
Dr. Ravinder Kumar	Dr. Yashika Negi
Mrs. Pallabi B Gohain	Dr. Rochak Saxena
Mr. Arpit Singh	Mr. Arpit Singh

FACILITIES VISITED HIMACHAL PRADESH

Team Bilaspur	Team Chamba
1. Village Sukdi	1. Village Chudra (Panchayat Thakri Matti)
2. Village Kunala, Community near AIMMS	2. Community near Dalhousie
3. SC Majari	3. SC Majhli Malal
4. SC Kunala	4. HWC Sundla
5. AWW Centrelakhimpur, Kunala	5. HWC Samote
6. PHC Toba, Rishikesh, Rajpura	6. CHC Salooni
7. CHC Talai	7. CH Kihar
8. CH Ghwandal	8. CH Dalhousie
9. CH Ghumarwin	9. DH Chamba
10. RH Bilaspur	

TEAM COMPOSITION JAMMU AND KASHMIR

Doda	Kupwara
Dr. Nupur Roy, MoHFW (Team Leader)	Dr. Sanjay Mattoo, MoHFW (Team Leader)
Dr. Jaspal Kaur – DHS	Dr. Neha Dumka, NHSRC
Dr. Lokesh Alahari – SRTL, WHO	Dr. Ashish Bhat – MOHFW
Dr. Sanjay Arora, WHO	Dr. Pragya Dube – PSI
Deepak Kumar – MOHFW	Dr. SadabBoghani – MOHFW
Dr. Jagdish Patil – MOHFW	Dr. Tasnim Syed – WHO
Sh. Shivam Jain, Consultant – Finance, MoHFW visited both the District	

FACILITIES VISITED JAMMU AND KASHMIR

	Kupwara	Doda
District Hospital	DH – Handwara	District Hospital, Doda
CHC	SDH Kupwara, SDH Kralpora, SDH Tangdhar, SDH Sogam	Block CHC, Bhaderwah
PHC	PHC Teetwal, PHC Lalpora, PHC Panjgam	Block PHC, Ghat
HWC/SC	HWC – Chandigam, HWC Putshai, HWC – Wavoora.	HWC Daranga
SC	SC Shulooora	
AWC	AWC Wavoora	
Others	Govt Primary school Sogam, DH-Baramulla, Kashmir Skill Simulation Center, Interacted with community and Frontline Workers	Royal Academy Islamia High School, Ghat Interacted with community & ASHAs at Bhaderwah, Chinta, Ghat

TEAM COMPOSITION JHARKHAND

Ranchi	Bokaro
Dr. J L Mishra	Dr. Teja Ram
Dr. Ajitkumar Sudke	Ms. Indhu
Mr. Juned Kamal	Dr. Mushtaq Dar
Ms. Arti Pandey	Ms. Ima Chopra
Dr. Rajabhau Yeole	Dr. Rajabhau Yeole

FACILITIES VISITED JHARKHAND

Facility/Community	Ranchi	Bokaro
Community Visit	Kakdaro Village, Kanke Block; VHND, Pancha Village, Bundu Block	Kura village, Chas Block; Sarubera village (Ganju Tola, Bhalmar Panchayat), Nawadih Block; VHND – Village Kumari, Chas Block
SHC	Taimara, Bundu Block	Chapri, Nawadih Block
HWC-SHC	Kakdaro village, Kanke Block	Kurra village, Chas Block

Facility/Community	Ranchi	Bokaro
HWC-PHC	Pithoriya, Kanke Block	Pindrajora, Chas Block
UPHC	Bada Ghaghra	UPHC Jhopdri Colony (urban slum), Ritudih, Chas Block
CHC	Ratu CHC; Sonahatu CHC	CHC – Nawadilh Block; CHC – Chas Block
UCHC	Doranda, Ranchi	NA
SDH	Bundu SDH	Sub divisional Hospital, Chas Block
Malnutrition Treatment Centre	SDH Bundu, UCHC Doranda, Ranchi	Chas Block
DH	Sadar Hospital	Sadar Hospital
Medical College	Rajendra Prasad Institute of Medical Sciences	NA
Miscellaneous		Bokaro General Hospital; Drug Warehouse Bokaro

TEAM COMPOSITION KARNATAKA

Chikmagalur	Udupi
Dr. Sudhir Gupta	Ms. Kavita Singh
Dr. K R Antony	Dr. Bhavnish Arora
Dr. Prakash Vaghela	Dr. Sunny Swarnkar
Dr. Richa Kandpal	Dr. Suhas Kadam
Dr. Rajeev Pathak	Dr. Spoorthi Gowda

