REPORT OF
Common Review Mission

Assam
November - December 2008

National Rural Health Mission (NRHM)

Government of India

REPORT OF
2nd Common Review Mission - Assam
National Rural Health Mission (NRHM)
Government of India
Chapter 1 Title Chapter

The 2nd Common Review Mission (CRM) under NRHM to the state of Assam comprised :

Dr Tarun Seem, Director	Room No. 210-D Nirman Bhawan, New Delhi - 110108Telefax: 011-23061360 Mob: 09868844114 Email: tarun.seem@nic.in
Dr Anil Kumar	Chief Medical Officer (NFSG) DtGHS Room No. 403, A-Wing, Nirman Bhawan, New Delhi-110011 23062940, 9811637663 dr.anilkumar@nic.in
Ms. N.Angami MSG	Convenor & Ex-President, Oking Hospital, Kohima – 797 001 Nagaland Email: neidonuoangami@yahoo.com Ph. 0370-2223319, 2291255 Mob. 09856146095
Sh. Gerard La Forgia	World Bank,70, Lodhi Estate, New Delhi -110003 Tele: 011-011-24652290, 011-24619491 Mob: 09999983956 Email: glaforgia@worldbank.org
Sh.Shyam Astekar, ASHA Monitoring Group	School of Health,21 Cherry Hills Society, Pipeline Road,Anandvalli, Gangapur Road, Nasik – 422 005 Mob. 09422271514 Email: shyamashtekar@yahoo.com

The state visits under the CRM started on 26th November 2008 and ended on 3rd December 2008 during which the team visited the state and interacted with the State Health Mission and health directorate. The teams also visited health facilities in the districts of Shivsagar, Bongaigaon and Chirang. The teams also visited the Boat Clinic at Dibrugarh. A briefing meeting with the state Health department was convened on 26th Nov 2008 and a debriefing meeting with the Health Minister of the state was conducted on 3rd December 2008. Key findings of the CRM were shared with officials from the Health Minister.

The team for CRM had a balanced mix - Dr Tarun Seem (MoHFW) focussed on funds and administrative issues, Gerard la Forgia, (World Bank) focused on systemic and institutional arrangements underlying NHRM, Dr Anil (Dt. GHS, GoI) focused on National Health Programmes and technical aspects of the programmes, Ms Angami had a NE community perspective, and Dr Shyam Ashtekar focused on Sub centers, PHCs and ASHAs. The state visits were comprehensive and in-depth and extensive study of the health system in the state was undertaken. The team believes that there was no attempt on part of the state to show case the good items and suppress possible weaknesses. The team received complete cooperation and managed to obtain the real and honest picture at ground level. This report is a summary of the findings of the team.

The report also highlights the team's finding regarding major systemic constraints that, unless corrected can threaten the long-term viability and effectiveness of NHRM. These findings are placed against the relevant para in this report. The evidence supporting these items was gathered from interviews with state and district officials, institutional staff, and village/NGO representatives etc. Based on these findings, the team recommends that instead of seeking to rapidly expand NRHM, MOHFW should now consider making effective what has already been put in place, and correcting the systemic/structural shortcomings that could thwart performance of NRHM in future.

Chapter 2 Introduction

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The detailed Framework for Implementation that facilitated a large range of interventions under NRHM was approved by the Union Cabinet in July 2006 (two years ago). Under the NRHM, the difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. From narrowly defined schemes, the NRHM was shifting the focus to a functional health system at all levels, from the village to the district.

The Common Review Mission (CRM) has been set up as part of the Mission Steering Group's mandate of review and concurrent evaluation. These are annual events and cover thirteen states. The CRM provides occasions for state review, sharing of experiences across the states, discussions with wide range of stakeholders and an opportunity for mid course corrections by the Mission at all levels.

The 2nd CRM was undertaken with the following overall mandate:

a. To review the changes in health system since launch of NRHM through field visits and spot examination of relevant records.
b. To document evidence for validating the key paradigms of NRHM including decentralization, infrastructure and HR augmentation, communitisation and others,
c. To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM

d. To recommend policy and implementation level adaptations which may accelerate achievement of the goals of NRHM.

Each state team in the 2nd CRM was authorized to adopt an additional, state specific mandate which would build on the overall mandate in the Ts of R.

The review Mission to state of Assam was undertaken in the above stated overall perspective. The state of Assam is one of the most important states of the country. It is one of the High Focus states under NRHM and is the largest state in the North East. The state entered into NRHM with rather poor base line indicators. The state exhibits diverse geographical contours and has a largely agrarian economy. A large part of the country's petroleum and production comes from the state. The large areas covered by the tea gardens provide unparalleled scenic beauty to the state and also present unique Public Health challenges.

The state of Assam was covered in the 1st CRM during Nov 2007 also. The summary note on status of NRHM in Assam, prepared by the 1st CRM in November 2007 was as follows :

THE POSITIVES	**AREAS FOR IMPROVEMENT**
► Increased Case load and bed occupancy at most facilities - due to better availability of doctors, and improved infrastructure and due to increased institutional deliveries. ►Commendable role played by ASHAs and ANMs, especially in organizing immunization where good progress is reported. ►RKS and untied funds have worked as enablers for improvement in amenities and over all functioning of CHC/FRUs. ►Perception of community is that there is a good improvement of services. ► Good Ambulance availability along with logbooks and accounting system- good ► 24 districts have completed District health plans.	► Availability of Nurses is a pressing issue. ►Village Health and Sanitation Committees have not been formed. ►Quality of care is varied with biomedical waste disposal being a problem everywhere. ►Diagnostics provision is very weak. ►Training infrastructure and training systems need improvement – essential skills not in place even where qualified staff is there. ► Logistics of drugs and supplies needs improvement. ►HMIS weak and needs much improvement. ►Delivery of Family planning services weak

The population of Assam is 2.66 crore (according to 2001 census) and is scattered over 27 district and 26,312 villages. Assam is divided into three regions, each headed by a commissioner. Under each commissioner, there are several Districts each. The Public sector Health System in Assam is headed by Health Minister Sh. Himanta Biswa Sharma. The officers heading the health establishment include Sh. P.P. Verma, Additional Chief Secretary (Health & P&D), Sh. V.S. Bhaskar, Commissioner & Secretary (Health & FW), IT & Sports and Youth Welfare department, Govt. of Assam Sh. J.C. Goswami, Secretary (Health), Department of Health & Family Welfare, Govt. of Assam. **The NRHM is headed by the Mission Director, Dr. J. B. Ekka.** The Director of Health Services, Assam, Dr. D. Hojai, Dr. M. Nunisa, Director of Health Services (FW), Assam and Dr. U.C. Sarmah, Director of Medical Education, Assam did not interact with the CRM team. The state also has officers for Immunisation, IEC, State cold chain officer, PD , SACS etc. The Respective NDCPs have Joint Director Rank Officers managing them. The Districts are headed by the Joint Director and each programme at District level has deputy directors managing it.

The CRM team also had a chance to interact with the Hon'ble . Health Minister of Assam. He interacted with the team on the last day and was briefed about the key findings of the visit. Hon' Health Minister was very well informed on NRHM and was fully aware of the contours of health system in the state.

The state has operationalised NRHM in letter and spirit and the renewed energy in the Public Health System was clearly visible. The State HQ has a robust and enthusiastic team of PMUs and the meetings of the SHM are being convened regularly. At District level also, the DPMUs are adding a lot of value to the system. The CRM team received warm reception at the state capital and cooperation from all the district PMUs. The visit of CRM teams was coordinated by the PMUs of state and respective districts who provided the required data and responded to the queries.

At the outset, it may be prudent to place on record a note on the visible rift between the existing state health directorate and the programme management persons

placed on contract under NRHM. The new blood in the PMUs has kick started a change in the public health system putting into use their knowledge of computer technology, their yearning for change and the mandate given to them under the Mission. With funds and mobility they are turning into fine change-makers. However, the old guard is not amused. The existing state health directorate was sadly missing from interactions with the CRM team. We did not meet the State DHS even once during the state visit. This almost stoic approach of the state health directorate was also mirrored at the district level. The District head (Jt Director) was often seen as a mute spectator to NRHM and at some places was even perceived by the officials as a bottleneck. The cleavage between the new age change makers introduced on contract under NRHM and the existing state health directorate was glaringly evident, especially amongst the doctors. The differential pay packets have further added to the rift. This cleavage appears to be a design issue with NRHM since many other states are also exhibiting a clear (and widening) fault line between the regular Health Directorate and the Programme management structures positioned under NRHM.

Base line of Public Health System in the state

Demographic, Socio-economic and Health profile of Assam State as compared to India figures

S. No.	Item	Assam	India
1	Total population (Census 2001) (in million)	26.66	1028.61
2	Decadal Growth (Census 2001) (%)	18.92	21.54
3	Crude Birth Rate (SRS 2007)	24.3	23.1
4	Crude Death Rate (SRS 2007)	8.6	7.4
5	Total Fertility Rate (NFHS-III)	2.4	2.7
6	Infant Mortality Rate (SRS 2007)	66	55
7	Maternal Mortality Ratio (SRS 2001 - 2003)	490	301
8	Sex Ratio (Census 2001)	935	933
9	Population below Poverty line (%)	36.09	26.10
10	Schedule Caste population (in million)	1.83	166.64
11	Schedule Tribe population (in million)	3.31	84.33
12	Female Literacy Rate (Census 2001) (%)	54.6	53.7

Functional Health Institutions as on as on 31st March '08													
Sno	**District**	**District Hospital**	**SDCH**	**Block PHC**	**CHC**	**FRU (upgraded CHCs)**	**MPHC**	**SHC**	**SD**	**Sub Centre**	**Others**	**Total**	
1	Barpeta	1	0	7	6	2	20	2	7	265	0	308	
2	Bongaigaon	0	0	4	3	2	16	0	7	58	19	107	19 RCH Centres
3	Baksa	0	0	6	5	0	18	3	13	161	0	206	
4	Cachar	1	0	8	1	0	14	3	2	269	1	299	**SMCH**
5	Chirang	0	0	2	2	0	5	3	11	76	0	99	
6	Darrang	1	0	4	4	1	14	2	5	164	0	194	
7	Dhemaji	1	0	5	3	0	12	1	1	98	1	122	One UrbanHealth Centre
8	Dhubri	1	0	7	5	1	8	5	14	277	0	317	
9	Dibrugarh	0	0	6	5	1	10	0	10	231	1	263	Medical College Hospital - **AMCH**
10	Goalpara	1	0	5	2	1	14	2	11	151	1	187	One **20 Beded Maternity Centre**
11	Golaghat	1	0	5	5	1	25	2	6	144	0	188	
12	Hailakandi	1	0	4	1	0	5	1	2	105	0	119	
13	Jorhat	1	0	7	6	3	19	1	12	148	0	194	
14	Kamrup (M)	1	0	1	2	1	8	0	12	51	1	76	Medical College **GMCH**
15	Kamrup ®	0	0	12	9	4	19	0	24	273	0	337	
16	Karbi Anglang	1	1	8	5	0	23	7	8	103	0	156	
17	Karimganj	1	0	5	1	0	7	3	7	217	0	241	
18	Kokrajhar	1	1	4	2	0	17	4	17	160	0	206	
19	Lakhimpur	1	0	6	5	1	11	3	6	157	0	189	
20	Morigaon	1	0	3	2	1	3	6	14	125	0	154	
21	Nagaon	1	0	11	10	6	23	4	20	389	0	458	
22	Nalbari	1	0	4	6	2	27	4	5	121	0	168	
23	NC Hills	1	0	3	2	0	2	3	2	65	0	78	
24	Sivasagar	1	0	8	3	2	19	4	1	223	0	259	
25	Sonitpur	1	1	7	5	2	22	6	12	281	2	337	2 **MCWC**
26	Tinsukia	1	0	4	5	2	10	0	5	164	0	189	
27	Udalguri	0	0	3	3	0	10	1	9	142	0	168	
Total		**21**	**3**	**149**	**108**	**33**	**381**	**70**	**243**	**4618**	**26**	**5619**	

Indicators

The statement of health indicators of the state of Assam are placed as Annexure ? to this report. These include :

1. NFHS rounds 1 to 3 comparison on key parameters
2. SRS comparison
3. DLHS 1 to 3 comparison on key parameters for the state of Assam

The complete list of the facilities visited by the team

2nd Common Review Mission					
25th November 2008 to 5th December 2008					
Name of State			Assam		
Sno	Name	District HQ	Name of DM	Name of JD Health	Name & Contact details of DPM
1	Sivsagar	Sivsagar	Mr. M.M. Hussain	Dr. C. N. Dutta	Ms. Namrata Sarma, DPMU, O/O The Joint Director, Sivsagar, 9435357518 dpm.sivasagar@gmail.com
2	Dibrugarh	Dibrugarh	Mr. A. Agnihotri	Dr. P.C. Hazarika	Ms.Monikha Buragohain, DPMU, NRHM, O/O of the DC, Dibrugarh, Mob. No.9435270086
3	Bongaigaon	Bongaigaon	Dr. M. Angamuthy	Dr. Kanak Ch. Talukdar	Mr. Sukumal Bsaumatary, DPMU, NRHM, O/O DC, Bongaigaon,9435021880 sukamalbasumatary@rediffmail.com
4	Chirang	Chirang	Mr. P.P.Baruah		Mr. Samir Bramha, Mob. No. 9954362435

Health Facilities visited			
Sno	Name	Level (SC / PHC / CHC/other)	Name & address of the Person in Charge
1	Sivsagar	Demow CHC/PHC	Dr. G. P. Sarma, SDM&HO, Demow PHC
2		Amguri CHC	Dr. D. Baruah, Suptd. Amguri CHC
3		Civil Hospital	Dr. (Mrs.) Sangmai
4		Sonari FRU	Dr. P.S.Dehinga, SDM&HO, Sonari CHC
5		Athabari SC	
6	Dibrugarh	Boat Clinic	
7	Bongaigaon	CHC	

OTHER INSTITUTIONS VISITED	
DISTRICT	FACILITY
MORIGAON	NAOKHOLA SHC
MORIGAON	NELLIE SD
NAGAON	SAMAGURI PHC
NAGAON	JAKHALABANDHA FRU

Chapter 3. Mandate of CRM

The mandate of the 2nd CRM was drawn from the terms of reference of the Review Mission as given by MoHFW, Govt of India. The progress of NRHM was examined against 19 key progress indicators mentioned in the Terms of reference of 2nd CRM. In addition to the same, key determinants of successful implementation of NRHM in the state of Assam were noted to be:

a. Appropriate skill mix and numeric adequacy of Human Resources
b. Community Link Worker
c. Technical supervision of service providers.

The comments of the teams on each of the above aspects are contained at the respective place in the paras addressing the ToRs of the 2nd CRM

Chapter 4 Findings of the 2nd CRM in the state

(Part 1 discusses change on 19 parameters and Part 2 (on page ?) discusses the progress against the approved PIP of the state for past two years)

Part 1
Change in key aspects of Health delivery system

1. Assessment of the case load being handled by the Public System at all levels

NHRM represents a "revolution" in terms of improving access of the rural poor to health care. According to one community informant, NRHM has already made a "huge difference" compared to the pre-launch situation, which was described as "the near zero supply of services and immunizations."

Although gaps in data availability and validation do not allow for a definitive statement about overall impacts, it clear that NRHM is propelling a significant increase in institutional births and outpatient visits. Table 1 demonstrates that since the outset of NRHM, institutional births have increased by 160% in District Savisagar while increasing by a whopping 368% in District Bongaigaon. Increases in OPDs were less pronounced, but still markedly significant.

Table 1: Change in Provision of Institutional Births and Outpatient Visits, Savisagar and Bongaigaon Districts, Various Years

Indicator	05-06	06-07	07-08	% change	% change
SAVISAGAR DISTRICT					
Institutional births	5,235	8,624	13,622	65	61
OPD	NA	12,475	15,776	--	27
BONGAIGAON DISTRICT					
Institutional births	1,660	3,497	7,774	111	122
OPD	NA	137,428	223,376	--	63

Both districts also report marked increases in IPD, however most of this increase is related to institutional births. There is general increase in utilization of services after implementation of NRHM, due to better availability of services, better infrastructure and 24x7 availability of services. Evening OPD has been started at many health facilities. Example of CHC Demoh is given below

Parametre	2006-07	2007-08	2008-09 (Apr tro Oct)
TotalOPD	34862	46758	34979
Avg. monthly	2905	3897	4997
Total IPD	4727	5597	4836
Average monthly IPD	394	466	691
Total ANC	841	1359	886
Average monthly ANC	70	113	126
Total Normal delivery	923	1124	683
Average monthly normal delivery	77	94	95
Total C Section	36	108	33
Average Monthly C Section	3	9	5
PPS	11	40	6

Understanding of the concept of referral units (FRU) is not clear amongst most persons in the system. Also, some of the programme interventions (like institutional delivery, IPPI mop up etc) have come to have a larger than life stature in the minds of the providers. As a result the data management at facility level does not have a logical flow. For instance, it was reported that the Sonari CHC/FRU was upgraded to FRU in December 2005 but received status of CHC only in April 2008. At most places the statistics of OPD is mixed up with ANC so it is not possible to know how much of the OPD was ANC. The titles like OPD (emergency) are used at some places and it is not clear if they are off OPD hour walk in cases or true emergencies (which have an entirely different connotation and which reflect immense faith of the community on the health facility.

2. Preparedness of health facilities for patient care and utilization of services

In Assam (as in several other states) there are many health facilities below the district level which are not as per recommended norms and nomenclature viz. State Dispensaries, Subsidiary Health Centres and Mini-PHC. Block PHC is the administrative unit for health activities of the block. At these levels, availability of specialists was also not as per a logical norms. For instance, at Demoh CHC,

Surgeon, Physician, Pediatrician and Radiologist were not available while 2 Gynecology & Obstetric specialists, 2 Anesthetists and 1 Dental Surgeon were available. At Amgura CHC, Dental surgeon was available but dental chair was not available. Here, there were no facilities for sterilizations and MTP. At District Hospital Bongaigaon, eye surgeon was available but not doing eye surgeries due to lack of facilities. At both the district hospitals (Sivasagar and Bongaigaon) visited by CRM team, psychiatrist and skin specialists were not provided. The average bed occupancy of CHCs was around 50% and of PHC was around 30%.

One or two ambulances with drivers were available at PHCs and CHCs and they were found to be equipped and functional at most places. Sterilization of equipments is done through autoclaves but confirmatory indicators are not being used anywhere. Blood Storage units were available at FRU but most of them were non-functional. Cold Chain maintenance was found to be proper at most places. At most places toilets for patients or attendants were found to be reasonably clean and maintained. However cleanliness of the services was a function of the interest being shown by the managers and the supreidtendents of the health facilities.

Emergency room at many places was found to be needing better management. Ambu bag, oxygen cylinder and emergency drugs were found missing in emergency room in many places. There was no disaster plan or preparations for disaster in any of health facilities. ORT corners are available in most of the facilities. ICTC facilities are available at most of the CHC or likely to start in near future. Incinerator available at some facilities but was not functional. Deep burial pit was being used as a method of disposal of biomedical waste. In the labs in PHC/CHC/FRU only few basic tests are being done. At many places, availability of Lab technicians appears to be sufficient, yet the **lab services** are very basic and primordial. At many places the supply of Reagents was found to be irregular. At most of the places same microscope was being used for sputum microscopy and malaria parasite.

Overall, it was apparent that Family Planning services are not available easily, and regularly. The associated IEC/BCC was also found to be weak. Sterilizations are not done as part of regular service at the health facilities and only one camp was reported every four months. The coordination between PHC and CHC for this purpose appears to be weak. As a result of this, there is a backlog of cases requiring sterilizations at PHC/CHC/FRU. At Demow CHC, 228 identified patients for tubectomy and 15 identified patients for vasectomy were pending despite availability of laparoscopy trained gynecologists and operation theatres. This pendency is highly undesirable and the state was advised to take remedial action on priotrity.

There is shortage of drugs and other supplies at most of the health facilities including district hospital. At all places patients have to purchase I/V drip sets and sutures. Inj. Magnesium sulfate and MVA kits were not available at PHC/CHC/FRU. Ayurvedic drugs are not provided for use by Ayurvedic Physicians and these doctors were found to be prescribing allopathic drugs only. Supplies of Dental consumables was also poor. At one place Dental Xray Unit was available but Xray films were not available. At some places equipments were lying unused. At civil hospital Bongaigaon, new rooms, new X Ray machine and new Ultrasound machine were available but were not being used. Here also stools for patients were not available in OPD chambers.

The team reviewed monthly registers of a number of PHCs and CHCs included in the sampled facilities. In most instances, the team was able to observe changes in institutional births and OPD and attempt to relate these changes to the introduction of JSY payments, posting of new personnel (doctors and nurses), upgrading of physical plant and equipment, and to a lesser extent, improved stocks of medicines. In the case of institutional births, the evidence suggests that the expansion of the JSY program is by far the main driver. Institutional births increased substantially almost immediately after the introduction of JSY payments (and the contracting of ASHAs). There was no corresponding (or simultaneous) upgradation of labour rooms or wards or any significant corresponding (or simultaneous) augmentation of human resources.

However, institutional births showed a higher rate of increase at institutions where additional doctors and nurses were posted.

The determinants of OPD increases are harder to flesh out, but appear to respond to three factors. First, the increase in institutional births appears to have had a secondary effect of increasing demand for services. Second, the postings of additional doctors raised demand. Finally, the improved availability of medicines may have also increased demand, although more analysis is needed to link stock availability to monthly patient flows. As mentioned above, there appears to be little relation between increased utilization of OPD and infrastructure upgrades. However, the any improvements in infrastructure and equipment may have an important quality impact. However, more detailed analysis is required to determine quality impacts (see below).

Possible Distortions: All informants reported that the main focus is on raising institutional births and this is driven by JSY. ANC checks are either flat or decreasing in both districts, as evidenced by respective institutional registers. Available district-level data suggests that immunizations and reproductive health activities have remained constant or have only marginally increased. (The preliminary data from DLHS-3 shows a decrease in immunization coverage state-wide since DLHS-2). Although ASHA workers have many responsibilities (perhaps too many), they are clearly directing their attention on identifying pregnant women and registering and accompanying them for institutional births. One state official stated that the ASHA's "only focus on making money." If other activities for which they are responsible are not linked to incentives (or the incentives are too low), then little is done. For example, the team observed a decreased emphasis on improving safe home births in backward areas where beneficiaries have limited access to institutional births.

It is clear that NRHM is making a big difference to the health system, but mainly to institutional deliveries only. NRHM is swelling the maternity wards, and this is probably the biggest achievement of NRHM. There is a facelift seen in all health facilities, additional equipment, better painting, more medicines, and additional contractual staff. All this is attracting lot of maternity cases. Some other

components of service delivery like malaria slides (no malaria deaths have been reported, OPD-IPD, Leprosy, TB etc are also improving. Yet, non-programme services are nearly the same as pre NRHM era. Perhaps the state need to remind itself that NRHM is about comprehensive health care, health sector reforms and addressing the fundamental deficiencies of the Public Health System.

Preparedness of Sub Centre to handle the new paradigms under NRHM

Most Sub Centres (SCs), visited by the team were adequately staffed with one or two ANMs. No deliveries are being conducted at the SCs by the ANMs. IUCD services are also not provided at SCs. Disease surveillance as envisaged under IDSP is not being done for all practical purposes and the reporting is done monthly. Village Health and Nutrition Day was being conducted regularly but the range of services on these days need to be expanded. It has to grow beyond the immunisation and RCH services mindset. There was no conflict between ANM and Sarpanch visible at the village level. Antenatal registration is almost 100%. However Haemoglobin and Urine examination were not being done by the ANM. Iron and folic acid have also not been supplied since July, 2008. The reporting of Maternal and Infant deaths needs to be improved as there is apparently no system for this in place. There appears to be over reporting of fully immunized children by the subcentre ANM. Many of the columns were found to be unfilled in the monthly reporting performa. Blind register is not maintained. No support for conducting delivery at home is being provided by ANM/ASHA. This should be taken up for remedy on priority. The health system should acknowledge home deliveries as an unavoidable reality in the field and strive to provide assistance and support for the same.

At the time of the visit of the team, the block PHC at Samagari was having a meeting of ANMs. Dr Ashtekar took the opportunity to meet and talk to them. Some common findings:

- ANMs attend the SC at 8 am and leave between 1-2 pm. Only 8 out of 52 in the group stay at the SC, due to lack of security and support.

- No delivery room is there at most SCs, hence there is no delivery work. The state apparently does not insist on SC deliveries at this stage fearing possible over reporting of institutional deliveries.
- The SCs lack delivery room, electricity, running water, compound wall are common. hence no delivery conducted (two exceptions) at SC All villages have ASHAs to whom Drug kits have been provided. However, the refill of drug kits has not been done so far.
- All SCs have received the untied funds of Rs 10,000 and are slowly learning to put the same to use.
- VHSC have been formed in most villages
- Most ANMs have divided the area between themselves with the second ANM
- Some medicines are available at the SC, but dressing material was not available at several places.

Preparedness of PHCs & Block PHCs to handle the new paradigms under NRHM

Most PHCS have undergone a positive change due to new construction/renovation and contract staff, repair, medicines etc. Delivery services are available only at block PHCs and most PHCs are closed at night. This is passe in Assam, partly attributed to insurgency.

Often the block PHC is located alongside the CHC, and hence has mainly administrative tasks. At the BPHC visited by the team, it was seen that ANC clinic does not include Urine and Hb test since last two years, allegedly for want of chemical agents/diagnostic strips. The Lab technician at the centre was unresponsive and stoic to the situation. The doctors (apparently quite senior) were without a clue on the subject. They had not thought of deploying untied funds for gap filling. Instead they were asking patients to visit private labs and get the tests done. Even this referral was never entered in the register. There was no mention of high risk care. There was lot of crowd of patients but the Quality did not seem important. Perhaps the NRHM should undertake some behaviour change trainings of service providers to introduce a sense of

responsibility amongst them and a sense of ownership of the service guarantees which are envisaged under NRHM.

At some block PHCs, delivers have doubled but quality is still to come. Clearly, quality will follow quantity in the next phase, with some efforts.

Preparedness of CHCs/FRUs to handle the new paradigms under NRHM

The Joklaband FRU CHC is quite impressive. It is 30 bed unit, with 10 docs, blood storage, anesthetist, vehicles, quarters for staff etc. The statistics was available, showing rise in deliveries and CS surgeries. However, other clinical work has not increased, and the extra work mainly comprises of JSY referrals. Hence preparedness for comprehensive health care services is not seen at the facilities. In Bongaigaon CHC, patients had to stand before the doctor since no stool existed in the OPD rooms. Doctors were clueless when asked about this. In the same CHC, new 300 MA X-ray and sonography machine and the new OPD were not at all used till now. The in charge doctor was away at Guwahati. Like elsewhere the JSY referrals had filled the wards.

It seems that at most health facilities, patients are discharged soon after delivery for want of beds, mostly in less than 24 hours. This puts quality of care at peril. This problem appears to be the unintended but inevitable result of PHCs being positioned as the first port of call for obstetrics as against the Sub Centres. The SCs could play valuable role in providing clean, safe deliveries and reducing maternal and infant morbidity and mortality. However, in order to reduce possibility of home deliveries being reported as institutional deliveries and in order to create images of booming maternity wards attributable to JSY, the SC has been given a more diluted role under NRHM. This may need to be reexamined if and when the quality of obstetric and postpartum care is addressed.

In the NGO meeting at ANT, it was reported by some participants that doctors in this CHC ask for money for delivery cases and will turn away few cases as they belonged to other district (just 10 km away). The RKS register was kept and

audit report was made available. At another facility (categorized in the records as CHC) there was only one doctor, very large physical infrastructure, almost no OPD and absolutely no IPD or Lab work. The doctor was staying alone at the facility since several years and had no clue about NRHM. Clearly the information gap amongst the service providers also needs to be addressed.

Recommendations:

1. The multiple nomenclatures below the level of CHC and above the level of SC may be examined for rationalization. The key could be as follows :
    - SC for 5000 population, PHC for 30,000 population
    - CHC for 1 lakh population (at Block HQ where CHC is located, PHC is not required)
    - DH for each district (at district HQ, where DH is located, CHC or PHC is not required)
2. Rationalize the postings of specialists as per the norms. It should be ensured that facilities and supplies are available to match the availability of doctors and specialists.
3. There is total absence of mental health facilities at district level. There is urgent need to provide at least one psychiatrist at district hospital level. Short term trainings in psychiatry may be provided to PHC/CHC doctors through medical colleges. Till the posting of regular psychiatrists, medical college faculty may be asked to provide services at nearby district hospitals on biweekly basis.
4. Emergency facilities need serious attention. Availability of emergency equipments, drugs, ECG, Xray and emergency laboratory tests should be ensured at all 24 hour facilities. Blood storage units at all CHC should be made functional. A disaster plan should be developed by each CHC and District hospital and reserve stock of emergency drugs, IV drips etc. for at least 50 patients should be kept separately in an Almirah in the emergency room.
5. There is a need to augment sterilization (tubectomy or vasectomy) facilities to clear the backlog of cases requiring sterilizations. All the available gynecologists have to be trained in laparoscopic sterilization and operation

theatres made functional. The facility for sterilization should be available at least once every week at block level. Faculty from near by medical college may be roped in for conducting sterilization camp at the FRU/CHC.

6. The availability of medicines and consumables including suture material, gloves, IV drip sets needs urgent augmentation at almost all facilities. Ayurvedic medicines should be made available wherever, Ayurvedic doctors are posted.
7. Most labs in public facilities are doing only very basic tests. The range can be increased. Supply of reagents should be made regular. A separate microscope should be used for sputum examination.
8. Encourage use of RKS money to purchase items like patient stool, essential drugs, laboratory reagents etc.
9. Standard operating procedures for autoclaving should be practiced.
10. Operationalise Sub Centres as the first point of contact.
11. Steps to be taken to improve quality of ANC and assured ANC and other MCH services as per NRHM must be available.
12. Timely and accurate reporting of data related to MCH, IDSP, and Blindness etc.
13. Local language NRHM formats may be developed to help in easy filling of data.
14. First one ANM should be provided at all the Subcentres before providing second ANM at any centre.
15. Decision to allow and facilitate deliveries at Subcentres may be taken especially in difficult and remote areas and here a third ANM may be provided to make it 24x7.
16. Home deliveries need to be attended to and disposal delivery kits provided and also paid the JSY benefit of Rs. 500. The gap on home births, neither paid nor supported for care is a problem in itself. Since at least 20-30% births are likely to continue to be conducted at home (especially in difficult areas) the systemic neglect of home births must be addressed.
17. Unless childbirth services are available at SC, there is no utilization of the second ANM. Till then at least quality ANC PNC services should be available at SC.

18. The male MPW is not available in Assam, and Govt is planning to appoint one at SC

3. Quality of services provided

At most places which were visited by the team, substantial improvement in physical infrastructure was seen. The doctors and nurses also commented about much better infrastructure being available to them. The patients on the other hand gave a mixed response. While they noted the improved infrastructure, the quality and range of services was still felt to be inadequate by the respondents. At most places the wards were patient friendly, with clean linen, sufficient lighting, clean toilets

On the other hand an opposite picture was also seen at some places. At one CHC-PHC the team saw that for last two years even Hb was not tested in ANC clinics, for want of Hydrochloric acid which could have been easily bought or borrowed. Instead, the patients were being sent to private labs. The doctors and even the nurses did not appear concerned at this outright denial of service. Even the ANC registers were not filled properly for high risk observations. These findings indicate serious gaps in quality of service.

Segregation of waste is proper but its disposal is through deep burial. Overall cleanliness is good. Infection rate for delivery and caesarian sections is reported to be within limits but the reports need to be validated and an independent supervisory protocol needs to be established to monitor quality. Patient satisfaction was found to be generally normal, however at some places complaints of patient not being attended by the doctor on duty were reported. Delivery patients are discharged 4 to 6 hours after delivery. As per PRI, complaints from community about the CHC have reduced now and they are functioning better. No dosimeter is being used by Radiographer at any of the facilities.

User charges are being collected for registration, laboratory, indoor etc. and are being used for CHC by RKS. Only a little amount of RKS money is being used to meet the shortage of drugs.

FP incentives continue in this state, despite all policy directives against it in NHP 2002. This state has poor FP profile, and surgery services are weak. Difficult areas like Chirang need special attention and involvement. It is necessary that all authorities visit this part and make additional efforts. The Mobile medical units are not making the desired impact. They should be rejuvenated and fully operationalized by removing the lacunae. The IEC budget was found to be underutilized. This needs to be augmented.

Recommendations:

1. Create a district wise central facility for treatment of biomedical waste. The waste should be regularly collected from all facilities.
2. Radiographer should be provided with protective clothing and dosimeter.
3. After normal delivery mother and child should be discharged after a minimum of 24 hours and preferably 48 hours.
4. RKS money can be used to meet the shortage of essential medicines
5. Referral audits should be undertaken. The public facilities are expected to treat as many cases as can and refer only the more serious cases. Even in that case the referral support has to be arranged and no one turned away.

4. Utilisation of diagnostic facilities and their effectiveness

The range of diagnostic services available at various levels has improved substantially. However much needs to be done to improve the technical skills of the lab technicians and the administrative supervision of the work done by them. At many places, even well equipped labs were seen to be doing only basic tests and many cases were being referred to private labs for investigations. The availability of trained lab technicians has improved substantially but the corresponding improvement in service delivery needs to be addressed urgently.

5. Drugs and Supplies

The availability of medicines at most health facilities was less than satisfactory. It was reported by the doctors that medicine availability during 2006-07 and 2007-08 was better than this year due to some reasons. At present most facilities are reporting serious shortages of basic medicines, surgical material and consumables. At almost all the places the surgical gloves, sutures etc were found to be purchased by the patients.

It was explained during the state briefings that an amount of Rs. 20 crore has been approved to the state for procurement of drugs at various levels and State. has placed order for the drugs. It was reported that situation shall improve by Dec'08. However, until then, the situation is quite grim. An amount of Rs. 54 lakhs was approved in the PIP for Maintenance of Integrated Drug Management. Apparently this money has not yet been utilized.

One Pharmacist (B.Pharma) was approved in drug warehouse for all the districts and one in state level The state has reported that this person has been Appointed. However their contribution is yet to become visible.

6. Health Human Resource Planning

There is shortage of human resources (Doctors and paramedics) in the state and efforts are on to rationalize through regular posting and contractual appointment.

Overall Situation

The state has reported availability of 689 regular specialists (for posting at 108 CHCs, 21 DHs and 3 SDHs) (84 more specialists have been appointed on contract). There are 1723 regular MBBS doctors for these facilities (163 more have been appointed on contract. There are 70 dentists in regular cadre (28 more have been appointed on contract). There are 358 Ayurvedic doctors in regular cadre (229 more have been taken on contract). There are 5130

ANMs in regular cadre (4088 more have been taken on contract). 1447 GNMs are in regular cadre and 2114 have been taken on contract.

The availability of specialists at Shivsagar District is as follows :

SPECIALITY (REGULAR GOVERNMENT DOCTOR)

Name of health institution (BPHC/CHC/FRU/SDCH/ MOHC/SD/SHC/DH/ OTHERS	MBBS	O&G	PATHOLOGIST	ANESTHESIST	PEDIATRICIAN	MS (GENERAL)	OPHTHALMOLOGIST	ORTHOPEDICS	RADIOLOGIST	MD(MEDICINE)	ENT	Institutional Total
BPHC galeki	3	0	0	0	0	0	0	0	0	0	0	0
BPHC agauri sagar	3	0	0	0	0	0	0	0	0	0	0	0
BPHC mor bazar	3	0	0	0	0	0	0	0	0	0	0	0
BPHC pat saku	1	0	0	0	0	0	0	0	0	0	0	0
BPHC khelua	2	0	0	0	0	0	0	0	0	0	0	0
BPHC kalugaon	2	0	0	0	0	0	0	0	0	0	0	0
Sapekhati BPHC	3	0	0	0	0	0	1	0	0	0	0	1
Ligiripukhuri SDH		0	0	0	0	0	0	0	0	1	0	1
Borhat MPHC		0	0	0	1	0	0	0	0	0	0	1
Demow CHC	2	2	0	1	0	0	0	0	0	0	0	3
Amguri CHC	3	1	0	0	0	0	0	0	0	1	0	2
Sonari CHC	1	3	0	1	0	1	0	0	0	0	0	5
Sivasagar Civil Hospital		5	1	3	1	3	2	2	2	2	3	**24**
DISTRICT SHIVSAGAR TOTAL		11	1	5	2	4	3	2	2	4	3	**37**

The availability of human resources at Bongaigaon District is as follows :

Name of health institution (BPHC/CHC/FRU/SDCH/ MOHC/SD/SHC/ DH/OTHERS-PLZ)	SPECIALITY (REGULAR GOVERNMENT DOCTOR)								INSTITUTION TOTAL
	MBBS	O&G	ANESTHESIST	PEDIATRICIAN	MS (GENERAL)	EYE	MD(MEDICINE)	ENT	
Bidyapur CHC	1 regular & 1 Contractual								**2**
Chiponsila MPHC	1 contractual& 1 AYUSH								**2**
Jhawbari SD	1 contractual& 1 AYUSH								**2**
Bongaigaon CHC/FRU	4, 2 BDS &1 AYUSH	2	1	1	2	1	1	1	**9**
Abhayapuri CHC/FRU	3 , 1 BDS and 1 AYUSH	1	1			2			**4**
Boitamari BPHC	2 &1 AYUSH					1			**1**
Manikpur BPHC	1 &1 AYUSH					1			**1**
District Bongaigaon Total		**3**	**2**	**1**	**2**	**5**	**1**	**1**	**15**

HR remains the critical determinant of availability of health services in Assam. There are several issues relating to this matter which can be addressed by the state on priority so as to accelerate the implementation of NRHM.

Some of the key issues on this subject are as follows :

i. **Physician Remuneration, Incentives and Motivation**: Physicians in district hospitals, CHCs, and PHCs voiced their dissatisfaction on three issues. The first concerns the poor payment scales. An eye-surgeon at one CHC told the team that he got mere Rs 9000 salary monthly! This pales in comparison to salaries of other vocations and cadres, other states, and is many times less than the market value of the technically qualified specialist. Parallel skills in medical colleges and even the CGHS get paid at much higher rates. This issue has not been addressed by the state for too long and remains the most critical structural issue needing immediate remedy.

Moreover, temporary physicians recently contracted by NRHM receive double the salary of regular staff. They also receive a large rental allowance. Younger

regular staff physicians expressed desire to be transferred to contract status. Older staff, however, prefers to remain in the system to secure their pensions. Regular staff with "retention posts" is irregularly paid, receiving one or two paychecks per year.

The second issue involves the lack of opportunities for and access to learning, new knowledge, medical conferences (unless paid for by pharmaceutical companies). Many feel out of touch with advances in medical science as well as new practices and technologies. Their medical work has settled into a "low-level routine" in which many have not upgraded their skills since graduating from medical college. This situation contributes to the above-mentioned low commitment to the public system.

The third issue concerns the dearth of career paths. In fact, the only career path for physicians is to become a physician-bureaucrat, which is rejected by most.

***Recommendations*:**

- Develop a strategy for the medium-term convergence of physician pay scales and development of a labor regime for physicians with more career path options. Government should study how other countries have established such career paths;
- Consider introducing a blended, performance-based payment scheme for salary raises for regular staff physicians (as well as salaries for new hires and contracted staff). Such a scheme can consist of two parts. The first would consist of a fixed salary, as is currently the case for most remuneration. The second would entail a variable payment tied to compliance with monitored and validated performance benchmarks. These can include: paying for additional births, production targets, infection identification and control, use of protocols, providing support to AMNs and ASHAs, compliance with reporting requirements, and ratings from communities through social audits on humane treatment, informal payments and absenteeism. Variable payments can be executed by the RKSs;

- Develop a program to upgrade the medical practice skills of physicians and nurses, providing them opportunities to acquire new skills and techniques. This can be done by offering "in service" courses via teleconferences or the web, and actively promoting and financing seminars, conferences and research;
- Consider establishing a user friendly, web-based clearinghouse of best practices and research for rural health.

ii. Informal Payments: It is common knowledge that physicians use public service to establish their reputations to establish a private practice. But villagers report that informal payments collected at public facilities plague the system at all levels. (District authorities also acknowledge this). Community representatives provided the team with numerous examples of physicians and nurses, including AMNs, charging for services, refusing services (unless payment is received) or directing patients to private chambers and nursing homes. Informal payments are so widespread that one NGO represent stated that villagers often think: "Whichever government institution charges less, I will go there." Considerable data exist of this widespread practice in India and the consequent negative welfare effects of driving people deeper into debt and poverty. It severely compromises citizens' satisfaction with public services.

***Recommendations*:**

1. Given that most villagers have cell phones or access to cell phones,[1] government should set up a dedicate 24/7 hot line to receive grievances regarding informal payments. Each institution should place a large sign with the number to call if informal payments are requested, services refused, or patients are directed to private practice.

[1] This was observed in villages and in the queues for services at PHCs.

iii. **Human Resource Rationalization:** As districts work to achieve an adequate supply of professional HR (physicians, nurses, diagnostic technicians), more attention needs to be paid to both their configuration and deployment. This would require conceptualizing the health system based on a district-wide network model. Currently, the delivery system is very fragmented with institutions acting like islands without horizontal communication, referrals or counter referrals. For example, district authorities acknowledged that duplication of ANC registration and consultations is common. Pregnant women may register for ANC in more than one institution.

Specialists are not being used to the best of their capacities. The team observed specialists (surgeons, anesthesiologists, and ophthalmologists) in all CHCs attending to routine OPD and participating in health camps. 80% of cases don't require a specialist attention, suggesting specialists are being used as jacks-of-all-trades. These scarce resources would best be used for cases referred from general practitioners and providing support to the latter in PHCs. As mentioned, absence of a defined network where clinical roles and responsibilities are specified is the main culprit. Available technologies such as video conferencing and telemedicine can be used to link specialists with general doctors.

A related deployment issue is the difficulty for districts to recruit physicians for postings in distant areas. Interviews suggest that non-monetary criteria contribute to physician reluctance to accept and retain such posts, including lack of education opportunities for their children, isolation, and lack of contact with health system. Alternative strategies need to be developed to attract physicians to backward areas (see below).

Finally, rationale deployment of HR also needs to account for productivity. Table 2 presents a simplified analysis of per day and per hour productivity data for physicians attending day OPD in dispensaries, PHCs, and CHCs. It applies conservative parameters: annual work days (225) to account for holidays and training/meeting days, and a five-hour daily OPD session. The data suggests that some institutions are significantly more productive than others. Whether this is due to demand or supply characteristics requires further analysis. The low levels of physician productivity of the recently established FRUs[2] – which have benefitted from an increased endowment of physicians – is particularly worrisome, suggesting weak accountability.

[2] For CHCs/FRUs, the table only considers those physicians attending OPD.

Table 2 : Day OPD productivity by Institution Type, 07-08			
Institution	No. of Physicians	Consultation/physician /day[1]	Consultations /physician p/hour[2]
DISPENSARIES			
SD	1	20	4
SD	1	5	1
SD	2	25	5
SD	1	48	9.6
SD	2	29	5.8
SD	1	16	3.2
SD	2	20	4
PHCs			
PHC	4	25	5
PHC	2	83	16.6
PHC	1	34	6.8
PHC	1	61	12.2
PHC	2	20	4
PHC	1	24	4.8
PHC	2	10	2
PHC	1	14	2.8
PHC	1	7	1.4
PHC	1	9	1.8
PHC	1	59	11.8
PHC	4	27	5.4
PHC	2	27	5.4
PHC	1	33	6.6
PHC	1	37	7.4
PHC	1	32	6.4
PHC	1	42	8.4
PHC	1	53	10.6
PHC	3	13	2.6
CHCs[3]			
CHC	2	67	13.4
CHC/FRU	10	12	2.4
CHC/FRU	6	27	5.4
AVERAGE	--	17	3.4

[1]225 workdays per year [2]5 hour OPD/day.
[3]Refers only to physicians attending day OPD

Recommendations:

As suggested in the recommendations on capital investments, consider deployment of HR according to network master plan that is linked to demand, availability of general practitioners and specialists, productivity, and public outreach objectives. Referral and counter-referral systems need to be structured with the appropriate paper trail. Consider issuing all citizens a smart card that can be linked to their medical records, particularly for priority services such as ANC, immunizations, etc. Specialists are scarce resources that should be used to treat referral cases and provide support to general doctors in PHCs. The latter should be considered the backbone of the delivery system. General practitioners can be connected to specialists at district hospitals and medical colleges through telemedicine or web-based video conferencing where by they can receive on time advice on recommended treatments for specific cases.

For physician postings in distant areas, consider a rural corps concept which aims to develop physicians' commitment to rural health care. For example, a program of this nature would encompass a team approach, accounting for physicians' non-monetary needs.[3] It would rotate physicians to these areas for 3 month periods - each not spending more than 6 months per year physically posted in a distant area. However, the communities benefit from full-time posting of a physician throughout the year. This would allow physicians' families to remain in urban areas. While not in the field they can take training courses on rural and public health, upgrade their medical skills, develop programs for targeted communities, and provide support to their colleagues in the field through teleconferencing. After 5 years participating in this program, they should be given priority for entrance into specialty residency programs.

iv. Supervision: Supervision is oriented to assessing the inputs -- availability of HR, equipment, and infrastructure. There is essentially no technical

[3] Raising physician salaries would probably be a necessary but insufficient measure to motivate recruitment and retention of physicians in distant rural postings.

supervision of institutional or HR performance (production, productivity, quality of care – such as following proper procedures for antenatal care, post-partum care, ORT, etc). The current check list approach is too long and complex, and is useful only to gauge that a facility has become functional. However, once a facility is functional, such an instrument is not technically appropriate. Protocols and instruments for technical supervision were absent.

Facility staff appear to receive little guidance or information on basic processes. For example, upon hearing an inquiry from a team member, a block officer instructed nurses that mother and child should remain for at least 24 hours. The nurses informed the team that this is the first time they had heard this. Doctors and nurses reported that they are rarely supervised, and if it occurs, the process is very ad hoc.

The state-based NRHMRI "facilitator model" appears ineffective for two reasons. First, facilitators are often used as "firemen" for the state authorities, and often have insufficient time to provide technical support to the districts. Second, and more importantly, they are spread too thin to be an effective technical resource for the districts. Given the reduced number of facilitators (3), and the large number of districts (27), they can only visit a district once or twice a year, and rarely have the time to provide follow-up.

***Recommendations*:**

- Establish a systematic supervisory system with the appropriate protocols and instruments for services provides at CHCs, PHCs, subcenters and ASHAs. Contract train sufficient HR to carry out supervisory functions.
- Contract additional supervisory HR for the state NRHMRI.

v. Rationalise the positioning of ANMs

There are 61 SCs with three ANMs (nine in Cachar, eight in Darrang, seven in Golaghat, five in Karbi Anglong, four in Shivsagar, seven in Sonitpur, At the

same time there are 45 Sc without a single ANM many of them located in these very districts.

Considering that the state has only 4592 SCs, the total available complement of over 9200 ANMs can be positioned so as to make almost all SCs functional with 2 ANMs. But a large number of ANMs are positioned at higher level institutions.

	ANM POSTED OTHER THAN S/C		TOTAL
STATE TOTAL	REGULAR	NRHM	
	1339	**315**	**1654**

There are 11 regular and four contractual ANMs at Kamrup SD Hospital, two regular and four contractual ANMs at CHCs in Kamrup, 40 regular and 81 contractual ANMs in Kamrup (M), two regular and five contractual in Kamrup (M), five regular and five contractual ANMs in CHCs in Darpang district.

Many other districts also have this sort of positioning of the ANMs. In almost all districts there are more ANMs at the facilities categorized as Mini PHCs than at the facilities categorized as SCs. The state may examine rationalizing its nomenclature of facilities and build up a logical referral chain.

In one PHC, the team noted that all posts of second ANM at SCs in its jurisdiction were filled. However the utilization of even the first ANM was not satisfactory, with SCs opening for service at 8 am and closing at 2pm. Most ANMs do not stay at SCs due to various factors. Even normal childbirth is not being conducted at SC. IN view of these facts, the job profile of ANMs (regular as well as the contractual) needs to be redesigned under NRHM for optimal utilisation of the precious human resources.

vi. Rationalise the positioning of Medicos

While new health infrastructure has come up at many places the corresponding human resource positions have not been created. The new

facilities are being staffed with staff which is relocated from pre-existing facilities thereby disrupting the services at those places. For instance, at present Doctors are posted in excess in Bongaigaon CHC/FRU because Bongaigaon CHC/FRU has been upgraded to District Hospital and as such the excess manpower has been posted there so that when the new DH is complete (Schedule March 09) these manpower can be shifted to the new DH. The state may need to urgently process the creation of more posts of doctors and specialists for its newly created infrastructure.

vii. Greater District level ownership of HR positioning

In the state, postings of Health Human Resources are done by secretary upto the District level. Below the district, the Jt Director concerned positions the HR as per need. It is noted that even the contractual positions are planned by the State HQ and not based on District demand. The District level authorities need to take greater ownership of the HR deficiencies and should be advised to plan for HR augmentation of key facilities through contractual positioning.

Rational and optimal positioning of Human Resources can assist in operationalising the health facilities in the short term. For instance, the Shivsagar District has population of 12 lakh. Theoretically, if one functional hospital is needed for every 1 lakh population, then the district needs 12 such locations. As is listed in the table above, the district has 37 regular specialists. By recruiting more specialist on contract and rationalizing their posting the district can indeed achieve the goal of having a fully functional 24x7 hosiptal for every one lakh population.

viii. Rationalise support staff and services at health facilities

It is seen in the state that at many places specialist doctors are available but the corresponding facilities are not available and at some places it is vice-versa. Several facilities had dentists without dental chair and equipments, eye surgeons without OT etc. . Dental paramedics are not provided at most of the facilities. The doctor-nurse ration is also not correct at most places. For

instance, at Civil hospital Shivsagar only 35 nurses were available as against 28 specialist doctors. It may be useful to rejuvenate the post of health worker male at sub centre level.

ix. .Improve service conditions

The medical/paramedical cadre in the state needs urgent and comprehensive reforms. This was seen as the fundamental reason behind the weak service delivery in the state public health system. In Assam, the entry level salary of MBBS doctor is around Rs.10000 per month which is very less as compared to the rest of country. Moreover the contractual doctors are paid higher salary of Rs. 20000 in case of MBBS and Rs. 15000 in case of Ayurvedic doctor.

Since there is no specialist cadre the specialists have to undertake general duties like emergency, mortuary, court duty etc. Further, the doctors are allowed private practice, which is affecting the service delivery adversely. Many of the doctors in the public facilities merely use the government facility as the OPD to service their private practice.

x. Doctors' and Nurses' salaries

The doctors get 9000+ at entry level, and incentives fetch some more. On an average it was all below 15000/-. The nurses get 6000 at entry level. These salaries are less even by Assam medical college standards where entry level gets 25000/-. The NRHM contractual docs get 20000/- per month. This is patent injustice for regular rural doctors, in comparison to urban and CGHS levels (60000/pm). The CGHS salaries may touch 80-90000 soon with the 6th pay commission. The vast gap in salaries will not help Assam NRHM. In fact this is generic problem of most state health systems. Doctors stay put because they can get other money and new ones join because of the bond of 5 years.

Recommendations:

1. Rationalize salary structure for doctors and paramedics and make it comparable to other states. Additional incentives may be planned for difficult areas so that regular services can be made available.
2. The system of private practice by public health doctors be re examined.
3. Create a Specialist cadre. The general duties can be done by Graduate physicians (MBBS or AYUSH). All post graduates should be used as specialists for respective departments at CHC/FRU/DH
4. Recruitment of contractual doctors and nurses through NRHM should be facility specific to fill the gaps in manpower and not for general purposes.
5. Create a cadre of health worker male at sub-centre who can specifically do the work of sanitation, family planning, health education, male involvement in MCH, surveillance of diseases and screening for non-communicable diseases etc. An Institute be identified for such trainings on regular basis.
6. The Joint Directors and other senior level officers in the Health directorate need to take on more responsibility. At present many JDs do not appear to have things in their control.

xi. Trainings:

The service providers in the state articulate a strong need for career advancement and training. There is almost no induction training for persons recruited to the public health system. Some Gynecologists have received laparoscopic trainings but the numbers are not sufficient to have a visible impact on the service availability. Administrative (PDC) and hospital administration trainings also need to be expanded as the skills were not found to be available at most of the facilities visited by the team.

Recommendations:

1. Senior doctors who have a minimum of 3 years of service left can be sent for trainings of Professional Development Course and Hospital Administration.
2. Visit to other states can be arranged to gain knowledge of good practices.
3. Planning for induction training for health staff may be started by the state.

7. Infrastructure

Need for Rationalization of Capital Investments

Norm-based criteria drawing on broad population-based parameters to locate and dimension capital investments are resulting in irrational upgradation and random expansion of infrastructure. Capital investments appear to be determined in an ad hoc manner (e.g., “spend the money”), with little concern to or estimate of need, demand, and geographical access, availability of HR, and future road upgradations. Also, priorities are not necessarily those specified by NRHM. For example, one district focused on upgrading PHCs in semi-urban areas to decongest births in a district hospital. Perhaps a more robust strategy would have been to direct efforts to improving access to institutional births in underserved areas with high rates of unsafe home births.

The team also found evidence of duplicating or unnecessary upgradations: (i) establishing a 24/7 PHC with birthing room within 20 minutes of a higher quality but underutilized CHC; (ii) constructing a new birthing room when the current one was more than adequate; (iii) upgrading of three CHCs (in different districts) close to district hospitals that are under construction, which once completed, would probably result in the closing of the upgraded facilities in the CHC; (iv) upgradations of PHCs in areas where roads are under upgradation, which would provide villages <30 minute access to larger and higher quality facilities. It is likely that these upgraded PHCs will remain underutilized upon completion of the upgrades. There are also instances of mammoth hospitals (viz over 100 beds in district Shivsagar, which incidentally already has a 200 bed District Hospital) fully constructed and depreciating and yet never utilized since the human resources, equipments and other logistics have not been simultaneously planned. This is highly objectionable in a

developing, resource scarce country like India and state should address this issue on priority.

The state has undertaken a massive infrastructure upgradation initiative. The upgradation is however not part of an overarching scheme or plan. A lot of physical upgradation is ad hoc and not really need based. While facility surveys have been undertaken at several places, the upgradation of physical infrastructure is however often not based on the felt needs articulated by the facility surveys. A large part of NRHM funds have been used for constructing new PHCs and it is not clear if the support of the state under the Minimum Needs Programme has been withdrawn

It is seen from the PIP of the state under NRHM that large scale upgradation of the medical colleges in being funded under NRHM. While the need for this activity is clearly justified, it needs to be examined if the funds intended for broad based, overarching health sector reforms can be moved away from more urgent albeit difficult HR and cadres reforms issues into brick and mortar initiatives like construction of new wings in medical colleges.

Finally, capital investments are determined with little concern regarding how to harness the existing private supply, which is by far the major provider of health care.[4] Similar to public institutions, district and state authorities acknowledge that many of the private nursing homes and hospitals are underutilized. In theory, the owners are “losing money” given the low utilization, and probably would be willing to negotiate a significantly discounted fee to receive public patients. This would be a more affordable solution than dotting the landscape with underutilized public facilities. The team also met with experienced NGOs who are willing to provide services or at least support government efforts to extent care to hard-to-reach populations. Requests from the organizations have been ignored.

[4] The state and districts health authorities have little systematic information on private providers even though most of the government doctors are practicing in market and there is really nothing like pure Government health service in the state.

***Recommendations*:**

1. Each district should develop a long-term master plan (10 years) for capital investments that account for: (i) projections of demand, demographic changes, epidemiological transitions, and population movements (urbanization, migrations); (ii) government plans for road upgradation and new constructions which would facilitate access to distant populations; (iii) use of available technologies such as telemedicine and videoconferencing to enable higher level institutions to provide technical support to their lower level counterparts; (iv) adaptation of a "whole system" perspective to effectively and efficiently harness private supply for public purposes; and (v) prioritization of investments according state public objectives and policies.

2. Lot of public infrastructure (building and equipment) is lying non operational for various reasons. This can be corrected.

3. State funded construction should not be replaced by NRHM funded constructions. NRHM funds are really for gap filling only and should be used accordingly.

8. Empowerment for effective decentralization and flexibility for local action

The state has reported that 20,309 VHSC have been formed and fund released to them. It was however noted during the field visits that VHSCs need a lot of capacity building. In many cases all the members were not even informed of the responsibilities. Is was explained that Panchayat elections have just been concluded and the work of VHSCs is only now gathering momentum. Rogi Kalyan Samitis have been formed in most of the PHC, CHC, FRU and District Hospitals. In most of the places it is headed by area MLA. The meetings were occurring at more than 6 monthly intervals instead of recommended 3 monthly intervals. Utilization of RKS money was satisfactory

but accounts maintenance and auditing of accounts needs improvement. At most places NGO was not involved as member of RKS.

The remarkable improvements in the Institutional delivery and OPD attendance in the districts of Shivsagar and Bongaigaon (as detailed in table 1) can be attributed to a large extent to the community activities undertaken in these districts. Both districts report a large number of outreach activities such as Village Health and nutrition days (VH&ND). For example, Shivsagar conducted 6,888 VH&NDs in 2007-08 while Bongaigaon carried out 8,130 such activities.

The regular public health system remains fundamentally a top-down, command-and-control system. Most regular staff at the district and block levels are used to "being told what to do" by the state or the MOHFW. They are uncomfortable with, and in some cases, reject calls to become key decision makers particularly regarding spending. District and block officials and managers appear unaware of their roles and responsibilities under NRHM. They don't appear to be familiar with the NRHM guidelines, nor do they feel empowered to make decisions. For example, district authorities were unaware that they can identify and contract HR. RKSs are not involved in facility management, rather they appear to simply approve purchases. Finally, RKSs do not appear to have accepted their governance role in terms of making institutions accountable to people. They do little more than make purchases with the available untied funds

***Recommendations*:**

- Institutional staff requires considerable ongoing support to enable decentralized decision making. It is not enough simply to inform them of their rights and responsibilities. Consider a special training program on institutional governance and leadership.

The state needs to take up capacity building for developing the Village health plans and Block level health plans.

9. Accredited Social Health Activist (ASHA)

The state of Assam has reported that all 4 Modules training has been completed for 26,225 ASHAs. The master training for 5th Module has been completed for 42 Master Trainer. The state is also in process of selecting 3458 new ASHAs. In the PIP of 08-09 ASHA supervisor at the PHC level was approved for 149 BPHCs. Block level ASHA supervisor (part of ASHA mentoring group) will perform the role. Application for these positions have been sought.

The team got a chance to meet many ASHAs singly and in many groups. At one CHC, Dr Ashtekar conducted a participatory exercise with 82 ASHAs wherein 65 responded on a sheet to questions asked by him. The observations on ASHA programme are as follows:

- The ASHA programme has created a groundswell for NRHM in the state, they are the face of NRHM and a have visible and audible presence, with their dresses, umbrellas, radio and JSY contact. They will be now given cycles, which will give them a visible presence on rural roads. ASHAs are the verily the wheels of NRHM in the hinterland.
- Very few ASHAs have left work, and those who have left did so because of getting elected to panchayats.
- The 4 modules (training) have been completed. The quality and process has been variable. All had received honorarium and books.
- They found the AIDS lesson most difficult to understand (abstract??) and diarrhea and MCH lessons easy to grasp.
- Their major task is taking pregnant women to PHC-CHC and next comes immunization. Medical aid gets a small place. Most took fewer than 20 pregnant women for delivery in the year. Pvt Vehicle was the most frequent means of transport to hospital. Most complained about transport problems and distances.
- They spend an average of 3 hrs daily on the ASHA work.

- Most have latrines at their homes even before they became ASHAs
- All have received JSY money thru cheques, had bank books and probably there is no complaint about corrupt practices in the transactions. This is laudable indeed.
- All complained about difficulty in pregnant/delivered women getting their JSY money (1400) because of DD and banks unwilling to open account for just one transaction. This needs to be solved thru bearer cheques. 17 ASHAs had taken payment for TB case holding and 8 thru cataract case detection.
- Most of them earned a less than 10000 Rs in the bygone year and had spent more than 1000 on the job. Few had earned more than 10000 and very few >15000. That makes the earning about 600 pm. for most of them.
- They put the earnings to household use or children's education.
- All of them (except the new ones) got the medicine kits but most had no stocks left at the moment.
- They asked for a cycle, torchlight and a mobile/cell phone. But 80% had mobile phones in their families-the husband.
- In this district-Shivsagar, home delivery has declined according to them. When it happens, the dhai does this job. Two ASHAs can perform home delivery.
- Water disinfection is major challenge in villages-esp in tea gardens.
- Many feel the necessity to become permanent in this job.
- The few urban ASHAs had different problems--they demanded the same payment for PW women as exists in rural areas.
- None of them knew their Hemoglobin--this was not done.
- When asked, only 19 of them (out of 82)-weighed 50 kg and more. But all had done their weight at some time. However except 3 none had done their Hb.
- They listen to the weekly radio programme, which is popular
- The post-card system has taken off and is found useful by the SPMU.

Comments on ASHA programme

- The ASHA programme has started off, and lot more inputs are necessary for improving and maximizing gains. Each state can exercise freedoms for improving the ASHA concept and implementation, but Assam has also not taken a chance or think out of box. JSY remains the mainstay.
- ASHA mentoring group needs to meet and ASHA resource center is planned, but yet to materialize.
- The kit needs to be replenished from SC and PHC supplies, which is rarely done.
- The medicine kit should be enriched at state level.
- AYUSH is nearly missing from ASHA kit and so also homeopathy.
- ASHA facilitators are about t be implemented (Dr Ashtekarfeel this is rather done y the second ANM)
- A telephone helpline may be very useful for support.
- ASHA associations are actually a welcome step, not to be resented. Supporting and empowering these groups at block level may be an asset for NRHM and the health system.

They are available in most of the villages. They are mainly doing the JSY work, health and nutrition day and some immunization work. Few had done work of DOT provider and bringing the cataract patient to health facility. As per PRI view ASHAs are not doing any other work except accompanying pregnant females. Institution deliveries have increased after the introduction of ASHA programme in July 2006. They were found to be accompanying women for ANC and at the time of child birth at most facilities. No conflict between AWWs and ASHAs was observed and AWWs perceive them as supportive. Few ASHAs reported difficulties in arranging referral transport for pregnant females due to non availability or high charges for hiring vehicle. Many ASHAs face problem of staying at the health facility at the time of delivery.

ASHAs usually receive money after about 1 to 2 month of delivery but have not received since July now. Beneficiaries receive the money after 15 days to 1 month of delivery and not at the time of discharge. As per the most of the ASHAs, PRI and some beneficiaries, account opening by the JSY beneficiaries for encashment of the cheque received is a problem as banks are not willing to open an one transaction account. Banks demand Rs. 500 for opening an account and many a times beneficiary has to travel a long distance to reach bank. They want the money to be paid by cash or bearer cheque. ASHAs want that the compensation paid under JSY should be same for both urban and rural areas. In urban areas many a times pregnant female goes to health facility without informing ASHA though ASHA provided support during ANC; this deprives the ASHA of the incentive amount.

ASHAs have been provided with a Radio and there is regular broadcast of ASHA programme on Radios. Postcards have been given to all ASHAs to enable them to give feedbacks. There is no ASHA resource centre available. ASHAs are willing to take more work and they feel they have capacities to do more health related work. They want Govt. to provide them with a cycle and a mobile. Most of the ASHAs identified availability of clean drinking water and toilets as major problems in their villages.

Recommendations:

1. ASHA programme needs strengthening with a Resource Centre and mentoring group and refilling of drug kits form the PHCs and SCs frequently.
2. More training to ASHAs apart from JSY tasks.
3. Operationalise Block level ASHA Associations.
4. Timely distribution of JSY money to both ASHA and beneficiary has to be worked out.

10. Systems of financial management

Untied funds and AMG for SC for FY 08-09 has not yet been released. This delay should be avoided. At higher levels these untied funds are reported to have been released.

The status of funds received by the state and utilized is as follows :

Sl.No.	Components	2005-06 (Audited)	
		Grant Received	Grant Utilised
A	Opening Balance B/fd		
B	RCH-II	6,491.50	247.61
	NRHM	1,932.19	11.05
	UIP	368.55	102.66
	IPPI	483.72	475.72
Total B	Total Grant Received	9,275.96	837.04
C (A+B)	Fund Available	9,275.96	837.04
	% of Utilisation	**9.02%**	

Sl.No.	Components	2006-07 (Audited)	
		Grant Received	Grant Utilised
A	Opening Balance B/fd	8,438.92	
B	RCH-II	4,826.00	6,611.17
	NRHM	15,972.78	4,528.09
	UIP	311.73	522.53
	IPPI	737.10	1,135.47
Total B	Total Grant Received	21,847.61	12,797.26
C (A+B)	Fund Available	30,286.53	12,797.26
	% of Utilisation	**42.25%**	

Sl.No.	Components	**2007-08 (Upto Dec'07) (Audited)**	
		Grant Received	Grant Utilised
A	Opening Balance B/fd	17,489.27	
B	RCH-II	12,646.44	9,021.93
	NRHM	42,605.72	33,155.03
	UIP	1,123.78	1,396.54
	IPPI	735.46	656.06
Total B	Total Grant Received	57,111.40	44,229.56
C (A+B)	Fund Available	74,600.67	44,229.56
	% of Utilisation	**59.29%**	

Sl.No.	Components	2008-09 (Provisional)	
		Grant Received	Grant Utilised
A	Opening Balance B/fd	30,371.11	
B	RCH-II	14489	5758.34
	NRHM	17592.91	14162.26
	UIP	750	451.26
	IPPI		731.35
Total B	Total Grant Received	32,831.91	21,103.21
C (A+B)	Fund Available	63,203.02	21,103.21
	% of Utilisation		

As is clear from the above tables, the capacity of the state to utilize the funds made available to it under various compoenetns of NRHM has consistently increased. This speaks volumes about the leadership provided by State Health Mission and the proactive and responsive conduct of the District Health Missions

Statement Showing month wise Status of Fund form April'08 to November'08

Month	Opening Balance Rs.	Fund Received					Fund Disbursed Rs.	Closing Balance Rs.
		RCH Flexipool Rs.	NRHM Rs.	UIP Rs.	Suspense Receipts Rs.	Other Receipts Rs.		
April'08	236.67	49.91			13.03	0.54	111.10	189.05
May'08	189.05					0.01	0.94	188.12
June'08	188.12	144.89				6.27	0.86	338.42
July'08	338.42		170.93		4.07	7.60	61.51	459.50
Aug'08	459.50			7.50	0.19	0.33	17.28	450.25
Sept'08	450.25			10.58	2.47	0.77	33.14	430.94
Oct'08	430.94				8.62	0.01	137.97	301.60
Nov'08	301.60				4.96	0.00	10.19	296.37
		194.80	**170.93**	**18.08**	**33.34**	**15.53**		

Status of Funds recd by SHS from state treasury route.

The SHS had recd a total amount of Rs. 60 crore from the state treasure (Rs. 27 crore on 28.11.07 and Rs. 33 crore on 8.3.08). During 2008-09 provision has been made in the State Budget for the state share but no funds have been recd till date directly by the SHS from the state treasury.

Financial records and HMIS

The state needs to undertake comprehensive improvement in Financial record keeping. While the District PMU has full control of the financial data and can generate accurate financial reports with regularity, the state directorate as well as the Joint Directors at District levels are unable to capitalize on this capacity. The state may like to take up trainings of the District level officials in financial management and record keeping.

The utilization of grants received under NRHM, has increased from 9% in 2005-06 to 59% in 2007-08, though it is still underutilized which is attributed to following:

- Civil work can only be done in 6 months in a year
- Tender process takes time

Fund management has been reported better after merger of different societies. There is problem of inter-sectoral coordination due to lack of interest by other sectors in health sector. There are underserved areas like in Chirang district and in Indo Bhutan Border areas and the situation there appears to be really poor.

Recommendations:

1. Audit report of NRHM funds may be published on website.
2. Deputy Commissioner can play an active role for developing intersectoral coordination between health and related sectors.
3. Underserved areas may be attended to on priority basis.

11. HMIS and its effectiveness

The data environment at district, block and facility levels is extremely weak. Some data is collected routinely through the monitoring system and periodic check lists and pro forma reports, but the information is rarely analyzed, interpreted or used to provide feedback, improve services or enhance planning. In some cases, data are incongruent, and this is either ignored or unnoticed, suggesting that information is directed to the state and MOHFW without validation or review. For example, new ANC registrations over a 3-year period in one district are nearly 30% higher than total births over the same period. Bed counts differ between district and institution reports. In short, judging the performance of the system is limited due to the low availability and poor quality of the data. The MOHFW's HMIS system will

partially resolve this problem. But greater effort will be needed to validate data entry.

Other information problems observed by the team include: (i) no information is collected on basic service indicators such as patient days, diagnoses, length of stay, readmission rates, post partum length of stay, etc.; (ii) some of the statistical rates included in district reports are incorrectly calculated (MMR, IMR); (iii) each district appears to calculate data tables based on different time periods making comparisons impossible. For example, some data is reported for Jan-Dec while others use April-March, and still others place partial year data; (iv) there is no standardized format for case registration in OPD and IPD. Most physicians write the name, age, gender, and primary diagnosis of the patient in a register book. Diagnoses follow no standardized methodology or coding. (v) the limited OPD information collected on the patients is not compiled; and (vi) there is no medical record system in OPDs, which seriously compromises quality.

***Recommendations*:**

- Once the electronic HMIS is fully functional in the state, provide instructions on how to calculate standardized rates and other indicators. Provide TA on how to analyze, interpret, and disseminate information on system performance, using trend analysis, facility comparisons, comparative population-based ratios, etc.
    - Each district should conduct biannual data reviews with each institution to demonstrate their performance and show how well they compare with similar institutions;
    - Establish a medical record system and implement it state-wide;
    - Establish standardized patient registration and consultation forms for the OPD and IPD. These forms should allow for the standardized registration of diagnosis through ICB coding system. Consult successful examples from other countries.

The state has partially operationalised the web based MIS created by the GoI. The State level data manager is aware of the contours of the web based MIS but has some queries regarding the same. Reported data in the appropriate format is available with the State Data manager and web based data can start flowing as soon as the trainings on the subject are completed for the SPMs and DPMs. There appears to be some confusion regarding the discontinuation of the format prescribed by the NHSRC after the web based protocols are started. Appropriate clarifications in this regard should be issued to the state by the M & E division or the NHSRC.

At district level, the state appears to be recovering from almost total data blackout for the period prior to NRHM. The District level Data manager is able to produce a lot of data relating to the period after 2005 but has almost no comparable data for the prior period. The Joint Director in the District is not very aware of the data which is available to his team of DPMs. The JD has almost no understanding of the data formats, data logic or the purpose for which the data is being collected or utlised. Clearly the HMIS has not received sufficient respect in the planning of the Districts. The fidelity of data and its regularity would therefore need to be discounted. In the period after 2005, a large amount of data has started to become available. However, since the district data managers are not really skilled at epidemiology, they are unable to focus on comparable data or present statistically valid analysis form the data available to them. It was noted that almost none of the DPMs were factoring the population growth while presenting the demographic data in their district level reports and plans.

The appropriate training of District level officers in data gathering, data analysis and management and at least basic epidemiology would be very useful for the state.

As part of monitoring and supervision protocol by District and Block level Health Officials, the state Govt has given checklist for monthly supervision. The districts are supposed to keep filled up all checklists for all facilities for the full year. The same were examined in Shivsagar district. It was noted that these checklists are not tabulated and no analysis appears possible from them. This makes the

supervision very weak. Also the checklist is inordinately long and never really charted fully or regularly. The administrative supervision of the district level functionaries therefore leaves much to be desired and the state may like to focus on this. The technical supervision is also not very robust and seve

12. Community Processes under NRHM

The Community Processes in the state of Assam need greater support and capacity building. Although the RKSs are operational and are maintaining the bank accounts, they need to be trained to use the funds appropriately on basis of the felt needs of the respective health facility. The state may like to take up a coherent and long term training plan for the RKSs, VHSC and the other elected bodies in the state.

The ASHA initiative in the state has been separately analyses in another para of this report.

The NGO sector needs to be involved more closely under the NRHM in the state. The CRM teams had a chance to interact with the representatives of the Voluntary Health Association of Assam who are the state nodal NGO for the first Phase of Community Monitoring initiative in the state. The Community Monitoring initiative reportedly started late in the state of Assam. The understanding of the strategy as also dissemination of the ideas to the district level NGOs has been relatively slower in the state. Apparently there are very few NGOs having state wide coverage in Assam and hence the process would not be able to achieve critical sustainable mass unless a major initiative for capacity building of the NGOs is taken up by the state. The state may like to involve the RRC in this exercise and dove tail the 1st phase of community monitoring activities into the long terms capacity building plan.

The team also had a long discussion with the community representatives at the ANT facility at Bongaigaon. The organisation ANT has substantial presence at the grass root level in the area. However the district establishments do not appear to be able to build on the capacities in the organisation. The involvement of ANT and other NGOs in RKSs, District Planning work and monitoring and mentoring of ASHAs needs to be expoanded. Meeting at the ANT NGO

Chirang district is newly formed district (two years) but has little infrastructure. An NGO ANT works in this area (Bodoland) on the Indo-Bhutan area. We met about thirty volunteers of this NGO and a dialogue on health. The important comments:

- NRHM has made big difference where there was a total absence of health system
- This part has many displaced communities due to civil strife, and have no services, with high maternal and infant mortality
- Community monitoring has been helpful
- Doctors and nurses do not stay in health centers
- Health care providers charge money for services
- Refusal of services is common, even at the nearby Bongaigaon hospital
- Cost of JSY transport is huge; ASHAs or families can not afford that thru the JSY support.
- ASHA training is poor. Need for local language (bodo) training[5]. Illegal bastis have no ASHA. We have formed ASHA associations, which is somewhat disliked by the authorities.
- IV sets have to be bought by the patient at Rs 50/- (common in Assam state), though saline comes free. This is how doctors fleece the patients
- there is some resistance to involvement of ANT in NRHM.

[5] Book 2,3,4 has been made available in Bodo language thru the effort of DPMU and ANT

The team also visited one of the health kiosks being run by the NGO called Drishtee where a business model of health service delivery using minimally trained workers is being used as a mode of empowerment of the women as well as provisioning of the health services to the underserved areas. This is a promising model for providing health and related services in remote areas through local participation and the state may examine it for expansion to other districts also.

13. Assessment of non-governmental partnerships for public health goals

The CRM team witnessed the partnerships in initiatives like the boat clinics in selected districts of the state. The arrangement is indeed working very well and is taking basic health care to hitherto unserved are as in the state. However, much greater efforts are needed on a much larger scale for Go-NGO partnerships to reach sustainable mass in the state. There are a large number of tea garden hospitals in the state. The tea garden areas are also admittedly the locus of greater morbidity and mortality because of lack of education, awareness and relatively poor sanitation and drinking water availability. This situation can be addressed through a detailed, long term plan for synergy with the Tea Garden Hospitals. The functionaries at State and District level may need training on the drafting of MoUs with nongovernmental partners. Several draft service provisioning MoUs are available in the World Bank research papers and the state may like to consult them as generic formats to build pro poor partnerships with non governmental providers.

NRHM should reach out to the larger society of Assam, the intellectuals, institutions, culture-groups, professionals and resource groups to be able to enrich the entire gamut of activities--from ASHA to district hospitals. The RKS is to be seen as instrument for this rather than fund management. There is need to look within and without, and forge non-monetary helplines. This calls for political initiative.

Involving ANT in ASHA programme will provide major boost in the state, but for some reason there is a kind of face off. The only assets in a difficult state are thus neglected.

Representative of NGO is a member in RKS in some places but no other involvement of NGO was observed for service delivery.

Recommendations:

NGOs may be involved to maintain continuum of services and for assured service delivery at different levels.

14. Systems in place for outreach activities of Sub-centre:

Some of the Sub Centres in the state were found to be functioning very well with a resident ANM, an additional ANM, high quality buildings constructed under various donar funded initiatives and signs of upgradation using the untied funding under NRHM. The variation between various parts of the district on this matter is however a cause of concern. A large number of SHCs in the state are in rented buildings. The ANMs are not resident is a large number of SHCs. A sustainable model for operationalising the SHC as a locus of outreach activities needs to be taken up by the state.

The Sub Centre building construction is going on at a steady pace. The pace is however not fast enough for the physical infrastructure shortage to be addressed adequately in near future. Also, the construction of SHCs is done by the State Government through the Assam state housing board. The District Officials are not able to take stock of the progress of work in this regard from the Board. Hence the ownership of the upgradation work at District level is rather deficient. If the construction is undertaken under the direct supervision of the district level functionaries, the ownership would be much greater. The state may like to examine this status.

The state does not have any Male Multipurpose workers. The cadre may be reexamined for rejuvenation at least in the remote areas where the husband of the ANM is often found to be a helping hand in her work.

The state has operationalised 108 scheme in some of the districts but the same needs to be scaled up and evaluated. The boat clinics also need to be supported with more boat ambulances to improve the reach of the medical teams.

15. Thrust on difficult areas and vulnerable social group

Special efforts are being made by the state to address health needs of tea estate workers and people living in the tribal and char areas. However, as on date there does not appear to be a very robust plan and these areas continue to be poorly serviced. The district of Chirang continues to be an underserved area. It is clear that these issues are in sharper focus since the launch of NRHM and some efforts have been made. However the lack of adequate, willing human resources and the poor planning capacity at the sub district level is a limiting factor to any improvement. The state may like to add a separate, dedicated chapter in its NRHM PIP about such areas and communities and make a time bound plan to bring about positive change as has happened in other parts of the state.

16. The preventive and promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health

The Panchayat elections have recently been concluded in the state. This offers a remarkable opportunity to the state to seek active engagement of the new Panchayat members in the change process under way under NRHM. While the elected representatives are indeed members of committees at various levels under NRHM, their understanding of critical issues and the overall perspective plan of the state needs to be shared with them. The state needs to operationalise a specific road map for this capacity

building. The other departments of the state government like sanitation, water supply, education etc are stated to be members of the Mission at all levels. However, Intersectoral convergence as an operational theme was not visible at most of the places visited by the team. Drinking water and sanitation are key issues in most parts of the state, more so in the tea estates and riverine areas. The stoic approach of (most of) the District heads of health system to Intersectoral convergence (and in fact to NRHM in general) is clearly the factor prohibiting true Intersectoral planning. The Joint Directors of Health needs to take on a more active role in addressing the Intersectoral issues. Until that happens, vertical, state or central interventions for malnutrition, age at marriage, education etc appears to be the only way ahead in the state. In fact in these activities even the PMUs are not able to make much contribution since these are not perceived as key reporting entities even at state level. While health system is gaining from the fast economic development in the state, the same cannot be said for the communities which are at the fringe of this economic development. The communities and themes which are getting left out of the overall economic development of the state are being left out by the health system also. The NRHM is mandated to address this inequality and the state may like to prepare a comprehensive plan for the same.

17. Effectiveness of the disease control programmes including vector control programmes

As has been stated earlier, the major impact of NRHM is visible on RCH related activities. The benefits to the overall service delivery, National Disease Control Programmes, usual hospital activities of OPD, Labs, Pharmacy et al appear essentially incidental and are much smaller in impact. While maternity cases are flooding the public health facilities, there is still much to be done to improve lab services and availability of medicines. It appears mostly to be a management problem but the team also got a feeling that the doctors were not very interested in running the public health facilities as self contained centre for curative services. There appears to be a pattern in letting even

good equipments remain unused or avoiding even new physical infrastructure for small reasons of convenience. The people's perception f health about performance of disease control programmes. Are required manpower available for disease control programmes like TB, Malaria, Blindness Control, etc.? Involvement of ANMs, MPWs and other supervisory staff in implementation of disease control programmes; vacancy of contractual staff like Senior Treatment Supervisors, Senior TB Lab Supervisors and the duration for which the posts are vacant under RNTCP; Availability of lab technicians and lab consumables for conducting quality diagnostic sputum smear microscopy activities at the Designated Microscopy Centres; Timeliness of payments to contractual staff; Progress on establishment of Eye Operation Theatres and increasing Eye Surgeons in rural areas; the time taken for reporting surveillance data and the ways of consolidating information.

No district level laboratory available under IDSP. IDSP reporting is not being done weekly.

Malaria cases and deaths have reduced mainly due to use of rapid diagnostic kits and ITBN (Insecticide treated Bed Nets). ASHAs are being trained in RDK use and blood slide making; about 25% have been trained so far. There is problem of DDT refusal in some areas.

T.B. and Leprosy programmes reported to be doing well.
Ophthalmic Assistant was found to be doing only screening of patients for cataract and their referral. He was not doing refraction or any treatment of common eye ailments.

Recommendations:

1. IDSP reporting needs correction.

2. Dis-incentive for over-reporting should be enforced. RKS/VHSC may be asked to supervise immunization work and village health and nutrition day.
3. Public health specialists should be made programme officers for national health programmes.
4. Ophthalmic Assistant should be made fully functional by providing all facilities as per guidelines for vision centre.

18. Performance of Maternal Health, Child Health and Family Planning Activities seen in terms of availability of quality of services at various levels

The state has set up a large number of New Borne Care Units at PHCs. In Shivsagar District, these units are being set up at Galekey BPHC, Gourisagar BPHC, Morabazar BPHC & Khelua BPHC It is however noted form the service statistics that the number of deliveries at most of the new born care units are very few,. These are located very close to preexisting bigger facilities. At some places the equipments are not utilized as renovation is not complete and so the service provider is not staying there.

DISTRICT : BONGAIGAON

1) Maternal & child death:

NAME OF BLOCK PHC	MATERNAL DEATH			INFANT DEATH			CHILD DEATH (Between 1 Yr & 5 Yr)		
	06-07	07-08	2008-09 (Upto Oct)	06-07	07-08	2008-09 (Upto Oct)	06-07	07-08	2008-09 (Upto Oct)
BALLAMGURI		0	Now in Chirang BTAD		0	Now in Chirang BTAD		0	Now in Chirang BTAD
BOITAMARI		2	1		6	2		0	1
BONGAIGAON	4	7	3		19	15		2	4
MANIKPUR		3	1		78	15		19	3
SIDLI	6	7	Now in Chirang BTAD		43	Now in Chirang BTAD		1	Now in Chirang BTAD
SRIJANGRAM	5	6	6		112	95		20	70
TOTAL	15	25	11	0	258	127	0	42	78

* The information for 2006-07 for infant / child death available as there was no system of reporting deaths from the periphery.

The blind spot on home births :

The state is notching a 60% institutional delivery from a low of 37% before NRHM started. Some districts have done better still. Yet the 40% home births have no services, no DDKs, no dais to support and no training for them. Apart from harming the maternity statistics, this is less than humane. NRHM can not get every pregnant woman to an institution, and must not cause a virtual neglect of home births.

Full coverage of immunization has improved in all places. Measles vaccine was not available for about 3.5 months till few days back. There are problems of resistant families and migrants in some areas which affect immunization. There is over reporting of immunization from most of the subcentres.

19. Assessment of programme management structure at district and state level

Programme management units have been formed at state, district and block levels. They are provided with all the functionaries as recommended. PHCs have also been provided an accountant at most places. They have been playing significant role in planning and monitoring. Most of them are young and enthusiastic. Due to lack of training, many of them were not doing the work of preparing the health plan especially at block level and were not helping the ANM in preparing village health plan.

In the state of Assam, there are 149 Block Programme Managers in position, 149 Block Accounts Managers in position and 454 PHC level accountantsin position.

During the state level interactions the team requested SPMU staff to write critical comments/remarks on a paper, and the responses read as follows;

Critical comments

Concurrent audit should be introduced and accounts monitored by experts.

Provide annual increments/incentives for the contractual staff in PMU/DPMU

Tasks are too many, reduce them

No MPW, hence shortage of surveillance worker

Need for coordination between NRHM and the Health system

Need to change modus operandi

Mismatch between PIP heads (budget) and activity heads

Improve numbers of support staff

Lack of baseline data-hence planning is difficult

Review the physical and financial activity

Micro planning of activities by respective heads is essential

Is ASHA expected to do ANM work? The former is only a voluntary worker.

Need to train medical and paramedic staff according to NDCP guidelines.

Negative comments

Too rigid structure for NGOs

community ownership is lacking

Lack of decentralization and decision process

Delayed approvals are harmful

Demotivation is a problem.

How to create ownership of the programmes by service providers ?

NRHM is not sustainable as there is no ownership by the health system. Hence IMR-MMR-TFR will not be reduced. Who will solve this problem-GOI or GO Assam?

NRHM is seen as a parallel or even replacement system for the usual Public health system. How long this will work at all?

Positive comments

Thanks to the Hon Health Minister, NRHM has revolutionized health system in the state.

Fund flow has become easy due to NRHM

JSY,FRU, 24*7 and ASHA have created a revolution in health care

NPCB experience is good, trained HR, 28 NGOs, but no designated eye OT

Recommendations:

1. Requisite trainings for programme managers may be completed at an early date.
2. They can be used for supportive supervision of the ANMs and ASHAs apart from other work.
3. They should play key role in accurate data collection and analysis.

Ownership and Commitment of Regular State Staff

"Sometimes you feel like you are doing so much and other times you feel like you have done nothing." This was expressed by a professional of the State Management Unit (SMU), displaying frustration in securing support for NRHM from the regular public health system. The lack of response was also observed at the community level. One NGO representative active in a large number of villages stated that "the system needs to find a better response or the people will give up on NHRM."

The root of this lack of commitment lies in the parallel managerial, human resource, and financial system that has emerged at the state and district levels with the emergence of NRHM.[6] For example, the Program is essentially managed by a cadre of young professionals with temporary contracts. These are the engines of change, but they lack the authority to move the broader state public health system. NRHM has been overlaid on a dysfunctional, state-run public health system in which accountability for performance (however defined) is nearly non-existent. Staff in the regular system is entrenched in an "old way of doing business" which is manifested by work shirking, absenteeism, informal payments, side payments for postings, poor quality of care, and little commitment to the community or the health system. According to HRHM personnel, regular system staff "thinks leisurely". . . "have no sense of responsibility" . . . and "respond in slow speed." In short, there is no accountability for results. Whether one works (or not) or is committed (or not) makes little difference since there

[6] A case can be made that elements of this parallel system began with previous and on-going CSSs.

are few consequences or sanctions in the system for poor performance (or rewards for good performance). Under these system conditions, NRHM can best be described as putting old wine in new bottles.

Regular public health staff heads the overall health system at the district and block levels. They are mainly physician-bureaucrats posted on the basis of seniority. Worse, districts have appointed very senior staff as Joint Directors – all are physician bureaucrats who are close to retirement. Many appear to be biding their time and are only marginally engaged in NRHM implementation. They could not respond to team inquiries regarding NRHM guidelines, roles and responsibilities, reporting requirements. Nor were they knowledgeable of simple demographic and service indicators related to their districts. This lack of engagement and leadership is a very serious constraint to NHRM expansion, and ultimately, performance and community acceptance. Senior health system personnel don't have the interest, energy and motivation to implement an innovative and complex program such as NRHM

Regular professional personnel, especially practicing physicians, are the de facto team leaders of PHCs, CHCs, and district hospitals. Many also display little ownership in and commitment to the spirit or letter of NRHM. They appear to have little concern for broken equipment, dirty conditions, lack of drugs and supplies, etc. In short, they take little initiative to improve the places where they work -- even given the availability of RKS funds.[7] If physicians don't make these demands, no one else will.

Recently hired DPU and SMU staff on temporary contracts is the main reason for NRHM's success. They make the difference through their efficiency, energy and negotiating capacity. However, all reported increasing frustration with working with regular staff and getting the latter to respond to the changes linked to NRHM. Extracting information and reports from program officers and institutions is particularly onerous. All appear overworked. One DPM reported that regular staff often tell him that NRHM "is your work, not mine." When a team member suggested training this

[7] As discussed below, low salaries may contribute to attitude.

staff, one state official suggested that training will not address this problem: "we have sent many training; but they come back and do nothing" [in terms of knowledge received from the training]

In sum, there exists a clear cleavage between public health system and NRHM. At best, convergence is not taking place. At worse, the gap may be widening as NRHM continues to expand. NRHM staff is not empowered in part because they are external to the public health system. But the public health system itself is unaccountable and ineffective and in need of major structural reform. In short, NRHM will not survive on the backs of temporary workers. As stated by one official, "the DPMs are a harassed lot; they are not going to last." If and when the current group of "young bloods' resign, NRHM will come to a standstill, and the system will revert to the status quo ante. One high level state official acknowledged: "the DPUs will last for 3 to 5 years; once the staff departs, we will have to start all over again from ground zero."

***Recommendations*:**

Short-term

- Carefully select joint directors and other senior staff to key positions based on commitment to system changes and NRHM rather than seniority;
- Consider placing professional personal in managerial positions with specialized skill sets such as in executive management, materials management, HR management, financial management, accounting, etc. Avoid using physician-bureaucrats for these positions;
- Consider using severance pay to reduce the number of "dead wood" in the system, replacing them with temporary workers on performance-based contracts and payment scales;

Medium-term

- Develop a public health cadre to become managers of disease-specific and other public health programs;
- Develop a strategy for real convergence. This may require public management reform involving the labor regime for health workers. For example, consider developing a separate labor regime for health professionals, particularly physicians that is performance linked (see below) does not provide life time employment.

Part 2
Progress against the approved PIP of the state

The state PIP for FY 2008-09 was appraised and approved by the National Programme Coordination Committee during its meeting on 26th March 2008 . Funds are being released to the states on basis of the approved plans. The CRM team charted the progress of implementation of the initiatives which have been approved under the state PIP. The progress of key initiatives approved in the PIP of the state for FY 2007-08 and 2008-09 (till October 2008) are tabulated in Annexure to this report.

Chapter 5 Recommendations

The CRM team interacted with the Health Minister of the state on the last day and briefed him about the salient features of the findings. Some of the key points discussed during the meeting included :

1. The multiple nomenclatures below the CHC and above the SC may be examined for rationalsiation. The key could be as follows :

   SC for 5000 population, PHC for 30,000 population

   CHC for 1 lakh population (at Block HQ where CHC is located, PHC is not reqd)

   DH for each district (at district HQ, where DH is located, CHC or PHC is not reqd)

1. Create a Specialist cadre. The general duties should be done by MBBS, PHC may have an MBBS and all post graduates should be used as specialists for respective departments.
2. Rationalise cross system practice. AYUSH recruits should have their system medicines. If they are mandated to prescribe modern medicines, then some training should be imparted.
3. The state should not replace state funded vacancies by NRHM funded recruitments. ANMs recruited on contract should first be positioned at SCs (and not at higher levels). Similarly recruit on contract only that specialty which is needed and not for general purposes.
4. State funded construction should not be replaced by NRHM funded constructions. Many new PHCs are being constructed through NRHM funds. This may be reexamined. NRHM funds are really for gap filling only.
5. The Technical Supervision may be institutionalised. The medical college can help in verifying the OPD and IPD turnovers of public health facilities and recommend HR rationalisation, equipment upgradation, supplies augmentation etc. The productivity of individual doctors could also be monitored in this manner

6. The private practice permitted to the public health doctors is seriously jeopardising the service delivery in Public facilities. This should be re examined.
7. Over all HR rationalization may be undertaken and mismatches corrected.
8. Referral audits should be undertaken. The public facilities are expected to treat as many cases as can and refer only the more serious cases. Even in that case the referral support has to be arranged. No patient should be turned away.
9. The availability of medicines and consumables including suture material, gloves, antibiotics needs urgent augmentation at almost all facilities.
10. Some behaviour change training of service providers so that they act to make available basic services (bulb in a Labour room light, chair for patient /attendant, BP instrument and other basic tools of business. Also to bring about basic respect for patient care.
11. The Infrastructure upgradation efforts should be part of an overall plan and not ad hoc. Lot of public infrastructure (building and equipment) is lying non operational for various reasons. This can be corrected.
12. Most labs in public facilities are doing only very basic tests. The range can be increased. At many places, availability of Lab technicians appears to be sufficient , yet the lab services are very deficient.
13. Basic Hb test should be undertaken in all ANCs since blood is already collected from all antenatal cases for HIV testing.
14. The Joint Directors and other senior level officers in the Health directorate need to take on more responsibility. state may examine positioning professional managers at public health facilities for managing HR, supplies, and overall service delivery. At present many JDs do not appear to have things in their control.
15. Services of dental, eye, ENT etc need to be augmented. Even where these specialists are positioned, the supplies of other tools are often not available. This needs to be corrected.
16. Improve telecom and travel support to supervisory cadres in the Health directorate. The JD's vehicles should be new and comfortable. The access to computers and internet also needs to be expanded

17. Allocation of state budget for health needs enhancement. 15% allocation (of total NRHM allocation) should flow into the Health Society account.
18. Underserved areas like in Chirang district and in Indo Bhutan Border areas may be attended to as the situation there appears to be really poor.
19. Data reporting and analysis may be improved. Very little quality data appears to be available even at the District HQ level. Analysis of the data which is available is also not comprehensive.
20. Special attention should be paid to maternal death and malaria death data which does not appear to be reported with adequate attention.
21. Rationalise the salary structure for doctors and paramedics
22. Additional incentives may be planned for persons who are posted in difficult areas so that regular services can be made available.
23. Availability of food (for patients and attendants) in public health facilities would go a long way in improving access and utilisation.
24. Decision to allow and facilitate deliveries at subcentre be taken.
25. Operationalise Sub Centres as the first point of contact.
26. ASHA programme needs strengthening with a Resource Centre and mentoring group and refiling ofdrung kits form the PHCs and SCs frequently.
27. More training to ASHAs apart from JSY tasks.
28. Operationalise Block level ASHA Associations.
29. Home deliveries need to be attended to and disposal delivery kits provided and also paid the JSY benefit of Rs. 500.

During the interactions Hon' Health Ministyer mad ethe following key observations :

- NRHM has made a big difference to the lackluster health system of the state, despite a late start
- We need to make available doctors-hence we have started new medical colleges (is it from state funds or nrhm?)
- We will appoint well trained MPWs at sub centers
- All SC needs to be operational for childbirth
- We know the non-involvement of health system doctors (JDs) but our approach is to ensure that some of them at least not to obstruct the progress.

- Salaries of doctors and nurses, despite incentives, are low indeed. Sixth pay commission will help to some extent, but the big gap is difficult to fill.

Some other recommendations include :

- Cost of running 108 service The team was told that contracting a 108 unit cost a monthly 70000/- bill to NRHM. The people and providers were happy about the 108 service. However it needs to be examined if the model is the most appropriate and cost effective model for managing an ambulance service / emergency response service.

- Quality Review of Upgradation and equipment: Need checklist to assess the quality of constructions, upgrades, and equipment. No information on the quality of investments.

- Stagnant pay of contracted workers: Contracted workers have not received a pay increase even though a number have been working for 3 years.

- PRIs: need considerable handholding. Health is not high on their agenda compared to economic infrastructure and transport. Village committees have no capacity

- AMNs do flavor of the month. Example is pulse polio

- Side payments and politically-driven postings guide transfers, especially for physicians. According to one physician informant, “those in good places (postings) are always in good postings.” Side payments and political connections appear to determine if and where one is transferred.

- Community monitoring can be beneficial if kept simple. Areas for monitoring include: (i) instilling in community their rights regarding service delivery; (ii) monitoring informal payments, service refusals, work shirking by staff; (iii) discrimination for racial and religious reasons

- Poor quality was observed in all institutions: “Functional” OTs without proper equipment, ICU or post-OP room. Dirty and unsanitary conditions in labor and birthing rooms. No data collection on infection rates. One nurse did not know how to use a blood pressure cuff. Observations of OPD suggest that many doctors perform only cursory examinations and rapidly dispatch each patient. Nurse not trained on how to use new equipment.—oxygen monitors, suction apparatus. No patient triage or management in OPD. Inhumane treatment by staff.

Assam

DLHS – Key Indicators

Indicators	DLHS-3 (2007-08)			DLHS-2 (2002-04)		
	Total	Rural	Urban	Total[1]	Rural	Urban
Sample size						
Households	37,830	33,118	4,712	24,269	17,399	6,870
Ever married women (age15-49 years)	30,243	26,628	3,615	NA	NA	NA
Currently married women (age 15-44 years)	28,307	23,240	3,067	17,778	12,983	4,795
Unmarried women (age15-24 years)	9,311	8,050	1,261	NA	NA	NA
Population and households profile						
Population literate age 7+ years (%)	78.0	76.4	90.8	72.1	69.6	89.0
Population below age 15 years (%)	31.8	32.6	25.6	33.4	34.5	26.4
Mean household size	5.0	5.1	4.6	5.3	5.4	4.6
Percentage of household that						
Have electricity	37.1	30.3	86.0	35.1	27.0	83.2
Have access to toilet facility	69.7	66.1	95.5	71.1	67.5	95.5
Live in a *Kachcha* house	71.2	76.5	34.0	68.2	74.1	28.7
Live in a *Pucca* house	5.5	3.0	22.8	15.1	9.7	51.4
Use piped drinking water[2]	9.5	6.3	32.2	13.1	9.1	39.6
Low standard of living	65.4	71.8	19.9	64.4	71.3	18.2
High standard of living	12.1	7.3	46.1	14.2	9.4	52.8
Awareness about Government health programmes (based on response from households)						
DOTS (Tuberculosis) (%)	58.4	55.6	78.2	NA	NA	NA
Leprosy Eradication (%)	35.7	31.9	62.4	NA	NA	NA
Malaria/ Dengue/ Chikun Guinea (%)	90.4	89.6	94.8	NA	NA	NA
Prevention of Sex Selection (%)	28.8	24.5	58.4	NA	NA	NA
Marriage						
Mean age at marriage for boys (marriages that occurred during the reference period)[3]	27.0	26.8	28.5	26.9	26.6	28.9
Mean age at marriage for girls (marriages that occurred during the reference period)[3]	20.9	20.6	23.2	20.4	20.1	22.4
Boys married below age 21(marriages that occurred during the reference period)[3] (%)	11.3	11.0	6.6	10.9	11.6	6.4
Girls married below age 18 (marriages that occurred during the reference period[3] (%)	21.8	23.2	8.2	25.8	27.7	13.0
Currently married women age 20-24 who were married before age 18 (%)	39.9	40.5	34.0	NA	NA	NA
Indicators based on currently married women (age 15-44)						
Characteristics of women						
Currently married non-literate women (%)	30.1	32.3	13.4	39.5	43.3	14.2
Currently married women with 10 or more years of schooling (%)	18.0	15.1	40.2	15.3	11.5	40.4
Fertility						
Births to women during age 15-19 out of total births[3] (%)	5.2	5.4	3.7	NA	NA	NA
Women age 20-24 reporting birth of order 2 & above[3] (%)	40.5	41.0	34.1	45.9	NA	NA
Women with two children wanting no more children (%)	70.1	78.1	87.2	68.2	63.6	73.0
Mean children ever born to women age 40-44 years	3.8	4.0	2.9	3.9	4.0	2.8
Current use of family planning methods						
Any method (%)	49.7	48.5	58.9	55.6	53.6	67.5
Any modern method (%)	31.2	29.8	42.2	28.9	25.2	38.3
Female sterilization (%)	10.7	9.8	16.9	11.6	10.6	19.2
Male sterilization (%)	0.2	0.1	0.3	0.1	0.1	0.1
Pill (%)	16.5	16.4	17.8	12.0	11.9	12.9
IUD (%)	1.5	1.5	1.0	1.3	1.3	1.0
Condom (%)	2.3	1.9	5.4	1.8	1.3	5.1
Any traditional method (%)	18.3	18.6	16.6	28.6	28.5	29.2

NA: Not available.

[1]Percentage of total (rural-urban combined) in DLHS-2 is adjusted according to rural-urban distribution of population as per 2001 Census.

[2] Piped drinking water in DLHS-2 includes tap (inside residence/yard/plot) or tap (shared/public) or hand pump/bore well, well covered; DLHS-3 includes piped into dwelling, piped to yard/plot, public tap/standpipe.

[3] DLHS-3 reference period is from 1-1-2004 to survey date; DLHS-2 reference period is from 1-1-1999/1-1-2001 to survey date.

Indicators	DLHS-3 (2007-08)			DLHS-2 (2002-04)		
	Total	Rural	Urban	Total[1]	Rural	Urban
Current use of family planning methods (contd.)						
Rhythm/Safe period (%)	10.8	10.9	10.1	20.7	20.8	19.8
Couple using spacing method for more than 6 months (%)	15.2	14.7	18.8	NA	NA	NA
Ever used Emergency Contraceptive Pills (ECP) (%)	1.4	1.3	2.0	NA	NA	NA
Unmet need for family planning						
Total unmet need[4] (%)	26.1	26.7	21.6	23.6	24.6	16.8
For spacing (Definition I) (%)	6.9	7.2	5.0	8.7	9.2	5.7
For limiting (Definition I)(%)	19.2	19.5	16.6	14.9	15.5	11.0
Total unmet need[5] (%)	-	-	-	NA	NA	NA
For spacing (Definition II) (%)	-	-	-	NA	NA	NA
For limiting (Definition II) (%)	-	-	-	NA	NA	NA
Antenatal care (based on women whose last pregnancy outcome was live/still birth during the reference period)[3]						
Mothers who received any antenatal check-up (%)	74.6	73.1	89.2	59.8	55.2	85.8
Mothers who had antenatal check-up in first trimester (%)	39.4	37.2	59.9	38.5	33.2	68.2
Mothers who had three or more ANC (%)	45.1	42.8	67.7	39.4	33.8	71.2
Mothers who had at least one tetanus toxoid injection (%)	69.3	67.7	84.9	55.0	50.1	82.9
Mothers whose Blood Pressure (BP) taken (%)	36.2	33.3	64.6	28.6	22.6	62.4
Mothers who consumed 100 IFA Tablets (%)	14.0	13.2	21.7	12.8	10.4	26.1
Mothers who had full antenatal check-up[6] (%)	7.5	6.6	15.2	9.7	7.6	21.9
Delivery care (based on women whose last pregnancy outcome was live/still birth during reference period)[3]						
Institutional delivery (%)	35.3	32.0	66.8	23.2	17.1	64.2
Delivery at home (%)	63.6	66.9	31.3	75.5	81.8	33.3
Delivery at home conducted by skilled health personnel (%)	7.7	7.3	14.5	9.2	8.4	14.8
Safe Delivery [7](%)	40.2	36.9	71.3	29.8	24.0	69.1
Mothers who received post-natal care within two weeks of delivery (%)	33.0	29.8	63.3	NA	NA	NA
Mothers who received financial assistance for delivery under JSY[8] (%)	24.9	25.0	23.4	NA	NA	NA
Child Immunization						
Number of children age 12-23 months	2,757	2,504	253	1,926	1,495	432
Children 12-23 months fully immunized (%)	48.0	46.9	59.0	16.0	14.4	26.7
Children 12-23 months not received any vaccination (%)	13.0	13.4	9.8	24.7	27.3	7.4
Children 12-23 months who have received BCG vaccine (%)	80.5	80.2	84.3	61.3	57.9	83.9
Children 12-23 months who have received 3 doses of DPT vaccine (%)	56.5	55.5	66.9	36.3	33.1	57.9
Children 12-23 months who have received 3 doses of polio vaccine (%)	63.7	63.0	70.2	27.6	25.6	40.6
Children 12-23 months who have received measles vaccine (%)	65.2	64.7	70.8	33.7	30.8	53.4
Children (age 9 months and above) received at least one dose of vitamin A supplement) (%)	51.7	50.4	64.7	17.3	15.3	30.3
Child feeding practices (based on last-born children) (%)						
Children under 3 years breastfed within one hour of birth[9]	65.7	66.1	61.0	50.6	49.8	55.9
Children age 0-5 months exclusively breastfed[10]	61.8	61.1	70.0	NA	NA	NA
Children age 6-35 months exclusively breastfed for at least 6 months	32.2	31.6	37.8	21.7	NA	NA
Children age 6-9 months receiving solid/semi-solid food and breast milk	66.7	67.1	61.7	NA	NA	NA

[4 & 5]Total unmet need refers to unmet need for limiting and spacing.

Definition I: **Unmet need for spacing** includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant who want more children after two years or later and are currently not using any family planning method. The women who are not sure about whether and when to have next child are also included .**Unmet need for limiting** includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant and do not want any more children but are currently not using any family planning method(These definitions are same as DLHS-2).

Definition II: Unmet need for spacing includes fecund women who are neither pregnant nor amenorrhoeic, who are not using any method of family planning, and say they want to wait two or more years for their next birth. It also includes fecund women who are not using any method of family planning, and say they are unsure whether they want another child or who want another child but are unsure when to have the birth. **Unmet need for limiting** includes fecund women who are neither pregnant nor amenorrhoeic, who are not using any method of family planning, and who want no more children (These definitions are similar to NFHS-3).

[6]Full ANC: At least three visits for antenatal check-up, one TT injection received and 100 IFA tablets or adequate amount of syrup consumed.

[7] Either institutional delivery or home delivery attended by skilled health personnel (Doctor/ ANM/Nurse/midwife/LHV/Other health personnel).

[8]Janani Suraksha Yojana for deliveries from 1-4-2006 to survey date.

[9]DLHS-2 data indicates children breastfed within two hours of birth.

[10] Children who were given nothing but breast milk till the survey date.

Indicators	DLHS-3 (2007-08)			DLHS-2 (2002-04)		
	Total	Rural	Urban	Total[1]	Rural	Urban
Awareness about Diarrhoea and ARI						
Women aware about danger signs of ARI[11] (%)	39.7	38.5	49.4	20.9	19.4	30.6
Treatment of childhood diseases (based on last two surviving children born during the reference period)[3]						
Children with diarrhoea in the last 2 weeks who received ORS[12] (%)	34.0	33.3	47.6	42.8	38.8	69.8
Children with diarrhoea in the last 2 weeks who were given treatment (%)	57.6	57.8	54.5	66.5	65.1	76.2
Children with acute respiratory infection or fever in last 2 weeks who were given advise or treatment (%)	63.4	63.0	68.0	61.3	59.0	77.0
Awareness of RTI/STI and HIV/AIDS						
Women who have heard of RTI/STI (%)	16.8	16.0	23.1	21.8	19.4	37.7
Women who have heard of HIV/AIDS (%)	54.8	51.2	82.1	44.0	39.3	75.5
Women who have any symptoms of RTI/STI (%)	27.3	28.3	20.0	24.1	24.5	21.1
Women who know the place to go for testing of HIV/AIDS[13] (%)	36.4	34.0	47.9	NA	NA	NA
Women underwent test for detecting HIV/AIDS[13] (%)	1.0	0.9	1.6	NA	NA	NA
Other reproductive health problems						
Women had primary or secondary infertility (%)	4.8	4.8	4.7	NA	NA	NA
Women had problem of obstetric fistula (%)	4.6	4.8	3.2	NA	NA	NA
Quality of family planning services						
Currently married non-users who ever received counselling by health personnel to adopt family planning (%)	16.3	16.4	15.5	6.0	6.1	5.0
Current users ever told about side-effects of family planning methods (%)	7.2	7.2	7.7	50.8	50.3	54.4
Users who received follow-up services for IUD/sterilization within 48 hours (%)	53.3	51.5	61.5	5.0	5.2	3.8
Indicators based on unmarried women (age 15-24)						
Characteristics of women						
Unmarried non-literate women (%)	6.7	7.3	2.8	NA	NA	NA
Unmarried women with 10 or more years of schooling (%)	38.2	35.3	56.5	NA	NA	NA
Family life education						
Unmarried women who opined family life education/sex education important (%)	67.8	66.2	78.3	NA	NA	NA
Unmarried women who ever received family life education/sex education (%)	27.7	26.3	36.7	NA	NA	NA
Unmarried women who are aware of legal minimum age at marriage for girls in India (%)	81.8	80.8	88.4	NA	NA	NA
Awareness of contraceptive methods						
Unmarried women who know about condom (%)	59.8	57.1	77.2	NA	NA	NA
Unmarried women who know about pills (%)	78.2	77.6	82.1	NA	NA	NA
Unmarried women who know about Emergency Contraceptive Pills (ECP) (%)	18.4	16.7	29.2	NA	NA	NA
Unmarried women who ever discussed about contraception with any one (%)	25.8	25.3	28.5	NA	NA	NA
Awareness of RTI/STI and HIV/AIDS						
Unmarried women who have heard of RTI/STI (%)	13.5	12.6	19.4	NA	NA	NA
Unmarried women who have heard of HIV/AIDS (%)	72.2	69.6	88.8	NA	NA	NA
Unmarried women who know the place for testing of HIV/AIDS[13] (%)	43.0	41.2	52.3	NA	NA	NA
Unmarried women underwent test for detecting HIV/AIDS[13] (%)	0.3	0.3	0.3	NA	NA	NA

[11] Acute Respiratory Infection
[12] Oral Rehydration Solutions/Salts
[13] Based on the women who have heard of HIV/AIDS.

Assam

NFHS - Key Indicators

	NFHS-3 (2005-06)	NFHS-2 (1998-99)	NFHS-1 (1992-93)
Marriage and Fertility			
1. Total fertility rate (Children per woman)	2.42	2.31	3.53
2. Median age at first birth for women age 25-49	20.7	19.9	18.8
Family Planning (Currently married women, age 15-49)			
Current use			
Any method (%)	56.5	43.3	43.0
Unmet need for family planning			
Total unmet need (%)	10.8	17.0	21.7
Maternal and Child Health			
Maternity care *for births in the last 3 years)			
1. Mothers who had at least 3 antenatal care visits for their last birth (%)	36.3	30.9	24.9
2. Mothers who consumed IFA for 90 days or more when they were pregnant with their last child (%)	15.6	NA	NA
3. Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	31.2	21.4	18.0
4. Institutional births (%)	22.7	17.6	11.7
Child immunization and vitamin A supplementation			
Children 12-23 months fully immunized (BCG, measles and 3 doses each of polio/DPT) (%)	31.6	17.0	19.4

Treatment of childhood in the last 2 weeks who received ORS (%)			
1. Children with diarrhea in the last 2 weeks who received ORS (%)	13.3	37.1	25.0
Child Feeding Practices and Nutritional Status of Children			
1. Children under 3 years breastfed within one hour of birth (%)	50.6	44.7	19.9
2. Children age 0-5 months exclusively breastfed (%)	63.1	NA	NA
Nutritional Status of Ever-Married Adults (Age 15-49)			
Women whose Body Mass Index is below normal (%)	36.5	27.1	NA
Anaemia among Children and Adults			
Children age 6-35 months who are anaemic (%)	76.7	63.2	NA
Pregnant women age 15-49 who are anaemuc (%)	72.0	62.3	NA

Assam

SRS – Key Indicators

	SRS, 2005	SRS, 2007
Birth Rate	25.0	24.3
Death Rate	8.7	8.6
Infant Mortality Rate	68	66

Assam

Activities supported under NRHM during 2007-08 & Progress against approved PIP

Mission Flexipool

(Rs. in crores)

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
	Village Level Activities			
1	Training of ASHA	9.63	Approved	Rs. 2.89 Training for 1st / 2nd module completed for all 26225 ASHAs. 3rd / 4th module completed for 13222 ASHAs upto March '08. (3rd/4th Module completed for all 26225 ASHAs in 2nd quarter of 2008-09)
2	Additional requirement for ASHA. Apron, Identity Card.	0.00	Not Approved	
3	Bicycle for ASHA @ Rs. 2000 for 50% of ASHAs i.e. for 13123 nos.	0.00		
4	Untied funds for VHSCs (villages)	13.12	Approved	3214 VHSC formed in last quarter of 07-08. No fund released during 07-08. (20309 VHSC were formed during 2008-09 and fund released upto Oct'08.)
5	Ensuring nutrition and health education programme for the woman groups. One health day per month in each of the AWC. Total 25416 AWCs. Rs. 100 per health day per month.	3.05	Approved. Funds not to be provided under this head after VHSCs are made functional and provided with untied funds.	Rs. 1.25 crore No. of VHND (Health Days) - 1,62,941
6	Train and enhance capacity of PRIs to own, control and manage public health services. 200 PRIs per district	0.16	Approved	Rs. 0.16 81 batches trained by SIRD. The batch size was 20.

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
	Sub Centers			
7	Untied funds for SCs	4.59	Approved for functional SCs. To be utilized as per guidelines	Rs. 4.59 Released for 4592 SC
8	Annual Maintenance Grant for SCs	4.59	Approved. To be utilized as per guidelines	Rs. 4.59 Released for 4592 SC
9	Up gradation of SC to IPHS – Recurring Second ANM for SCs to be provided in all the SCs. Altogether 4592 additional ANM required. Already appointed 1975 under NRHM. Therefore 2617 additional ANM to be appointed. But for 2007-08 1000 ANMs will be appointed.	14.85	Approved. A mechanism to monitor patient load and assessment of work carried out by each ANM may be instituted. Details of deployment of regular ANMs to be provided.	1385 nos. recruited and positioned in SC as per need
10	Construction of New SCs (functional in rented buildings)	18.75	Approved. To be constructed as per Assam PWD SOR and in line with IPHS norms. Construction of 50% of the SCs was approved during last year and could not be carried out.	Rs.9.98 80% & above → 11 nos 50-80% → 72 nos 0-50% → 417 nos
	PHCs			
11	Rogi Kalyan Samitis	6.10	Approved for 610 PHCs. Detailed proposal for rationalizing nomenclature of different categories of health institutions may be submitted.	As per RHS there are 610 PHCs. But as per Facility survey by an independent Agency done by the State the total No. PHCs are 839. So fund released to 839 PHCs rationalizing the approved fund. Audit of RKS done.
12	Untied funds for PHCs	1.53	Approved for 610 PHCs. To be utilized as per guidelines	As per RHS there are 610 PHCs. But as per Facility survey by an independent Agency done by the State the total No. PHCs are 839. So fund released to 839 PHCs rationalizing the approved fund. Audit of untied fund done.

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
13	Maintenance Grant for PHCs	3.05	Approved for 610 PHCs. To be utilized as per guidelines	As per RHS there are 610 PHCs. But as per Facility survey by an independent Agency done by the State the total No. PHCs are 839. So fund released to 839 PHCs rationalizing the approved fund. Audit of maintenance done.
14	4 additional quarters (one for MO and three for GNMs) for 50 PHCs @ 28.80 lakh per unit (4 quarters) already taken up in 2006-07	14.40	Approved Only PHCs which are not being block pooled to be taken up.	Rs. 13.81 100% → 2 nos 80% & above → 12 nos 50-80% → 22 nos 0-50% → 67 nos
15	GNM in 24x7 health facilities (123 existing 24x7 PHCs and 120 new proposed 24x7=243 health facilities)	4.08	Approved for 2 contractual GNMs per PHC. 1 GNM should be a regular employee of the State. A mechanism to monitor patient load and assessment of work carried out by each of each GNM may be instituted.	1053 GNM recruited Details of deployment of regular GNMs to be provided by the state
16	Public Heath Nurse (PHN) at the block level	0.00	Approved	Approved in 2006-07, but not recruited as there is shortage of PHN in the state
17	200 AYUSH doctors (Ayurvedic) already appointed in 200 PHCs in 2006-07	3.60	Approved The State should be able to provide PHC wise deployment status.	Rs. 3.09 218 AYUSH doctors recruited (18 additional doctors were recruited as there was vacancy) There are 358 AYUSH regular doctors under State Govt. posted in Health Institutions. Limited AYUSH medicines have been provided.

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
18	ASHA supervisor at the PHC level @ Rs. 5000 p. m. for 149 BPHCs	0.89	Approved Mentoring guidelines may be strictly followed	In 08-09
19	One Pharmacist for 149 PHCs	0.10	Approved. The State may fill up the regular posts required for these PHCs during the current year. Provision has been made till the time State fills up the vacant posts.	149 appointed in last quarter of 07-08 (Annexure – III)
20	Hiring of vehicles for supervision at the Block PHC level	2.68	Approved	Rs. 0.51 Rs. 25,000 given per Block PHC per month for monitoring and mobility.
21	Ambulances for PHCs	10.00	Approved	Rs. 9.3 Total 350 nos. Wherever there is regular driver, the ambulances are driven by them. In Facilities not having driver, they have been recruited and salary is paid by RKS. (Point No. 35)
22	Construction of new PHCs – New BPHC to be established as per the population norms in those areas where there is no PHC including civil construction of building and quarters. As per the population norms, 216 new PHCs are to be established. For the year 2007-08, 50 PHCs will be constructed.	13.25	Approved. SoR of State PWD/CPWD and IPHS norms to be followed	(Plan & estimate ready for 15 nos of PHCs) Work allotted and construction to start shortly.
23	Set up 50 homeoclinic in the PHC areas. One room will be taken up on rent @ Rs. 2500 p. m. Also there will be one doctor or dispensing the medicines @ Rs. 3000. For furnishing the room Rs. 10000 is proposed.	0.00	Not approved. The state may propose to AYUSH department.	
	CHCs			

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
24	Rogi Kalyan Samitis	0.96	Approved for 93 CHCs and 3 SDHSs. Excess fund released last year may be adjusted	Released for all 93 CHCs / 3 SDCHs Audit completed
25	Untied funds for CHCs	0.47	Approved. Excess fund released last year may be adjusted	Released for all 93 CHCs / 3 SDCHs Audit completed .
26	Maintenance Grant for CHCs	0.93	Approved. Excess fund released last year may be adjusted	Released for all 93 CHCs / 3 SDCHs Audit completed
27	Physical infrastructure of CHC already under provision of IPHS. As per estimates submitted under NRHM PIP @ 40 lakh for 103 CHCs (already taken up in 2006-07. Work under process)	21.20	Approved. Up gradation to IPHS norms was approved during earlier year for which funds are still available with State (Rs, 20 crore). Funds released earlier for 103 CHCs whereas State has given figures of existing CHCs as 93. Excess amount released in earlier year may be refunded/adjusted	Rs.16.96 100% → 66 nos 80% & above → 23 nos 50-80% → 10 nos 0-50% → 4 nos
28	Block pooling of quarters for medical officers. 1 Cr. Each for the 50 such functional CHCs already taken up in 2006-07. For 2007-08, another 30 CHCs for block pooling. This block pooling of quarters will have 3 quarters for doctors. 3 quarters for paramedical staff and 3 quarters for the grade IV	30.00	Approved for additional 30 CHCs. SoR of State PWD/CPWD and IPHS norms to be followed. List indicated the PHCs and other health facilities bring covered under the respective CHC may be provided first.	Rs.21.55 80% & above → 9 nos 50-80% → 21 nos 0-50% → 46 nos
29	Contractual GNM in CHCs @ 6 GNM per CHC for 93 CHCs	3.12	Approved	Rs.3.12
	District Hospitals			
30	Rogi Kalyan Samities	1.05	Approved	Rs. 1.05 Released for 21 DH Audit completed

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
31	For improving physical infrastructure, equipment, manpower etc. based on facility survey it is proposed to taken up work @ 1 Cr. For existing district hospitals. Already sanctioned. Recently MMCH in Kamrup and Medical college in Dibrugarh declared as district hospital.	1.00	Approved for additional 1 DH in addition to DHs approved during last year.	Rs. 1.00 Work nearing completion
32	District hospitals to be converted to IPHS standard. For the year 2007-08, 4 DH (Karimganj, Dhemaji, Barpeta and Morigaon) will be taken up for IPHS standard	0.00	Approved 'in-principal'. Detailed Protect Report on the basis of facility survey indicating the short term requirements (to be met from the Rs. 1 crore already provided) and long term requirements may be provided.	
33	Contractual GNM in 21 DH and 3 SDCH. 15 GNM in each hospital	0.00	Approved 'in-principal'. Analysis on the basis of District Hospitals/ SDH wise deployment of existing GNMs. Medical officers and Specialists along with case load may be provided for consideration.	
34	5 new DH in Kamrup (Amingaon), Udalguri, Baksha (Masalpur), Dhubri and Bongaigaon @ Rs. 5 Cr. Each. 2 Cr. released in 2006-07. Another 3 Cr. for 5 DHs for the year 2007-08 is being proposed.	0.00	The activity has already been approved by NPCC in 2006-07 subject to certain conditionalties laid thereof. Further releases during the year subject to satisfaction of conditionalities.	
	Common for PHC/CHC/ District Hospitals			
35	Ambulances for PHCs/CHCs/ DHs	3.75	Approved last year. Expenditure being made in the current year	Rs.3.75 (350 nos.) (Also point no. 21) Wherever there is regular driver, the ambulances are driven by them. In Facilities not having driver, they have been recruited and salary is paid by RKS.

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
36	For telephone connection in 780 PHCs	0.48	Approved. Conditions made during approval last year may be complied with.	Rs.0.14 Work under process
	Strengthening of Nursing Schools			
37	For ANM Training Schools for repair of class room, hostel, field practice areas book, furniture) for 17 schools. Already sanctioned for 17 schools. Proposed for one additional school	2.12	Approved	Work under process for 18 schools 2 completed, rest 16 to be completed by 2009-10 Batch size in ANM school 25.
38	GNM schools	7.50	Approved DPR to be provided	
39	New GNM schools in all functioning District Hospitals. As per new INC norms, cost of new GNM school is Rs. 7.5 Crs. So, for 2007-08, no additional fund is proposed. DPR will be submitted in due course	8.00	Approved This is last year's approved activity to be completed this year. Comments on DPR provided will be conveyed separately.	Work in progress in all projects except in Karimganj and Karbi Anglong
40	New proposal for B. Sc Nursing college with Dibrugarh Medical College and Silchar Medical College @ Rs. 7.5 Cr per college. DPR will be submitted in due course	0.00	Approved 'In principal'. DPR may be submitted.	
	Strengthening Tertiary Care Hospitals			
41	Up gradation of the Gauhati Medical College. The detail proposal of GMC for Rs. 119 Crs has already been submitted to the Govt. of India and sanctioned for 31.2 Crs for up gradation. Another 10 Crore required.	10.00	Approved Additional funds for already approved activity.	Rs.7.02 Work in progress
42	Up gradation of the Regional Institute of Ophthalmology at Gauhati Medical Colleges, Guwahati. Sanctioned for Rs. 10 crore in 2006-07	5.00	Approved Additional funds for already approved activity.	Rs.2.53 \Work in progress

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
43	One Anti Retroviral Therapy Unit in Silchar Medical College and one CD4 count machine	0.00	Not approved	
44	Additional Obstetrics and Gynecology Wing in the 3 Medical colleges. The wing will be a 2 to 4 storied building consisting of OPD, 10-15 bedded pre-labour room ward, labour room, post natal ward, OT, post operative ward, observation ward, septic ward, SNCU. DPR will be submitted in due course. One wing costs approx. Rs. 17.67 Cr. (only civil construction), excluding equipments, instruments, furniture	0.00	Not approved The 33% limit of civil cost has to be maintained.	
45	Contractual GNM in 3 Medical College	0.00	Not Approved	
46	Oncology Ward to be established in 3 district hospitals in Jorhat, Sonitpur and Nagaon. There will be separate wing including an OPD ward and indoor patients ward	0.00	Not Approved	
47	Special Programme for early detection of cancer	0.00	Not Approved	
	Public Private Partnership			
48	Introducing Boat Clinic (Mobile Clinic) for Char areas (under PPP)	2.15	Approved Guidelines for MMU may be adapted for the purpose	Rs.2.11 5 boat clinic functional
	Others			
49	Preparation of health action plans	0.40	Approved	Rs.0.10

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
50	Organizing Health Melas	1.35	Approved	Rs.1.00 27 health melas conducted
51	Support to Mobile Medical Units (MMU)/ Health Campus (recurring cost @ Rs. 23.46 lakh per vehicle for two quarters). Capital cost for 23 MMU (total Rs. 16.66) has already been sanctioned. Additional MMUs for additional 4 districts. Also, it is proposed to set up MMUs in the sub divisional areas in the subsequent years	2.88	Approved for 4 additional MMUs. Recurring and capital cost for 23 MMUs released last year to be utilized during the current year	Rs.2.88 (10 MMU functioning, others delivered)
	Procurement of Drugs & Equipment			
52	Drugs (IPHS)			Rs.48.50 All drugs procured and supplied to Health Facilities procured through TNMSC.
	a. SC @ Rs. 18135	9.20	Approved	
	b. PHCs @ Rs. 3 lakh	23.40		
	c. CHCs @ Rs. 10 lakh	9.30		
	d. SDH @ Rs. 10 lakh	0.30		
	e. DH @ Rs. 30 lakh	6.30		
	f. Equipments for CHCs (as per IPHS) along with AMC	0.00	Approved 'In- principal'. Details may be provided as per facility survey	

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
	Strengthening of Procurement Logistics			
53	Provision of 1 vehicles for each district to ensure the regular supply medicines/ vaccines etc	0.49	Approved. The State has been provided 12 vehicles under IPP IX for procurement and is lying unused. These may be utilized optimally before hiring of vehicles is done	Rs.0.49
54	Drug Warehouse for each district. There are already 5 regional warehouses. There-fore additional need 22. Also one warehouse for the state as well @ Rs. 50000 to be taken up on rent till the construction of a new warehouse	0.456	Approved. Stores/ Warehouses within the District Hospitals etc may be properly maintained. The existing regional warehouses, wherever possible, may be used for catering to the neighboring districts also. These facilities should be made fully functional and utilized first.	Rs.0.56
55	Construction of a State Drug warehouse. For 2007-08 1 Cr is proposed	1.00	Approved	Under construction
56	One pharmacist (B. Pharmacy) for drug warehouse for all the districts. They will be a part of DPMU. And one for the state level	0.27	Approved for current year only. Existing pharmacist/staff may be redeployed/trained in the meanwhile	Recruited in 08-09
57	One Office Assistant for the (B. Pharmacy) of the drug warehouse for all the districts. They will be a part of DPMU. And one for the state level	0.24	Approved for current year only. Existing pharmacist/staff may be redeployed/trained in the meanwhile	Carried out by Amtron for NRHM
58	To strengthen the health institutions in terms of proper waste disposal	1.25	Last year's approved activity for DHs should be completed. Further expansion for CHC and lower level health facilities should be part of comprehensive up gradation to IPHS norms, implementation and management should be through RKS	Initiated in last quarter of 07-08

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
59	Preparation of District and State level public reports on health annually by independent agencies	0.14	Approved for Rs. 0.50 lakh each	Not published
	HMIS / M & E			
60	Mobility for monitoring & supervision			
	a. State	0.0500	Approved	Released as per approval
	b. District	0.5400		Released as per approval
	c. Block	0.7540		Released as per approval
	d. Block level computers	0.8940		Released as per approval
	e. Software and AMC	0.7500		Released as per approval
	f. Printing of formats			
	g. Sc to PHC	0.0562		Released as per approval
	h. PHC/BPHC to BPHC/ District	0.0101		Released as per approval
	i. District to State	0.0004		Released as per approval

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
	j. Review Meetings			
	k. BPHC level-monthly	0.8940		Released as per approval
	l. District level-monthly	0.6900		Released as per approval
	m. State level-monthly	0.0600		Released as per approval
	Innovative initiatives			
61	Health insurance	0.00	Approved 'In-principal'. Details need to be worked out separately	
62	Incentives and rewards	0.00	As per approval accorded last year, expenditure to be made in the current year. Conditions as laid down in the approval may be followed	
63	Laboratory Technician for 631 (780-149) PHCs	3.87	Approved for 610-149 = 461 Lab Technicians. The state may be fill up the regular posts required for these PHCs during the current year. Lab technicians provided under other Disease Control Programmes may also be utilized. Provision has been made till the time State fills up the vacant posts	461 recruited in last quarter of 07-08
64	One dental surgeon for each 50 CHCs	1.08	Approved. The state Government may ensure availability of dental equipment before deployment	Rs.1.06 61 Dental Chairs purchased in 2006-07 and placed in 21 DH, 3 SDH, 37 placed in CHCs and FRUs where Dental surgeons are in position.

Sl. No.	Name of Activity	Amount Approved	Remarks	Progress
65	Baseline Survey by independent agency	0.00	Approved 'In-principal'. RFP may be finalized and provided before finalization	
66	Sensitization workshop for all \SDH & MO, 2 days (23 DH/SDH, 149 BPHC, 93 CHCs). Per batch 30 participants will be there. Therefore 8 batches. Per batch Rs. 45000	0.04	Approved	
67	Block Programme Management Unit	3.70	Approved	In position. 149 Block Programme Manager and 149 Block Accounts Manager in position.
68	IEC/BCC	15.00	Approved	Rs.11.49
69	School Health Programme	0.00	Approve 'In-principal'. The proposal needs to be re-designed defining clear linkage with outcome/ output	
70	Management Cost	0.00		
71	Grant-in-Aid to NGOs	0.00	Last year's activity to be completed this year	

ANNEXURE – IIB

PHYSICAL PERFORMANCE UNDER NRHM DURING 2008-09

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
A	**Village level Activity**			
1	Untied grants to 26247 Village Health and Sanitation Committees (VHSC) @ Rs10000.00 per VHSC. In 06-07 it was approved for 50 % of the villages and in 07-08 fund approved for another 50% of villages.	2624.70	26247	Fund released Rs.1998.70 20309 nos. of VHSC formed and fund released
2	Support to 29693 ASHAs @Rs.10,000 per ASAHA.	2969.30	29693	All 4 Modules training completed for 26225 ASHAs. 5th Module master training completed for 42 Master Trainer. Selections of new 3458 ASHAs going on.
3	Organizing Health Melas in 27district @Rs. 5 Lakhs per district.	135.00	27	135.00 Scheduled for March,2009.
B	**Sub Centre level activity**			
4	Untied Fund to 4592 SC @Rs.10,000/- per SC	459.00	4592	Fund release under process
5	Maintenance fund Govt. SC @Rs.10,000/- per SC	263.70	2637	Fund release under process
C	**PHC level activity**			
6	Untied Fund to 912 PHCs @Rs.25000/- per PHC.	152.50	610	199.50 • As per RHS there are 610 PHCs. But as per Facility survey by an independent Agency done by the State the total No. PHCs are 839. After rationalizing fund was released to PHCs. • (Details will be sent later)
7	Maintenance fund to 912 PHCs @Rs.50000/- per PHC.	305.00	610	384.50 • As per RHS there are 610 PHCs. But as per Facility survey by an independent Agency done by the State the total No. PHCs are 839. After rationalizing fund was released to PHCs. • (Details will be sent later)

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
8	Hiring of vehicle for supervision at the 149 Block PHC level @Rs.15000/- Per BPHC.	268.20	149	268.20 Released.
D	**CHC level activity**			
9	Untied Fund to CHCs @Rs.50000/-	50.00	100	54.00 • As per RHS there are 93 CHCs. But as per Facility survey by an independent Agency done by the State the total No. 103. After rationalizing fund was released
10	Maintenance fund to CHCs @Rs.100000/-	100.00	100	108.00 • As per RHS there are 93 CHCs. But as per Facility survey by an independent Agency done by the State the total No. 103. After rationalizing fund was released
E	**Rogi Kalyan Samitis**			
11	Fund for Rogi Kalyan Samitis / Hospital Management Committees @Rs.500000/- per DH, and Rs.100000/- per SDH, CHC and PHC.	818.00	21 DH, 100 CHCs, 3 SDCHs, 610 PHCs,	666.00 RKS fund released to 21 DH, 3 SDCHs, 100 CHCs and PHCs. • (Details will be sent later)
F	**Drug Ware House**			
12	Drug Warehouse for each district (22) @Rs.15000/-pm on Rental basis in addition to already existing 5 regional warehouse. Also one warehouse for the state as well @ Rs 50,000.00 to be taken up on rent till the construction of a new warehouse.	45.60	22 rent. 5 regional, 1 at state level	46.80 Fund released for rent.
G	**Civil Works**			
	Sub Centre			
13	Construction of 1000 sub-centre building (which are functioning at the rented houses). 500 sanctioned in 07-08 and additional 500 SCs to be taken in 08-09 @ Rs.7.5 Lakh per Sc Building. Rs. 9.38 Lakh outstanding from 06-07.	1875.00	250	199.27 • 2007-08 SC construction Status 0-50% - 298, 50-80% - 90, > 80% - 27 • Sub Centre for construction for 2008-09 is selected and order for implementation is under process.
	PHC			

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
14	New BPHC to be established as per the population norms in those areas where there is no PHC including civil constriction of building and quarters. As per the population norms, 216 new PHCs are to be established. For the year 2007-08, 50 PHCs will be constructed.	1325.00	Approved for earlier 50	1325.00 15 nos. is selected and work under process of allotment.
15	Wards in 245 MPHCs where labour rooms has been constructed @Rs7.5 Lakhs.	875.00	122	948.00 Under process of allotment.
	District Hospital			
16	District hospitals to be converted to IPHS standard.	800.00	4 DH	132.68 Work initiated in 2 DH.
	Nursing Schools			
17	For ANM training Schools (18) @ 25 lakhs (repair of class room, hostel, field practice areas book, furniture) for 17 schools. Already sanctioned for 18 schools.		18	• 2 completed, rest 16 to be completed by 2009-10 • Batch size in ANM school 25.
18	GNM schools @ 2 Cr. For 15 schools.	750.00	15	12.59 Progress: 0-50% = 5, 50-80% = 3
19	New proposed GNM schools in all functioning District Hospitals to produce qualified nursing personnel @ 9.6 Cr. for 8 GNM schools as per INC norms.(DPR sumbitted to GoI)	3600.00	8	900.92 Work is in progress.
20	New proposal for BSc Nursing college with Dibrugarh Medical College and Silchar Medical College. In 07-08 Rs. 7.5 Cr per college was approved and in 08-09 the state propose Rs 9.8 Cr per college. DPR submitted to Govt. of India for Rs. 19.6 Cr for 2 colleges	1000.00	2	• In AMCH, work just started. • In SMCH work in progress.
	Tertiary care hospitals.			

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
21	Upgradation of the Gauhati Medical College. Construction of auditorium and library cum lecture hall. In 06-07 Rs. 31.2 Cr was approved and in 07-08 Rs. 10 cr was approved	1120.00	1	14.04 Work in progress (35%)
22	The detail proposal for up gradation of the Regional Institute of Ophthalmology at Gauhati Medical College, In 06-07 Rs. 10 Cr and 07-08 Rs. 5 Cr was approved. For 08-09 Rs. 3.45 Cr is propsosed as per DPR		1	Work in progress (80%)
23	Construction of Obstetric & Gynaecology ward in medical college			
	Drug Ware house			
24	Construction of a State Drug warehouse.	300.00	1	60.90 Work is in progress (25%)
H	**Public Private Partnership**			
25	Boat Clinic (Mobile Clinic) for Char areas (under PPP)	260.00	5	67.81 5 is running
26	**Procurement**			
	Drugs (IPHS)			
	SC @ Rs 18135.00	2000.00		2000.00 The State Govt. has placed order and drugs will be provided by Dec'08.
	PHCs @ Rs.3 lakhs			
	CHCs @ Rs 10 lakhs			
	SDH @ Rs 10 lakhs			
	DH @ Rs 30 lakhs			
	Equipments & Kits			
27	Equipments for CHCs (as per IPHS & Facility Survey) along with AMCH.	1000.00		350.00 Following items have been procured: 300 mA X-ray machine- 10 nos., B/W USG machine – 6 nos., Cardiac Monitor – 3 nos., Boyle's apparatus – 6 nos., Hydraulic OT table – 7 nos., Laparoscope – 5 nos, Dental chair – 18 nos. , Semi-auto analyser – 8 nos.

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
28	Provision of 1 vehicles for each district to ensure the regular supply of medicines/ vaccines etc	48.60	27	24.30
I	**HMIS/M & E**			
29	Maintenance of Integrated Drug Management	54.00	28	54.00 Working.
J	**Human Resource**			
	Sub Centre			
30	Second ANM for SCs to be provided in all the SCs. At present total no of contractual ANM - 4088 and for 08-09 827 nos is proposed	2187.90	827	1929.60 539 new selected. (Annexure – I)
	GNM			
31	GNMs in CHCs, BPHC , 24x7 hr delivery institutions, SDCH and DH	2319.24	1064	1914.40 350 new selected. (Annexure – II)
	AYUSH doctors			
32	AYUSH doctors in PHCs	457.20	0	356.40 220 in position
	Pharmacist			
33	In 07-08, 149 pharmacist were appointed in PHCs	125.16	149	125.16 Already appointed 149 pharmacist. (Annexure – III)
	ASHA supervisors			
34	ASHA supervisor at the PHC level for 149 BPHCs. Block level ASHA supervisor (part of ASHA mentoring group) will perfor the role.		149	Application sought for.
	Public Health Nurse(PHN)			
35	Public Health Nurse (PHN) at the block level.	143.04	149	
	Laboratory Technician			
36	Laboratory Technician@ SD, SHS,PHC	387.24	461	387.24 Appointed.
	Doctors			

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
37	One Dental Surgeon @ 50 CHCs .In 07-08 39 nos were recruited	108.00	11	58.32 28 in position, 22 more to be recruited
38	155 Specialist @Rs.30,000 pm	558.00		216.00 77 in position, 34 recruited this year
39	Medical Officers, 144 nos. proposed	720.00		168.40 163 in position
	Drug Ware house			
40	One Pharmacist (B.Pharma) in drug warehouse for all the districts and one in state level	50.40	28	50.40 Appointed.
41	Block Programme Manager	321.84	Already exist, approved for salary	204.00 149 BPM in position
42	Block Accounts Manager		Already exist, approved for salary	208.32 149 BAM in position
43	PHC Accountant	420.00	500	420.00 454 PHC accountant posted in Health Facilities other than BPHC.
K	**Training & Capacity Building**			
44	Train and enhance capacity of PRIs to own, control and manage public health services.	45.00	26225	Will be trained from December.
45	Sensitization workshop for all SDH&MO, 2 days (23 DH/SDH, 149 BPHC, 93 CHCs). Per batch 30 participants will be there. Therefore 8 batch.	2.00	8 batch	One workshop held for district level training team, further sensitization started from Nov.,2008.
46	Training of 26247 VHSC Members	260.00	26247.	Will start on 4th Quarter.
L	**Others**			

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
47	IEC/ BCC	1000.00		755.00 <u>Mobile Theatre</u> • Display of NRHM spots in over 20 mobile theatres existing in the state., MoU signed with two agencies to release the spots in the theatres <u>Print Advertisements</u> • The Pulse Polio immunization round, The Vitamin A supplementation week, Family Planning through focus on safe motherhood , JSY, EMRI, malria, Routine Immunization <u>Television Advertisements</u> • The Pulse Polio immunization round, The Vitamin A supplementation week, Family Planning through focus on safe motherhood , JSY • Routine Immunization <u>Radio (including campaign on FM) – spots as well as RJ mentions</u> • The Pulse Polio immunization round, The Vitamin A supplementation week, Family Planning through focus on safe motherhood, JSY, Routine Immunization, EMRI • The ASHA Radio programme, covering all the above mentioned topics
48	School Health Programme	212.00	2 districts as pilot district.	0.99 Preparatory work started, Will launch on 4th quarter.
49	Preparation of health action plans at district level.	54.00	27	29.68 Started.
50	Support to Mobile Medical Units (MMU)/ Health Camps (recurring cost)	675.00	Approved for all 27 MMUs.	491.52 In position.
51	Procurement of Computers with UPS, OS, Antivirus and Printers PHC Accountant	300.00	500	406.41 Order placed.
52	Procurement of Computers with UPS, OS, Antivirus and Printers District HQ	16.00	27	
53	Procurement of Computers with UPS, OS, Antivirus and Printers State HQ	6.00	10	
54	Software and AMC	3.00	Approved.	

Sl. No.	Activity	Fund approved (Rs. In lakhs)	Target	Achievement
M	**New initiatives:**			
55	ASHA Mentoring Group		2	Formed.
56	Evening OPD	1281.00	265	1347.92 Ongoing on 210 Health Institutions.
57	Introducing Emergency Referral & Research Institute	5045.00	27	3000.00 Launched.
58	Mobile Phones/ WLL Connection to SC(recurring cost)	110.21	4592	Launched.
59	Hospital Administrators for DH	50.40	21	2 in position.
60	Homeopathy doctor	78.00	50	Selection procedure is waiting for court verdict.
61	Incentive to Hospital (FRU/CHC/BPHCs)	5.80	40 FRU, 69 CHC, 149 BPHCs.	
62	Difficult area allowance for doctors.	60.00		Given.
63	Outsourcing of CHCs to charitable/ army hospitals/NGOs	12.00		To be taken up in 4th Quarter.
64	Developing e-health		21.74	
65	RNTCP			
66	NIDDCP			
67	NVBDCP			
68	IDSP			
69	NPCB			
70	NLEP			
71	UIP			
72	Programme Management Cost	398.00		365.26
	Total	**43840.73**		**22426.01**