FACILITIES VISITED KARNATAKA

Community Interaction		
Chikmagalur	Udupi	
1. ASHA (2) 2. Adolescent (1) 3. 15-49 year women (2) 4. PRI/Stakeholders (2) 5. House hold interactions 6. ANM (2) 7. AWW (2)	1. ASHA (1) 2. ANMs (1) 3. Adolescent girls group (1) 4. PRI/RKS (ARS – Arogya Raksha Samiti) (2) 5. MAS members under UPHC2 Manipal 6. AWW & ASHAs of UPHC2 Manipal	
INSTITUTION		
	Chikmagalur	Udupi
Sub Centre/AWC	1. Halamuthur 2. Suryadevasthana 3. Garje 4. Aatigere (AWC)	1. Ballur 2. Ballur (AWC) 3. Manipal (AWC) 4. Mudradi

	Chikmagalur	Udupi
PHC / UPHC	1. Kammaradi 2. Hirekodige 3. Lingadahalli 4. Hulikere 5. Garje 6. Chikmagalur (UPHC)	1. Bayundoor 2. Kandalur 3. Kadri Lady 4. Manipal (UPHC) 5. Mangalore (UPHC)
CHC	1. Birur	1. Bayandur 2. Kota
Taluk Hospitals	1. Narasimha Rajpura 2. Kadur	1. Kundapur
District Hospitals	1. Chikmagalur	1. Udupi 2. KSSM MCH Hospital
Others	1. Urban slums 2. District Early Intervention Centre, Chikmagalur 3. Blood Bank / Blood Storage Units 4. District Magistrate Office 5. District Health Office	1. Health Kiosk Shaktinagar, Mangalore 2. District Magistrate Office 3. District Early Intervention Centre, Mangalore 4. Blood Bank and District Hospital Udupi 5. Blood Storage Units and MCH Hospital, Udupi

TEAM COMPOSITION MADHYA PRADESH

Dr. Suman Lata Wattal	Mr. Bhaswat Das
Dr. Prakash R. Deo	Ms. Bhanu Priya Sharma
Dr. P. K. Srinivas	Ms. Mitakshi, MoHFW
Dr. Raghunath Prasad Saini	Dr. Ravi Prakash

FACILITIES VISITED MADHYA PRADESH

Category	Betul	Rajgarh
District Hospital	DH Betul	DH Rajgarh
Civil Hospital (SDH)	–	Civil Hospital, Biaora
CHC	CHC Amla, CHC – Multayi (addl) CHC – Sehra, CHC – Bhaisdehi (addl)	CHC, Jeerapur
HWC	PHC/HWC – Bordehi, PHC – Jhallar (addl), PHC – Khamla (addl)	Arogyam – PHC, Machalpur Arogyam – PHC, Kurawar
Urban PHC	UPHC Vinobha Nagar	UPHC, Biaora
SC	SC – Chhipaniha-Piperia, SC – Parmandal	SC, Rajahedi, SC Paroliya

Category	Betul	Rajgarh
Community	Village – Bamla Village – Kuthkedhi, Village – Hethikhapa, Uddan – Village (LLIN), Urban slum – Ojha Dhana, Village – Jhambada	Village Pipalda, Village Meena Gaon, Village Manpura Dev, Urban Area – Ward 2
Others	District TB Centre, District Training Centre, ANM Training Centre	ASHA Training Centre, GNM Training Centre, District Training Centre
District level debriefing	District Collectorate	Rajgarh & Betul

TEAM COMPOSITION MAHARASHTRA

Satara	Gadchiroli
Dr. Himanshu Bhushan Advisor, PHA, NHSRC	Dr. B. S. Arora Ex-DGHS, Uttar Pradesh
Dr. V. K. Mathur DHS, Rajasthan	Dr. Pushkar Kumar Sr. Public Health Specialist, PHFI
Ms. Sumitha Chalil Sr. Consultant, MoHFW, Gol	Dr. Biraj Kanti Shome Sr. Consultant, CP, RRC-NE (NHSRC)
Dr. Aashima Bhatnagar Consultant, PHA, NHSRC	Dr. Akriti Mehta Consultant, NOHP, MoHFW, Gol
Dr. Sandeep Bharaswadkar RNTCP Consultant, WHO	Dr. Anirudha Kadu RNTCP Consultant, WHO
	Dr. Manish Gawande, Sub Regional Team Leader, WHO
	Mr. Rahul Govila Finance Consultant, NHM, MoHFW

FACILITIES VISITED MAHARASHTRA

Type of Facility	Satara	Gadchiroli
DH	DH Satara	Gadchiroli GH, District Women Hospital, Gadchiroli
SDH	Karad	Aheri, Armori
Rural Hospital	–	Vadhsa, Chamorshi
VHND site	–	Simultola AWC
PHC	Kavathe, Helwak, Nagthane	Potegaon HWC-PHC, Ghot-HWC, Mahagaon PHC, Delanbari PHC, Koregaon PHC-HWC, Delanbari PHC
Sub Centre	Bopegaon, Karhar, Shindurijane	Maroda SC, Pettola SC, Sankarpur SC, Dhodraj SC, Indaram SC
Anganwadi Centre	Bopegaon, Karhar	Potegaon, Simultola, Sriniwaspur, Allapalli AWC, Simultola AWC, Nagarbahi AWC
Villages visited for community interaction	Karhar, Shindurijane, Bopegaon	Potegaon, Simultola, Sriniwaspur, Sankarpur, Kasari, Rani Paddur, Madhutura, Allapalli, Nagarbahi,
Schools for RBSK	Godali	Zila Parishad Uccha Prathamik School, Sriniwaspur, Pettola Zila Parishad Primary School

Type of Facility	Satara	Gadchiroli
Others	Urban Slum – Joshi Gali, UPHC – Godali, District Health Training Centre, Public Health Lab, IDSP office, District TB Centre, ADHS Leprosy Office, NVBDCP Office, Kusht Vasahath	SEARCH – Gadchiroli, Lok Biradari Prakalpa, Bhamragarh, District Health Training Centre, IDSP office, District TB Centre, ADHS Leprosy Office, NVBDCP Office

TEAM COMPOSITION PUNJAB

Gurdas Pur	Moga
Dr. M.K. Aggarwal, DC (Imm.), MoHFW	Dr. J.S. Thakur, PGI – Chandigarh
Dr. Parminder Gautam, NHSRC	Dr. Bharat Jesalpura, AD, Gujarat
Mr. Ratish Kumar, MoHFW	Mr. Manish Saxena, PSI
Dr. Priyanka Agarwal, RNTCP-WHO	Dr. Pooja Kapoor, RNTCP-WHO
Dr. Mayank Shersiya, ITSU	Mr Sahil Chopra, JPIEGO
Mr. Indranil Chakravartti, MoHFW	Dr. Vikas Madaan, ITSU

FACILITIES VISITED NA

TEAM COMPOSITION RAJASTHAN

Jodhpur	Baran
Dr. Sushma Dureja, DC(AH) MoHFW	Dr. Garima Gupta, Sr. Consultant, NHSRC
Dr. Narendra Goswami, Consultant Maternal Health, MoHFW	Dr. Sridhar Prahlad Ryavanki, Health Specialist, UNICEF
Dr. Vivek Mishra, WHO, RNTCP	Latika Rewaria, Consultant NLEP, MoHFW
Dr. Sonalini Khetrapal, Health Specialist, ADB	Ms. Neha Singh, Consultant – Financial Analyst, MOHFW
Ms. Pumani Kalita, RRCNE, NHSRC	Dr. S Sinha, RNTCP, WHO
Dr. Aarti Singh, Sub Regional Team Leader, WHO	

FACILITIES VISITED RAJASTHAN

Category	Jodhpur District	Baran District
Community Interaction	Village Karnia Ki Dhaani and Rajashni	Village Semliphatak and Sorsan
MMU	MMU at DH Paota	MMU at Mayatha village
Schools	Senior Sec. School, Rajashni	Rajkiye Sr. Sec. School, Mayatha
SHC	KarnionkiDhaani,Rajashni (HWC)	Semliphatak, Sorsan (HWC)
PHC	Tewari, Bhimkaor	Mirzapur, Semrania
CHC	Mathania	Kelwara
Medical College District Hospital Satellite Hospital	Ummed Hospital & MC DH Paota Satellite Hospital, Mandor	DH Baran

TEAM COMPOSITION TAMIL NADU

Ramanathapuram	Perambalur
Dr. Basab Gupta	Dr. Mihir Mallick
Dr. Mukta Gadgil	Dr. Joydeep Das
Arindam Moitra	Dr. Prashanth Kumar
Mandar Randive	Dr. Raja
Dr. Suma	

FACILITIES VISITED TAMIL NADU

Ramanathapuram	Preambulur
Community interaction – 4 group discussion	
Health SC – 4	Health SC – Sirivachur, Perambalur, Valapadi
PHC/APHC/UPHC – 6	PHC/UPHC – Tungapuram, Labbaikudikadu, Urban PHC
TH – 1	TH – Veepur, Vepanthattai
Mental Health Centre	District Headquarter Hospital
MMU	MMU
TNMSCL District Drug Warehouse	TNMSCL District Drug Warehouse
Madurai and Chennai Corporations – UPHC, UCHC, Slums, Night Shelters	School – Kolakanatam

TEAM COMPOSITION TELANGANA

Dr. Raghuram Rao, Deputy Director (TB), MOHFW and Team Leader	Mr Satyajit Sahoo, Finance Analyst, MOHFW
Dr. Sathuluri Ramachandra Rao, Reader, NIHFW	Dr. Shweta Singh, NHSRC, MOHFW
Mr. Nikhil Herur, Senior Programme Coordinator, DELL	Dr. S Sandesh, NHM, MOHFW
Mr. Pradeep Chaudhary, SPO, NIPI-Jhpiego, Rajasthan	Dr. Sneha Shukla, Consultant (WHO)
Ms. Jayati Nigam, Health Specialist, Asian Development Bank	Dr. Jaya Krishna K, Consultant WHO

FACILITIES VISITED TELANGANA

NA

TEAM COMPOSITION TRIPURA

South Tripura	Unakoti
Ms. Mona Gupta	Dr. Archana Chowdhury
Ms. Sweta Roy	Lt. Aseema Mahunta
Dr. Mainak Chatterjee	Dr. Rajeeb Kumar Sharma
Dr. Gaotom Borgohain	Dr. Kim Patras
Ms. Priyanka	Ms Charisma Khongwir

FACILITIES VISITED TRIPURA

	South Tripura District	Unakoti District	West District (Agartala)
Villages/ Slums covered	Sukanto Nagar Colony	Panchanagar ADC Village	Gwalabasti
	Udai Hari Pada	Ramdulapara ADC Village	
	Kamalakanta Nagar	Durgapur ADC Village	
Anganwadi Centre	Notun Colony AWC	Ramdulapara AWC	Gwalabasti AWC
	Trishna AWC		
Health Sub Centre	Sukanto Nagar Health Sub Centre	Mailwong Health Sub Centre	
	Trishna Health Sub Centre	Krishna Tilla Health Sub Centre	
Primary Health Centre/ Urban PHC	Baraphthari PHC	Konica Memorial PHC	Ashrampara UPHC
		Machmara PHC	
Community Health Centre		Kumarghat CHC	
Sub Divisional Hospital	Belonia SDH	Rajiv Gandhi Memorial SDH	
District Hospital	Shantirbazaar DH	Unakoti DH	
	Goumati DH (Gomati District)		
Medical College			G B Pant Hospital/ Agartala Medical College

TEAM COMPOSITION UTTAR PRADESH

Varanasi	Farrukhabad
Dr. S.K. Sikdar	Dr. Pragati Singh
Sh. Sanjeev Gupta	Mr. Ajit Singh
Dr. Pranav Bhushan	Dr. Priya Kashyap
Dr. Nidhi Bhatt	Dr. Sanjeev Kamble
Dr. S.S. Reddy	Dr. Sanjeev Upadhyay
	Dr. Sharad Ayenger

FACILITIES VISITED UTTAR PRADESH

Facility Level	Varanasi	Farukhabad
Community	Focused Group Discussions – <ul style="list-style-type: none"> ▶ ASHA/AWW-(3), ▶ 15-49 years women (2), ▶ Adolescents (2), ▶ Panchayat members (1), House hold interactions 	Focal Group Discussions – <ul style="list-style-type: none"> ▶ Rural ASHA (3), Urban ASHA (2), ▶ 15-49 years women (1), ▶ Adolescents (1), ▶ Stakeholders (2), Men's group (1) ▶ Household Interactions

Facility Level	Varanasi	Farukhabad
Sub health Center	► SHC - Basni, Jagdishpur	► SHC- Gadalpur (HWC), Bharjhala ► (HWC)
Primary Health Center	► PHC Badgaun, ► APHC Mahagaon (HWC), ► UPHC Mandwadia (HWC)	► PHC Faizabag, Amritpur, Jehanganj ► UPHC- Bholepur, Rakabganj
Community Health Center	► CHC Azarilines	► CHC -Kayamganj, ► CHC- Kamalganj
District Hospital	► Deen Dayal Upadhyay Hospital, ► District Women's Hospital, ► Banaras Hindu University	► District Women Hospital, ► District Male Hospital

TEAM COMPOSITION UTTARAKHAND

Dr. Zoya Ali Rizvi	Dr. Harsha Joshi
Dr. Sanjay Mehrotra	Mr. Saurabh Raj
Ms. Shruti Dhara	Mr. Gaurav Kumar
Dr. Bhumika Talwar	Dr. Vikas Sabarwal
Dr. Sushant Agrawal	Dr. Sandeep Chauhan

FACILITIES VISITED UTTARAKHAND

Facilities/ Communities	Haridwar	Uttarkashi
Communities	Villages Sidhudu, Imlikheda and Shyampur, BHEL slum area including Rag pickers colony	Villages Pujargaon and Ponty
HSC	HSC Sidhudu (Laksar Block), HSC Shyampur	HSC Jaridumka, HSC Gevala
PHC	HWC/PHC Imlikheda, PHC Laldhang	PHC Dunda and APHC Brahmakhal
CHC	CHC Laksar	CHC Naugaon
SDH	SDH Roorkee	—
DH	DH Haridwar, CRWH, Mela Hospital,	DH and District Female Hospital



NATIONAL HEALTH MISSION
Mission of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi