MAHARASHTRA

Common Review Mission II- Report of Maharashtra- 26th to 30th November, 2008

CRM-II Team visited the State of Maharashtra from 26th to 30th November, 2008. On 26th Nov, 08, a detailed presentation on the NRHM Implementation in the State was made by Smt Vandana Krishna, Commissioner (Health) of the State. The meeting was also attended by Smt Chandra Iyengar, Addl. Chief Secy. (Health) along with JDs and DDs of the Directorate of Health of the State.

The presentation gave the detailed account of the new initiatives taken by the State alongwith the implementation of the continuing programme of RCH, and Disease Control Programmes. Some of the significant steps taken by the State include-

- Ranking of districts and Medical Colleges on the basis of performance in FW, JSY, MCH and RI activities.
- 397 (22%) out of 1818 PHCs made 24x7.
- 43 (12%) out of 372 CHCs, 33 (100%) DH and 9 (100%) Women Hospital made FRUs.
- Ideal PHC and CHC criteria led down and rewarded in a district
- Anti-anaemia drive with one year campaign to be launched in 11 districts for the age group of 13-18 years.
- Matrutva Anudan Yojana for institutional deliveries (Rs. 400/- each for medicines and cash (irrespective of caste and income).
- Incentive of Rs. 200/- to Dai for bringing a delivery case to the hospital and felicitation of dai for highest performance.
- A 'Thermocol Box' with baby clothes and sanitary napkins provided to the lady after delivery from the state budget.
- Rs. 100/- to doctor/nurse and Rs. 50/- to sweeper (for delivery) in PHCs in 99 blocks in 21 districts.
- In tribal areas the attendant of the mother to be is paid wages provided the lady stays in the institution for 48 hours after delivery
- Additional labour room built in the Sub-centres. An amount of Rs. 3.0 Lakhs each has been made available from the state budget.
- Free referral transport for delivery in the rural areas

- Child Development Centres (CDCs) to improve nutritional status of Grade III and Grade IV children **(Well run, clean and furnished halls with toys for children, nutrition chart with individual child indicator in PHCs were seen. The children are admitted for 3 weeks where they are put on 2-3 hourly special nutritious diet. The diet is provided by the SHGs. The children are examined and treated by the pediatrician. The State has established 438 CDCs wherein 3191 children have been admitted till now. 1222 children have improved.)**
- Sengaon pattern mother and child health camps launched to reduce IMR, MMR and to increase health facilities at PHC. Main characteristics of the same include bringing all ANC and malnourished children from Sub-centre to PHC on fixed day in a month, provision of referral facility for delivery facilities including family planning at delivery camp etc.
- Infrastructure Development Wing (IDW) established in all districts with one deputy engineer in each district and one junior engineer for 4 blocks.
- IPHS Wing with the cell at state HQ and district IPHS Coordinator at each district HQ established.
- Powers of administrative and technical sanction decentralized.
- 34 telemedicine centres operational in DHs
- Geriatric care scheme in 12 selected districts with house to house collection of data on senior citizens.
- School health programme in coordination with education department. Under the programme heart surgeries performed from state budget funds.
- Water surveillance by Grampanchayat has improved**(Public Health Laboratory in Pune has indigenously made a water checking tube which is provided to all Sub-centres for checking the quality of water)**.
- RKSs have made provision of water supply and coolers wherever not existing. The MOs are allowed to get water tanker spending pre determined rate funds from state budget.
- Dedicated feeder lines given to DHs.
- Regular five minutes telecast on DD on importance of care of underweight borne babies for mothers
- Special web based MIS system developed from May, 2006 with online data entry done at Taluka level.

The State has been successful in getting NRHM at centre stage of development programmes through holding 4 rounds of meetings in one year under the Chairpersonship of Addl Chief Secretary of Public Health. These meetings are attended by DCs, CEOs, DHOs, CSs and DPMs.

Indicators for review are decided on the basis of volume of grant and importance of the subject.

Districts- Raigad (Alibaug) and Pune

1. Title

Name of CRM Member	Designation	Address
Shri T. V. Antony*	Advisor, Min of H&FW	6, 4th main Road, Gandhi Nagar, Chennai-20
Smt Sushma Rath*	PAO, NHSRC	NIHFW Campus, Munirkha, N. Delhi-67
Shri Rajesh Kumar#	Consultant, FMG	Min. of H&FW, Nirman Bhavan
Shri Karan Singh#	Consultant, GTZ	GTZ
Dr. A. C. Baishya#	Dir, NE-RRC	NE-RRC, Guwahati, Assam

- **Team I # Team II**

2. Introduction

a. Introduction of the State

Maharashtra is the third largest state in India both in area and population. The state is bounded by the Arabian Sea in the west, Gujarat in the north west, Madhya Pradesh in the north and the east, Andhra Pradesh in the south east and Karnataka and Goa in the south.

The state of Maharashtra has an area of 307713 sq. km. and a population of 96.88 million. There are 37 districts, 358 blocks and 43711 villages. The State has population density of 314 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 22.73% (against 21.54% for the country).

The state has 6 revenue divisions, 7 health circles, 35 districts, 354 talukas, 27920 grampanchayats, 41095 inhabited villages, 22 municipal corporations and 222 municipal councils.

The capital city Mumbai also the biggest city of India is the second largest producer of

films in the world. The cosmopolitan style of living of the people makes it a world class city. The state today has become a major destination for the film stars and cultural celebrities. The big cities of the state like Mumbai and Pune are famous for their educational institutions and research centres. The modern Maharashtra is a mixed result of indigenous traditions and western education. Tourism and culture are its main heritage and it unifies every community in it with same harmony and love.

One among the richer states, with a per capita income that is 40% higher than the all India average, Maharashtra's income is derived more from the secondary and tertiary sectors.

Maharashtra's net sown area is around 17,732,00 hectares of which only 14.5 per cent is irrigated, of which more than half i.e. 55 per cent, is by wells. This renders agriculture vulnerable to droughts, a fact borne out by the periodic fluctuations in farm output, which in a normal year produces only about 90 per cent of the States' food grain re4quiremnets. The rural economy is not diversified, though the mineral base is abundant-coal, manganese, iron ore and tin being some of the important minerals. The mineral belt stretches across Chandrapur, Gadchiroli, Bhandara and Nagpur districts. Limonite is found in Ratnagiri District.

The state also has the country's second largest urban population, with about 43 persons out of every 100 living in towns and cities. It has a large migrant population of which nearly 72% speak Marathi, which is the most widely spoken language. Other prominent languages are Hindi, Urdu and Gujarati.

Despite Maharashtra's higher level of economic growth and being on the higher echelons of income states with growth rates that exceed that of several states, in terms of Human Development Index (HDI), the state was ranked third among 17 states in 1991 with a HDI value of 0.532.

b. Base line of Public Health System in the State

i. Infrastructure

Tertiary Care

Superspeciality Hospital-2

Secondary Care

District Hospital- 23

Women Hospital-8

Rural /Sub-district Hospital-446

- *200 beds-3*
- *100 beds-22*
- *50 beds-56*
- *Rural Hospital-365*

Primary Care

Primary Health Centre-1816

Sub-center- 10579

Primary Health Unit-172

ii. HR

Public Health Staff	Sanctioned posts	In position
MMHS Grade-A Senior	1437	633(44%)
MMHS Grade-A (MO)	7281	6566(90%)
LHV/HA (Female)	3740	3323(89%)
ANM	12645	12027(95%)
HA(Male)	4598	3068(67%)
MPW(Male)	12210	9961(82%)

DPM Unit (In position)

DPM	1
DAM	1
DEO	2

Community Mobiliser	1
IPHS Coordinator	1
Telemedicine Facility Manager	2

District Infrastructure Wing (In position)

Deputy Eng	1
Junior Eng.	3
DEO	1

District School Health Programme Unit (urban area) (In position)

Doctor	26
Social Worker	1
GNM	13
Pharmacist	13

Block Programme Management Unit (only in 3 tribal blocks)(In position)

Accountant	13
DEO	13
Block Facilitator	33

- Postings under NRHM were done open house in presence of all candidates.
- Merit and permanent residence was considered for posting.
- Powers of recruitment are decentralized to Taluka Health Officer (THO).
- For vacant posts, walk- in- interviews are conducted on every Tuesday.

iii. Indicators

Birth Rate-18.1

Death Rate-6.6

IMR-34

CBR-18.1

CDR-6.6%

CMR-9.1

MMR-139

TFR-2.5

Selected Indicators

Indicator	**NFHS- 1**	**NFHS-2**	**NFHS-3**
Median age at marriage	16.1	16.7	-
TFR	2.9	2.5	2.1
Current use of any contraceptive method	54.1	60.9	66.9
% with total unmet need for FP	14.1	13.0	9.6
Delivery by trained staff	53.1	59.5	70.7
% of children age 0-3 months exclusively breastfed	30.5	38.5	-
Fully vaccinated children	64.1	78.4	58.8
% of children underweight (less than 3 yrs)	51.4	49.6	39.7
Any antennal care	85	91	93
Institutional Delivery	44.5	52.6	66.1

Iv. Status of the PRI framework in the State

- 27920 Gram panchayats in 43711 villages (41095 inhabited villages).
- Out of 41095 villages, VHC established in 33619 (82%) villages. Bank accounts opened in 32006 (78%) villages.
- Village-wise 41095 Gram-sabhas are organized to finalise village plans.
- Cooperation from Panchayat Samiti and Zilha Parishad officials is total.
- Zilha Parishad CEO is the Chairman of the District Health Society and takes active interest in the implementation of NRHM.

- RKS Governing Body Chairman of a PHC is a ZP member, that of a RH/SDH(CHC) is a Sub-divisional Magistrate and that of a DH is a District Collector.
- PRI involvement is very evident. (Shri Ranjit Shivthare, Chairman, Health Committee, Pune actively accompanied the Team to all the facilities).
- Governing Council in the district constituted under the Chairmanship of the Collector of the district and regular meetings held.
- District Monitoring and Advisory Committee formed under the Chairmanship of the Guardian Minister of the District. The Committee reviews progress of NRHM activities in the district and gives important suggestions for planning at village and block level;
- Block Monitoring and Advisory Committee formed at block level under the Chairmanship of MLA.

v Other Indicators

Total Population- 96879

Rural Population- 55778 (57.6%)

Urban Population- 41101 (42.4)

Male- 50401 (52%)

Female -46478 (48%)

Total Literacy- 77.27%

Female literacy-67.5%

Sex Ratio-922

Child Sex Ratio- 913

Population density- 315

SCs-9882 (10.2%)

STs- 8577 (8.85%)

Basic Amenities (NFHS-3 & DLHS 2002-04)

House holds	**Urban**	**Rural**	**Total**
Availability of electricity	96.9	76	83.5
Improvement in drinking water	-	45.2	92.7
Source of drinking water in house/ yards within 1.5 kms	91	60	74

Availability of flush toilets	86.4	16	52.9
Availability of pucca house	49.3	9.5	24

Nutrition and food security

- 40.6% of below 2 years children - < 2 SD for Weight-for-age
- 54.6% of below 2 years children - < 2 SD for Height-for-age
- 40% of adult women show chronic Energy Deficiency.
- Adequate Calorie intake of adult women
  - in 25% of the rural areas
  - in 28% of urban areas.
  -

Causes of maternal deaths

Pre-eclampsia/toxemia	26%
Anemia	21%
PPH/PH	19%
Maternal Infections	17%
Septic Abortion	13%
Ruptured Uterus	5%

Performance of Family Planning Sterilization for 3 years

Sr No.	Year	ELA	Performance	%
1.	2006-07	680000	595438	88
2.	2007-08	625000	554284	89
3.	2008-09 (upto Sept 08)	600000	207153	35

Performance of Vasectomy for 3 years

Sr No.	Year	Total sterilization	No. of vasectomies	%
1.	2006-07	595438	20480	3
2.	2007-08	554284	25611	5
3.	2008-	207153	14514	7

	09(upto Sept 08)			

Performance of IUD for 3 years

Sr. No.	Year	ELA	Performance	%
1.	2006-07	500000	427251	85
2.	2007-08	450000	408689	91
3.	2008-09(upto Sept 08)	450000	174270	39

Total deliveries for 3 years

Sr. No.	Year	Expected deliveries	Reported deliveries	%
1.	2006-07	2405384	1425940	59
2.	2007-08	2254433	1802857	80
3.	2008-09(upto Sept 08)	2197235	749660	34

Institutional deliveries for 3 years

Sr. No.	Year	Total deliveries (Home +institutional)	Institutional deliveries	%
1.	2006-07	1425940	1000853	70
2.	2007-08	18027857	1346693	75
3.	2008-09(upto Sept 08)	749660	577617	77

Janani Suraksha Yojana- Physical performance

Sr No.	Year	Expected beneficiaries	No. of Beneficiaries covered	%
1.	2006-07	173403	46428	26.95

2.	2007-08	200000	219552	109.77
3.	2008-09(upto Sept 08)	300000	93829 upto Oct 2008	31.27

List of the Facilities Visited

Name of State: Maharashtra

Names of Districts visited: Pune, Raigad

S.No.	Name	District HQ	Name of DM	Name of CMO
1	Raigad	Alibaug	Shri Nipun Vinayak	Dr. Pandit
2	Pune	Pune City	Shri Chandrakant Dalvi	Dr. H. H. Chavan

Health Facilities visited

Name	Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
DH	Alibaug	Other	Dr. S. M. Pandit
PHC	Nagothane	PHC	Dr. G. G. Wadaje
ZP, Pune	Pune	Other	Shri Shyam Vardhane, CEO
PHC, Khedshivapur	Pune	PHC	Dr. A. M. Karanjkar
Sub-centre, Kikawi	Pune	Sub-centre	Ms. D. C. Thopte
PHC, Ambavade	Pune	PHC	Dr. Imran Khan
Sub-dist Hos, Bhor	Pune	Sub-dist. Hos.	Dr. S. R. Virdhe
Sub-centre, Shinoli	Pune	Sub-centre	Ms T. F. Mali
PHC, Dimbe	Pune	PHC	Dr. R. G. Raut

CHC, Manchar	Pune	CHC	Dr. L. R. Dahihande
Public Health Laboratory	Pune	Other	Shri R. S. Waghmare
IEC Bureau	Pune	Other	Shri Vilas Deshpande
SHRC	Pune	Other	Dr. P. Doke, ED
State Transport Depot	Pune	Other	-

3. Findings of the 2nd CRM in the State

(i) Progress of operationalisation of Institutional Framework of NRHM (Village Health & Sanitation Committtes, Rogi Kalyana Samitis at various levels, State and District Health Missions etc)

- RKSs formed at the DHs under the Chairmanship of the Collector and the meetings are held regularly
- RKSs at all Rural Hospitals is formed under the Chairmanship of SDOs and the meetings are held regularly
- RKSs at all PHCs formed under the Chairmanship of ZP Member of local constituency and the meetings are held regularly
- Sub-centre level Committees formed under the Chairmanship of Sarpanch of SC- HQ Village and the meetings are held regularly
- Village Health, Sanitation, .Nutrition and Water Supply Committees formed the Chairmanship of Sarpanch of that village
- State Health Mission is chaired by the Chief Minister; State Health Society GB chaired by the Chief Secretary and EC chaired by the ACs (PH&FW); State Project Management Unit headed by the MD (NRHM)
- District Health Mission- District Monitoring and Advisory Committee chaired by the Guardian Minister and headed by the President of ZP

ii) Comments on various TORs

- ***Change in Key Aspects of Health Delivery System***

(1) Assessment of the case load being handled by the public systems at all levels –

Definite improvement seen in the outpatient load of Sub-centres, PHCs and Rural Hospitals (CHCs). 24X7 Block PHCs are offering outpatient, emergency and institutional services. Sub-centres are regularly doing deliveries. (A separate labour room built from the State budget has increased the numbers) Basic reason for increase in inpatient load at PHCs and CHCs is increase in institutional deliveries partly due to JSY and also because of upgradation of the quality of the infrastructure, clean toilets, water availability, inverter for alternate source of electricity, free meals and also due to feel good factor generated by the beautification of the Centres and Hospitals and their surroundings. On the other hand in-patient load at the Sub-district Hospitals is below optimum due to not so comparatively efficient facilities available (as told demand for services was not there due to presence of a 24X7 PHC nearby. It was informed that the State had been proposing to shift the Sub-distt Hospital- Bhor to an area where it was required in the same district). Increase in OPD cases from 793727 in 2005-06 to 880339 in 2006-07 and to 1005247 in 2007-08.

(ii) Preparedness of health facilities for patient care and utilization of beds for such care-

Extremely committed health functionaries in coordination with public representatives have been able to deliver good quality services to the public. 30% Sub-centres and PHCs have been upgraded to Indian Public Health Standards (IPHS). Nurses, doctors, specialists have been appointed. Rationalization of anesthetists is needed. Well stocked drugs and consumables, laboratory facilities for conducting malaria, TB tests exist. Water quality checking is done at the Sub-centres. Blood storage facility exists in the IPHS PHCs and CHCs. Eight DHs in the State have OPD and IPD facility for AYUSH and salary for AYUSH and medicine facility in CHC/SDH. IPD cases increased from 16559 in 2005-06 to 17431 in 2006-07

to 21582 in 2007-08. Increase in institutional deliveries is from 71345 in 2005-06 (77%) to 71987 (84%) in 2006-07 to 72759 (87%) in 2007-08.

(iii) Quality of services provided for institutional deliveries–

Institutional deliveries have increased on a large scale. There may be a shift from private to public health care in institutional delivery. Sub-centres are well equipped with infrastructure and equipments and also untied funds to carry out deliveries. Free meals provided to mothers have helped in making their stay comfortable in the institutions. Stay of women in the Centres at least for 24 hours minimum needs to be ensured. JSY funds were seen to be disbursed well to eligible delivery cases. Clean and well equipped labour rooms were seen. Waste management found to be satisfactory. Panchayat representatives were totally involved in improving trhe quality of services. Mothers are given a saree alongwith the kit for the new borne having a dress and toys from the state budget funds.(One peculiar observation is that the new borne was not made to wear any clotrhing and just covered with the blanket. BCC required.) Increase in caesarian section due to increase in periphery referral and availability of specialists and blood storage facility in CHCs. (MTPs decreased by 9%). JSY beneficiaries in tribal areas are given free transportation facility. Fee is paid from VHSC or untied funds.. Meeting of vehicle owners is called and tariff for ANC cases is decided. Information of vehicle owners is given to ANCs. After discharge, the delivery patient is given a package of essential medicines, sanitary napkin, bathing and baby soap. 528 private hospitals accredited for giving JSY benefits for institutional deliveries,. At every PHC village – wise record of estimated and actually registered JSY beneficiaries is kept. JSY Redressal Cell at district HQ established.

(iv) Utilisation of Diagnostic facilities & their effectiveness –

All 24X7 PHCs are provided with lab providing basic facilities; semi-auto analyzer and special services like ECG, X-ray in these PHCs; DHs have ECG, X-ray, Ultrasound with CT-Scan. These services are available at

reasonable user cost. Use of pregnancy diagnostic kit for early diagnosis of pregnancy, hemoglobin, urine for albumin and sugar test to rule out anaemia, diabetes and pregnancy induced hypertension.

Public Health Laboratory Services (PHLS)

There are 30 PHLs under State PHL at Pune. In brief, the functions are water quality monitoring , industrial waste /effluents examination, stool examination of bacteriological diseases and food poisoning cases, analysis of food, urine sample examination under IDDCP and training and health education.

(v) Drugs and Supplies-

Drugs and supplies are in abundance in the Sub-centres, PHCs and in CHCs. They are well stocked in newly made racks and cupboards with proper marking for easy retrieval. Vaccines are also available (except measles vaccine) and in proper condition stored in IPL and deep freezer.

(vi) Health Human Resource Planning –

State has taken a number of steps to improve availability of nurses. AYUSH doctors are manning the PHCs due to non availability of MBBS doctors (The State has been facing the problem for a long time and in fact is interested in seeking solutions). Specialists are available except an anesthetist. The State needs to seriously carry out the rationalization exercise to post specialists especially anesthetists wherever required. Even in case of ANMs, NRHM has made a contractual ANM available in the Sub-centres. MPW(M), pharmacists and lab technicians are there.

Actions taken to improve availability of manpower

Nurses

- Appointment of retired nurses on contractual posts
- Powers of appointment given to THOs and Medical Superintendents
- Walk-in interviews
- Doubling the capacity of govt. nursing schools
- Establishment of new nurses training schools

- Increase in salary of nursing staff
- Decentralization of appointment powers
- Under PPP, all nursing schools to increase their capacity. They would be provided beds from SDH/RH and PHCs, fees of Rs. 25,000/- to be paid as loan for students entering into 5 year bond, monthly stipend to them on non-returnable basis and separate batch and higher stipend for girls from tribal areas.
- Multi-specialty training on priority of nurses posted in tribal and extremism affected areas
- Special batches of nursing training in government and private nursing schools to fill up the vacancy on priority
- Rs. 1000/- higher payment to nurses in tribal areas and Rs. 1500/- higher payment (both contractual and regular) working in extremism affected Nagpur Division. Exact per month payment of ANMs is as below-

  ANM in rural area Sub-centre- Rs. 7000/-
  ANM in Naxal area Sub-centre- Rs. 7500/-
  ANM in unreachable Sub-centre – Rs. 10,000/-

Doctors

- For post graduation reservation of 12.5% seats for serving MBBS doctors (with the condition to get above 50% in entrance exam) and full salary with increment during post-graduation.
- Multi-speciality training on priority for doctors posted in tribal and extremism affected areas
- Rs. 1500/- higher payment to doctors working in extremism affected Nagpur Division.

Specialists

- Filling up regular posts
- Raising support through professional organizations
- Delegation of powers to finalize honorarium of specialists to medical superintendents
- Procedure simplified for fixing honorarium/salary
- Proactive motivational initiatives by RKS of hospitals
- Honorarium for specialists within the service

(vii) Infrastructure-

Excellent construction of new infrastructure and repair/up gradation of the existing infrastructure. Care has been taken to beautify the inside as well as gardening/ landscaping. For children play toys have been placed in the garden outside. An extra labour room has been constructed from the State budget in the Sub-centre. Staff quarters at the places visited were in good condition. The condition in other places is not as good as told and requires repairing/upgradation.. Instructions issued by the State to spend for this current year civil infrastructure funds only for new construction needs to be revised and to be issued for both new construction as well as repair including for staff quarters.

(viii) Empowerment for effective decentralization and flexibility for local action-

Excellent involvement and cooperation of the PRIs. Not only current but also ex-sarpanches have been helping the health care in facilitating its functions. Health Committee Chairman of the ZP of the district with his personal involvement has been working on improving the infrastructure and monitoring the functioning. Village Health and Sanitation Committees are fully functional. Untied fund used for cleanliness and beautifying the surroundings. Self Help Groups are involved in providing meals at PHC level. ANM providing meal to the delivery cases in the Sub-centres. RKSs meetings are held regularly. Sarpanch, members of VHSC, gramsabha and employees of health panchayat and ICDS involved in the preparation of the village health plan. For action plan at Sub-centre level sarpanch, members of VHSC, employees of health panchayat and ICDS involved. For action plan at PHC level RKS president and members and employees of health Panchayat and ICDS involved. Chairman panchayat samiti, ZP members and employees of health panchayat and ICDS involved in the action plan at taluka level.

(ix) ASHA

ASHAs in tribal areas are functioning. Third module training is ongoing. ASHAs are well motivated and enjoy confidence of the community. They are

knowledgeable. Average per month income of a ASHA is Rs. 800-900/- and the maximum is 1500/-/ per month. They have been paid regularly. ASHAs have maintained their records well. Strict delineation of the coverage of the area per ASHA as per the population is not followed. ASHAs who are enthusiastic and good communication skills have been able to .get the patients from the areas covered by other ASHAs. Block level ASHA libraries established at 3 blocks with purchase of furniture, books and magazines.

(x) Systems of financial management

Societies have merged. SPMUs and DPMUs are functional Block level Programme Management Structure with Block Monitoring and Advisory Committee under the Chairmanship of MLA/MLC, Block Mission under Chairman Panchayat Samittee and Project Management Unit under Block Health Officer are functioning. Important Management Structure consists of Infrastructure Development Wing, IPHS wing, School Health Programme Coordinator, Procurement Officer, two FMGs (one at Mumbai for NRHM, NPCB, IDSP and other at Pune for RCH, RNTCP, NLEP, NVBDCP). Audit wing is headed by State Accounts Manager under RCH. Roles of FMG are budgeting and planning of funds, timely submission of fund requirements to GOI, release of funds to districts, monitoring of funds released at district levels and financial accounting and its reporting.

(xi) HMIS and its effectiveness –

Very well functioning web based HMIS formats, user friendly software for data entry, analysis and report generation at different levels and trained health staff in use of software database are the features of the state HMIS. 539 Sub-centres and 96 PHCs have ongoing HMIS linkage. HMIS Report is filled on the web site address- www.phd.nic.in with each Institution having separate Login ID. The structure has resulted in early availability of monthly reports, improvement in efficiency, accuracy, low cost solution, less paper work district onwards, easy decision making, less resources required,

identification of low performance areas with possibility of cross checking. (The data has not however been made available on the national web-site).

(xii) Community Processes under NRHM-

7887 ASHAs have been appointed in tribal areas. Process of ASHA appointment in non-tribal areas has started and guidelines issued to all districts. It is proposed to appoint 40,000 ASHAs in non-tribal areas by March, 2008. Support mechanism for ASHA is in place with programme managers appointed in all 15 districts, establishment of ASHA mentoring group at block, district and state level. Block facilitator is being appointed per 10 ASHAs. LHV/ Mukhya Sevika supervising the work of ASHA and paid Rs. 500/- pm for this. Monthly reorientation meeting conducted at all PHCs during which ASHA is paid Rs. 100 DA per meeting. Continuous education and payment of performance based remuneration is done during review meeting. Village Health Sanitation Water Supply and Nutrition Committee to be established in all revenue villages of the state. Out of 41095 villages, VHCs established in 33619 (82%) villages, bank account opened in 32006 (78%) villages and committee and bank account opening in progress in remaining villages. Maximum utilization of village health funds is on providing safe water supply and thereafter on village health and nutrition day. Maximum utilization of untied funds to SCs, PHCs, CHCs, and DHs is for purchase of pillow, mattresses etc. followed by purchase or maintenance of equipments. RKS functioning with utilization pattern reflecting maximum use of funds for purchase of medicines for individual patients and repairs or new construction of building/quarters for common services for patients. Innovative utilization includes expenditure on food facility for patients.

(xiii) Assessment of non-governmental partnerships for public health goals –

State is in the process of starting emergency medical services with the help of emergency medical research institute. Module for ASHA prepared with NGOs

and training held. One NGO per district for sickle cell disease control programme for creating awareness among community for testing, maintaining carrier register and marriage counseling to avoid marriages between carriers. MMUs providing services to un served and underserved areas run by NGOs. Other initiatives include publication of monthly magazine “Mahasanjeevani” for rural women with the NGO helping in identifying potential authors, collect articles, editing of articles and design of the magazine. NGOS have been willing to join the telemedicine project and provide specialist advise free of cost. Community based monitoring is being implemented with the help of NGOs under which committees established from village to district level and doing Jan Sunwai and similar activities. RNTCP services are made accessible to high risk group of HIV/AIDS by involving target intervention NGOs working on the same.

(xiv) Systems in place for outreach activities of Sub-centre-

Immunization sessions (VHNDs) at fixed day/fixed site and fixed time at each village, vaccine transportation by health supervisor, involvement of support group (AWW, Helper, SHG etc.), cold chain maintenance, vaccination done under supervision and health personnel trained in RI. For strengthening routine immunization mobility support of Rs. 50/- per session is offered in addition to hiring ANM services at Rs. 300/- per session in urban slum, mobilizing the children by support Group at Rs. 150/- per session, vaccine van, POL and maintenance done.

(xv) Thrust on difficult areas and vulnerable social groups-

ASHAs in the beginning only for tribal areas, multi speciality training on priority of nurses and doctors posted in tribal and extremism affected areas, separate batch of girls for nursing schools from tribal areas with higher stipend (twice of the regular), Rs. 1000/- pm higher payment to nurses in tribal areas and Rs. 1500/- pm higher payment (both contractual and regular) working in extremism affected Nagpur Division. Exact per month payment of

ANMs is ANM in rural area sub-centre- Rs. 7000/-,pm, ANM in naxal area sub-centre- Rs. 7500/-pm and ANM in unreachable Sub-centre – Rs. 10,000/-pm..

Rs. 1500/- pm higher payment to doctors working in extremism affected Nagpur Division. Promotion of Copper T (IUD-380A) in 2 low performing districts (Parbhani, Amravati), anti anemia drive in 11 districts, incentives to dais for increasing institutional delivery in low performing 31 blocks in 11 districts, incentives to PHC health staff in 99 blocks in 21 districts for increasing institutional deliveries (Rs. 100/- to doctor/nurse and Rs. 50/- to sweeper per delivery). Mother and child health focus initiatives in underserved block Sengaon of the Hingoli district is innovative. Geriatric care scheme in 12 selected districts, 2 units of MMU each I in Nandurbar and Gadchiroli and one each in remaining districts, sickle cell disease control programme in 15 tribal districts.

(xvi) The preventive and promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health–

School Health Programme (353 teams at Taluka level) in coordination with education department, geriatric scheme implemented in cooperation with volunteers from Kishori Shakti Yojna and senior citizens attending the sessions at Aaganwadis and doing exercise, constitution of VHSCs in partnership with the water and sanitation committee, VHSC funds utilized for improvement of amenities in aanganwadi, safe water supply, RKS funds utilized for drinking water facility, viable partnership with ICDS through ASHAs in tribal areas at present , 438 Child Development Centres established to treat malnutrition children of Grade III and IV with weight monitoring follow up by AWW after discharge etc. State Public Health laboratory implementing the project of Accelerated Rural Water Supply Scheme under which facility of water quality testing is done at the block level in the 337 mini labs in Rural Hospitals (CHCs) by H2S- Strip test.

(xvii) Effectiveness of the disease control programmes including vector control programmes–

Excellent coordination and overall supervision of Mission Director on all disease control programmes, enough resource availability at the health institutions, sub-centres have pregnancy detection kit, diabetes detection kit, water quality monitoring kit. PHCs have facilities for sputum examination for TB and blood smears for malaria parasite. Gappy fish breeding in all PHC and CHCs, supply of rapid diagnostic kits for immediate detection of malaria cases in remote and inaccessible area through MPW/ Pada Workers/ ASHA volunteers., sufficient stock of anti malarials, Malaria surveillance workers and MPW(M) are working in coordination. Integration of laboratory technicians of malaria for doing other blood related tests is satisfactory. ASHAs (in tribal areas) taking blood slides of malaria and also involved in distribution of anti-malaria drugs, RNTCP has linkages with all ICTC and ART Centres.

(xviii) Performance of Maternal Health, Child Health and Family Planning Activities seen in terms of availability of quality of services at various levels –

Significant increase in institutional deliveries (Shift from private sector to public sector is evident but needs to be evaluated), needed to make women stay at the facility at least for 24 hours after delivery and its strict monitoring, good quality delivery rooms with required equipments available even in the Sub-centres, 24x7 PHCs have blood storage facility, women are given free meals but needed to ensure free meals at least for 48 hours stay, women given gift package to mother and baby at the time of discharge after 48 hours. Anesthetics available in 24x7 PHCs and CHCs, referral transport with clear directions available. High quality child health services facility with well maintained Child Development Centres for malnutrition exist. Performance of

family planning services has been on the rise., promotion of copper-T scheme in 2 low performing districts of Parbhani and Amravati. Incentives are given to PHC health staff for increasing institutional deliveries in low performing 99 blocks in 21 districts, de-worming and Vitamin 'A' supplementation drive twice in a year clubbed with health and nutrition day. ASHA aware of and gets delivery cases to the institution and getting her compensation on time. One ANM at Sub-centre and one ANM for touring. Timetable for tours and staying at headquarters displayed prominently in sub-centre along with mobile phone numbers. Pregnancy test kit available and used in the sub-centres. Specialists appointments facilitated through various means including raising support through professional associations, delegation of powers to finalise honorarium to medical superintendents, procedure simplified to fix it, proactive motivational initiatives by RKS of hospitals etc. Suction machine (in 90% CHCs) , X-ray machine (in 65% CHCs), ECG machine (in 24% CHCs), radiant warmer (in 38% CHCs), and Boyles machine in 29% CHCs. ICU in all DHs with additional staff of 18, neo-natal ICU in all district and women hospital with additional staff of 10, burn ward in all DHs with additional 3 staff, emergency services trauma care units provided in CHCs on highways and available in all DH and 16 CHC/ SDHs, Greeting cards to the pregnant ladies wishing safe delivery and mentions essential services available at government hospital. Stickers related to high risk antenatal condition are stuck on ANC card for providing priority services. High risk ANC kit provided to the pregnant woman

(xix) Assessment of programme management structure at district and state level –

SPMU and DPMUs are fully functional. BPMUs are functional at present in three tribal blocks. Directorate staff is totally involved in implementation of NRHM. There is excellent coordination among NRHM and directorate including disease control programmes. District Infrastructure Wing and District School Health Programme Unit functional. District Health Officer/

Chief Medical Officer and Civil Surgeons are also involved in the implementation of NRHM.

- ***Progress against the Approved PIP of the State***

  Filled-in Checklist for the State of Maharashtra is attached.

4. Other State specific Issues/Observations/ Innovations-

- Cleanliness of the Centres/ Hospitals and souroundings is apparent.
- IEC Material displayed in all the Centres on nearly all health issues.
- Community participation esspecially women members seen.
- Equipments and drugs found to be sufficient.
- Beds were all occupied (except at SDH Bhor)
- Increase in institutional deliveries observed during visit as well as through records.
- Labour rooms adequately equipped & clean.
- The newly borne were without clothes and sometimes exposed.
- JSY funds disbursement was in order. List of JSY beneficiaries was displayed in sub-centres.
- Payment of JSY is done by the bearer cheque except in the case done by cash if bank is more than 25 kms from the village.
- Incentives of ASHAs has been disbursed.
- Operation theaters equipped with shadow less lamps and air-conditioned.
- Operation theater equipped with operation table, suction machine, boyle's apparatus.
- Operation tables in good condition except at SDH Bhor.
- Clean toilets and reliable water supply seen.
- Solar water heater and solar battery backup existed in all the centers.
- Sub-centers having Lab Test Kits for detection of pregnancy, malaria, hemoglobin, water quality and chlorine content of water
- OPD attendance at all PHCs found satisfactory.
- OPD attendance in rural hospitals is less than expected.
- Disposable unused material collected by the institutions needs to be disposed off as it occupies the space.
- Child Development Centers functioning in all PHCs for Gr.III & Gr.IV malnourished children. The beds were all full.

- Malnourished children at CDC monitored closely by a pediatrician and dietician. Children are discharged after 21 days (after gaining requisite weight)
- Medicines stocked in nicely designed closed cupboard & racks in order
- All centers have hatcheries for Guppy fish for biological control of mosquitoes
- A well organised IEC bureau functioning in the state is an extraordinary achievement (compared to other states in the country). The bureau prepares good quality IEC material for the health sector.
- PHCs have battery operated lamps.
- Additional labour room built in the sub-centres.
- A 'Thermocol Box' with baby clothes and sanitary napkins provided to the lady after delivery.
- Medical Officer allowed to enter into a contract for giving 2 teas and 2 meals to a delivered mother.

5. Recommendations

For ensuring systematic inspection of all health facilities to achieve the goals of NRHM the state was requested to pay kind attention to following suggested recommendations-

1. Always maintain "A Woman Friendly " atmosphere.
2. Assured water supply particularly in the delivery rooms, bathrooms and **toilets –** and as an absolute necessity **clean toilets.**
3. Ensure power supply particularly at night by battery and solar back-up. This is vital to ensure 24 hour stay by the patients.
4. A clean and perhaps nicely decorated women's wards with daily changed bed-linen. Perhaps also a few nice picture calendars donated by local companies and a little perfume!
5. Clean and well equipped delivery rooms with **absolute privacy** with at least a simple baby warmer.

6. Clean and rust-free equipment in the operation theatres with proper equipment, shadow less lamp and ideally an A/C.
7. Permission for the expectant mother to be accompanied by a relation as '**birth companion**' with a condition that the companion has had a bath and is wearing fresh clothes.
8. The new born child to be provided immediately with a set of protective clothes. (For various reasons it is a practice in the state to clothe the child only after about 12 days – thereby exposing it to chances of hypothermia).
9. Bright and clean reception rooms, with nicely designed and framed IEC material, a roster of doctors and nurses with their phone numbers, and also a TV set, which plays popular local programmes.
10. A well maintained garden with plants which do not require watering eg. bougainville and shade trees such as neem and not coconut trees which requires 60 litres of scarce water every day. The garden can be maintained by a reliable private company which may be permitted to place in the garden some of its advertisements.
11. Supply of good hot meals to delivery, abortion & sterilization patients .
12. Good reliable quarters in the PHC compound for at least 1 doctor, 3 to 4 nurses/ANMs and for at least 2 or 3 cleaning and watch staff.
13. The civil work funds be utilized in the proportion of $3/4^{th}$ for repair and 25% for new construction as against the directions issued by the state government for using them only for new construction during the current year.
14. Tight monitoring of performance especially in terms of outpatient per doctor per day, inpatients per bed, institutional delivery and sterilizations on a monthly basis.
15. A regular inspection by superior officers who visit the Centres both in the day and **at night**. An inspection format of standard design be made available. Copy of the inspection note should be available in the PHCs so that it could be perused by successive inspection authorities.

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6. Medical cadres and career progression of the Medicals and Para-medicals

Doctors

|

|

1	**2**	**3**	**4**
MBBS/BAMS 12.5% posts of Asstt.DHO	Post-graduate Degree/diploma Public Health	Post-graduate degree in clinical subject	Post-graduate degree/diploma in clinical subject (Class-I)
	Distt. Health Officer	Civil Surgeon Cadre (Interchange in 3 &4 allowed)	13 Disciplines
		DD (23 posts)	
		JD(11posts)	
		Additional Director(3 posts)	

Director(1 post)

Paramedicals

ANM	GNM (SN)	B.Sc. (Nursing)
|	|	|
LHV	Staff Nurse----------|	
	|	|
	In-charge Sister	Sister Tutor
	|	|
	Asstt. Metron	Prin(Nursing School)
	|	|
	Metron	Asstt. Director(N)
	|	
	Chief Metron	
	(500 beds)	

7. Views of State for consideration

- Home deliveries should not be given incentives of any kind as it discourages women from going to institution for the delivery.
- Under RCH complex financial expenditure report classification hinders implementation.
- For immunization expenditure ANMs could have sub-accounts to spend from their end.
- For urban health data collection and feeding resources are required.
- Funds required under NRHM for heart surgery of non-school going children. (Rs 70,000/- per child)
- Stricter punishment for violation of the PC&PNDT Act (ACS, PH thought it to be the most important requisite in Health for the state due to extent of the problem and inability of the State to get a single doctor punished in spite of having enough proofs)

- State wants to have serious discussion and directions for getting MBBS and specialists as due to large private sector opportunities they have not succeeded in getting doctors in spite of taking steps as given above.

MIZORAM

REPORT OF THE SECOND COMMON REVIEW MISSION OF NRHM

MIZORAM

16-21st December, 2008

Chapter 1. Title

The second Common Review Mission (CRM2) of the National Rural Health Mission (NRHM) was undertaken in Mizoram. The Mission comprised members from the government of India, the autonomous bodies and the independent institutions. The members of the team were Shri Rajesh Bhatia, MoHFW, Govt. Of India; Dr. Ashoke Roy, RRC NE, Guwahati and Dr. Vijay Aruldas, Christian Medical Association of India (CMAI), New Delhi; Shri M. K. Talukdar, NHSRC, new Delhi and Dr. Sharad Iyengar, Action Research and Training for Health (ARTH), Udaipur. The team comprising S/Shri Bhatia, Roy and Aruldas was coordinated by Dr. Sangzuala, Dr. Zahmingthangs and Ms. Lalsangkimi Zote; the other team comprising S/Shri Talukdar and Iyengar was coordinated by Dr. Hmingthanzuala and Shri P. Ragui (RRC's State Facilitator).

Of the two teams mentioned above, the former visited district Kolasib and the other visited districts East Aizwal and Serchhip for overseeing the progress made under the NRHM. The CRM2's visit in the state was from December 16, 2008 through December 21, 2008.

The members of the CRM2 in Mizoram would like to place on record its deep sense of appreciation and thanks to everyone relevant to the Mission's visit. Thanks are due to Shri Ramthana, Secretary and Commissioner, Dr. N. Pallai, Director Health services and the Mission Director NRHM in the state, the facilitators of the Mission. But because of the active support and assistance provided by the Doctors and relevant staff members of the District Hospitals, CHCs, PHCs, members of the District Programme Management Support Units, the functionaries of the supervising institutions like 'Main Centres' of the Sub-Centres, the ANMs, the Male Health Workers and members of the community level organisations like Rogi Kalyan Samitis (RKS) and the Village Health and Sanitation Committees, the Mission would not have been able to have a clear idea of the progress made by the NRHM in the state.

With the above backdrop, this report is prepared generally in line with the terms of reference (ToR) given to the CRM2.

Composition of the Teams

District Kolasib

Rajesh Bhatia Joint Director MOHFW 353 A Wing, Nirman Bhawan, New Delhi Tel: 23061960 jdstat-mohfw@nic.in	Dr. Ashoke Roy Advisor, Public Health, Regional Resource Centre – NE , Guwahati 09864031735 ashokeroy@yahoo.com	Dr. Vijay Aruldas CMAI, General Secretary, Christian Medical Association of India, Plot No. 2, A-3, Local Shopping Centre, Janakpuri, New Delhi 58 Ph.: 011-25599991/2/3, Fax: 25598150 Email:varuldas@cmai.org,cma@cmai.org
Accompanied by Dr. P. Sangzuala, Jt. DHS (FW), Dr. Zahmingthanga, CMO Ms. Lalsangkimi Zote, DPM		

District Serchhip

Sh. M.K. Talukdar Senior Consultant/ Research Officer NHSRC mukultalukdar.nhsrc@gmail.com, 9810340406	Dr Sharad Iyengar AGCA, Secretary, Action Research and Training for Health (ARTH), 772, Fatehpura, Udaipur – 313 004, Rajasthan Telefax: 0294-2451033 Mob. 9799498349 Email: arth@softhome.net, sdiyengar@gmail.com
Accompanied by Dr.Hmingthanzuala MO, NRHM, Mizoram Mr P Ragui, State Facilitator, RRC	

Chapter 2. Introduction

Introduction of the State

Geography

The state is bordering by Myanmar in the east and south and Bangladesh in the west, Mizoram occupies an area of great strategic importance in the north-eastern corner of India. It has a total of 630 miles boundary with Myanmar and Bangladesh. Mizoram has the most variegated hilly terrain in the eastern part of India. The hills are steep and are separated by rivers that flow either to the north or the south creating deep gorges between the hill ranges. The average height of the hills is about 900 metres. The highest peak in Mizoram is the Phawngpui (Blue Mountain) with a height of 2210 metres. Mizoram has a pleasant climate. It is generally cool in summer and not very cold in winter. During winter, the temperature varies from 11 C to 21 C and in the summer it varies from 20 C to 29 C. The entire area is under the direct influence of the monsoon. It rains heavily from May to September and the average rainfall in Aizawl is 208 cm. Its latitude lies at $21^{o}58'$&$24^{o}35'$N and longitude- 92^{o} 15' & 93 ^{o} 29' E.

Map of Mizoram showing its district and neighboring international borders and States.

Administration

Mizoram is a mountainous region, which became the 23rd State of the Union in February 1987. It was one of the districts of Assam till 1972 when it became Union Territory. Mizoram is a state with one of the highest literacy rates in India. Situated on the extreme south of the north-eastern India, it is a land of unending natural beauty with an array of flora and fauna. It has 40 seats of legislative assembly.

One member each represents the state in the Lok Sabha and Rajya Sabha. The traditional chieftainship is gradually abolishing and the District and Regional Councils (created under the sixth Schedule of the constitution of India) gave a substantial measure of local control and development in the state. The Villages Councils are the grassroots of democracy in Mizoram, the state has 9 districts, 3 autonomous district councils, 23 sub-division, and 26 rural development blocks, 366 villages Health Council, covering 817 villages.

Demography

The population of Mizoram is 0.89 million according to 2001 census and is scattered over 9 districts, 26 blocks and 817 villages. The State has the density of 42 persons per sq. km. As against decadal growth rate of 21.54% at the national level, the population of the State has grown by 28.82% over the period 1991-2001. The sex ratio of Mizoram at 935 females to 1000 males is higher than the national average of 933. Female literacy of the State rose to 86.13% from 78.6% in 1991.

State Capital

The capital of Mizoram, Aizawl is wonderfully blue in the winter, and in the enchanting view of wide stretches of a vast lake of cloud. This place has great natural beauty and endless variety of landscape and is very rich in flora and fauna. Almost all kinds of tropical tress and plants thrive in Mizoram, especially in Aizawl. The hills are marvelously green.

Baseline of Public Health System in the State

Health Indicators of Mizoram

The Total Fertility Rate of the State is 2.9. The Infant Mortality Rate is 23 and Maternal Mortality Ratio is NA (SRS 2001 - 03). The Sex Ratio in the State is 935 (as compared to 933 for the country). Comparative figures of major health and demographic indicators are as follows:

Table I: Demographic, Socio-economic and Health profile of Mizoram State as compared to India figures

S. No.	Item	Mizoram	India
1	Total population (Census 2001) (in million)	0.89	1028.61
2	Decadal Growth (Census 2001) (%)	28.82	21.54
3	Crude Birth Rate (SRS 2007)	18.2	23.1
4	Crude Death Rate (SRS 2007)	5.2	7.4
5	Total Fertility Rate (NFHS-III)	2.9	2.7
6	Infant Mortality Rate (SRS 2007)	23	55
7	Maternal Mortality Ratio (SRS 2001 - 2003)	NA	301
8	Sex Ratio (Census 2001)	935	933
9	Population below Poverty line (%)	19.47	26.10
10	Schedule Caste population (in million)	0.0003	166.64
11	Schedule Tribe population (in million)	0.84	84.33
12	Female Literacy Rate (Census 2001) (%)	86.7	53.7

Table II: Health Infrastructure of Mizoram

Item	Required	In Position	Shortfall
Sub-centre	146	366	-
Primary Health Centre	22	57	-
Community Health Centre	5	9	-

Multipurpose Worker (Female)/ANM	423	421	2
Health Worker (Male)/MPW(M)	366	303	63
Health Assistants(Female)/LHV	57	57	0
Health Assistants(Male)	57	57	0
Doctor at PHCs	57	39	18
Surgeons	9	0	9
Obstetricians & Gynaecologists	9	0	9
Physicians	9	0	9
Paediatricians	9	0	9
Total specialists at CHCs	36	0	36
Radiographers	9	9	0
Pharmacist	66	35	31
Laboratory Technicians	66	31	35
Nurse Midwife	120	243	-

(Source: RHS Bulletin, March 2007, M/O Health & F.W., GOI)

The other Health Institution in the State are detailed as under:

Health Institution	**Number**
Medical College	
District Hospitals	8
Referral Hospitals	
City Family Welfare Centre	
Rural Dispensaries	
Ayurvedic Hospitals	-

Ayurvedic Dispensaries	-
Unani Hospitals	-
Unani Dispensaries	-
Homeopathic Hospitals	-
Homeopathic Dispensary	1

Facilities Visited

District Kolasib

District Hospital Kolasib	CMO: Dr. Zahmingthanga
Vairengte CHC	MO IC: Dr. Febiola
Bilkhawthlir PHC	MO: Dr. C. Lalduhsaka
Kanpui PHC	Dr. (Ms.) Zonuntluangi

Lungdai PHC	MO: Dr. Daniel Zomawia
Bilkhawthlir Sub Centre	ANM: R.C. Parkungi
Diakkaun Sub Centre	ANM: Ms. Lalengzami
Thingdawal Sub Centre	ANM: Ms. Thanhmingliani
Bualpui Sub Centre	ANM: Lalrinliani
Zanlawn Sub Centre	ANM: Ms. Klalremruatpui

District Serchhip

District and District Hospital Serchhip	DC Mr H Darzika CMO Dr ** MO Dr ZD Lalmuanawma Gynecologist Dr Lalbiakdiki DPM Lalmuankima ICTC counsellor David Zaitinvawra
Thenzawl CHC	MO Dr Remlalnghaki MO Dr Christopher ASHA Saihmingthangi ASHA R Lalbiakzami ASHA R Lalnunmawi
Chingchhip PHC	MO I/C Dr Mary FHS R Hmangaizuali
Thingsuliah PHC (District Aizawl West)	MO I/C Dr Varkung Valte MO Dr Zonunsangi
Chinchhip Sub Centre	FHW CS Lawmzuali

	FHW Lalthankungi MHW M Zanghingloua
Buangpui Sub Centre	MHW Lalramthara FHW Lawmsangi
Thenzawl Sub Centre	FHW Laldilithangi FHW R Vanlalbiaki FHW Lilipari MHW Birangthanga

Chapter 3. Mandate of the CRM

As mandated, the CRM2 would discuss the general findings of the field visits, interactions with the state through grass root level functionaries, the progress made, shortcomings, if any and the way forward as well as the recommendations.

Chapter 4. Findings of the CRM

Progress of Operationalization of Institutional Framework of NRHM (As reported by the State)

1. Upgradation of District Hospitals

District Hospitals Kolasib, Saiha, Lawngtlai, Lunglei, Serchhip and Mamit project has been taken up for upgradation under NRHM. District Hospital Serchhip has got a new trauma wing and blood bank building, but the DC of Serchhip made a strong case for undertaking renovation of the main hospital building

Civil Hospital Aizawl and Champhai District Hospital upgradation project initial stage has began.

2. Upgradation of CHC

Infrastructure upgradation of Six CHC Viz:- Vairengte, Sakawrdai, Saitual, Ngopa, Thenzawl and Chawngte CHC upgradation completed.

3. Reconstruction Of Sub-Centre

Sub – Centre cum quarter 86 nos, Sub – Centre only 15 nos, staff Qtr. 26 nos. Is completed

Aizawl East District	-	9
Aizawl West District	-	8
Mamit District	-	6
Kolasib District	-	5
Champhai District	-	5
Serchhip District	-	6
Lunglei District	-	7
Lawngtlai District	-	5
Saiha District	-	14

Another reconstruction Sub- Centre under progress are as follows.

Aizawl East District	-	4
Aizawl West District	-	3
Mamit District	-	9
Kolasib District	-	11
Champhai District	-	9
Serchhip District	-	10
Lunglei District	-	11
Lawngtlai District	-	8

5. Logistic And Procurement

For increasing the reach of Medical care to the rural population Nine Units of Mobile Medical Units consisting of three Vehicles each per Unit has been procured. The Mobile Medical Units has greatly benefited the rural population as they can now access special medical care with diagnostic and laboratory services at their doorstep. However, the capacity utilisation of the MMUs merit attention as its use, so far, remained as once a month only.

Seventeen (17) Ambulances has been procured for patient Referral system and distributed to eight (8) District Hospitals and 9 CHC.

Another thirty (32) Ambulances were also procured for distribution to the thirty two 24X7 PHC. These thirty two PHCs are also supplied with a back-up generator for improving the quality of services especially delivery and maternal and child health.

6. Village Health & Sanitation Committee

NRHM realize that community participation is the key for any health intervention and health programmes and without the proactive participation of the community the goals set forth will not be achieved.

Thus Village Health and Sanitation Committees are established in the villages of Mizoram. The VHSC is under the chairmanship of the community elected representative, the village council chairman with members from different cross – section of the community. 786 VHSC has already been constituted in Mizoram and are actively working in the areas of planning, monitoring and implementations of health interventions in their community. Meetings with members of VHSCs reveal that participation is high, aided by persons from civil society groups such as the Young Mizo Association, Mizo Womens' and Elders' Associations.

7. Untied Fund

In order to empower the community to take local health actions from time to time untied funds are provided to various committees. Untied funds are provided as follows:-

a. Village Health & Sanitation Committee @ Rs. 10.000/- per annum to 786 VHSC

b. Sub-Centre Untied Fund @ Rs. 10,000/- per month to 366 Sub-Centres

c. PHC Untied Fund @ Rs. 25,000/- per annum to 57 PHCs

d. Untied fund to CHC @ Rs. 50,000/- Per annum to 9 CHC

8. Annual Maintenance Fund (Amf)

For taking up minor maintenance of health institutions, different health institutions are provided with an annual maintenance fund as follows.

a. Sub – Centre AMF @ Rs. 10,000/- to 236 Sub – Centres

b. PHC AMF @ Rs. 50,000/- to 51 PHC

c. CHC AMF @ Rs. 50,000/- to 5 CHC

9. Rogi Kalyan Samati (Rks)

Name of RKS	No.of RKS Registered
Civil Hospital	2
District Hospital	6
Sub- District Hospital	1
CHC	9
PHC	57
Total	75

Each RKS Society are provided a seed money for taking up local initiatives at the rate of Rs. 5 lakhs to eight District Hospital, and Rs. 1 lakh each to 1 Sub- District Hospital, 9 CHC and 57 CHC.

10. ASHA

ASHA is a community volunteer who worked for the promotion of health at the community level, they are involved purely on a voluntary basis and worked closely with the village health and sanitation committee, health workers and Anganwadi workers in their own village.

The distribution of ASHA in Mizoram is as follows.

Sl.No	District	No.of ASHA
1	Aizawl West District	124

2	Aizawl East District	120
3	Kolasib District	73
4	Mamit District	61
5	Serchhip District	50
6	Champhai District	122
7	Lunglei District	184
8	Lawngtlai District	174
9	Saiha District	70
	Total No.of ASHA	**978**

11. Mampower And Human Resources

The State faces immense scarcity in trained manpower. For better implementation of the programme the following personnel are recruited on a contractual basis under the Mission.

- Medical Officer - 20
- SPMSU Staff - 4
- DPMSU Staff - 43
- AYUSH doctor - 10
- Health Worker - 276
- Staff Nurse - 9
- Lab Tech - 19
- X-Ray Tech - 13
- Pharmacist - 14
- Account Clerk (PHC/CHC) - 64
- Block Extension educator - 9

Total - 481

12. Equipments And Furniture

In order to meet the standard prescribed by the Indian Public Health Standards, a facility survey has been conducted in all the health institutions and gaps as per IPHS were identified. Equipments and furniture has been procured meet the IPHS standard as follows.

a. Rs. 40,000/- per Sub- Centre for 130 Sub – Centres

b. Rs. 2 lakhs per PHC for thirty two (32) 24X7 PHC

c. Rs. 3 lakhs per CHC for 9 CHC.

Comments on Various TORs

i) Assessment of the case load being handled by the Public System at all levels

- **The official statistics show that The IPD and OPD Attendance appears to remain more or less similar over the last three years at all levels**
- **However, it was observed that the presence of Regular Medical Officer has made positive impact on the trend in IPD / OPD at PHCs that were visited**
- **Deliveries not being conducted normally at Sub Centres inspite of available space for Labour Room – a significant number of home deliveries being conducted by ANMs of the same Sub Centres**
- **Significant number of deliveries at PHCs and CHCs, with increase after introduction of JSY**
- **Utilization of delivery facilities at district hospital Serchhip has gone up considerably, but the physical infrastructure is inadequate**

ii) Preparedness of health facilities for patient care and utilization and Quality of services

- The medicos and paramedics available at all levels – except for specialist manpower
- Young doctors in position, appear confident and capable of handling most conditions
- At subcentres attached to PHCs and CHCs, the greater challenge is to effectively utilize health workers' time and to coordinate their inputs with those of the PHC or CHC that they adjoin.

- District Hospital (Kolasib)

- Well equipped with infrastructure and manpower – functional Blood Bank – New Trauma Care Centre being under construction, have all basic specialities, good laboratory

- Lacking in separate new borne care corner and children's ward

- Delayed equipment repair: A new Baby Warmer machine being non-functional for about last six months - make-shift baby warmer being used; drum steriliser not repaired, incinerator out of order for more than 6 months

- ECG Machine supplied but not being used due to incomplete parts

- Operating Microscope procured but not used till date for want of eye OT

- District hospital Serchhip

    - Physical infrastructure, especially the maternity wing, appears to be inadequate. The labour room is poorly ventilated.
    - Blood storage unit is not fully functional

- CHC lacking in specialist manpower, non-functional OT – referrals to District Hospital

- All PHCs adequately equipped in laboratory facilities with regular tests being done – some shortage in reagent supply has been noticed. Rapid diagnostic kits available to ASHAs but not to health workers even on contingency basis. Hence health workers , have to rely on the traditional but slower method of sending slides to a PHC/ CHC and awaiting result. This creates a potential anomaly between the speed of response by a health worker (slower) and ASHA (quicker) to managing a case of malaria.

- CHC not receiving annual maintenance grant; AMG not available in all PHCs/SCs (236/366 subcentres as per ROP)

- Untied fund and RKS grants are being kept in separate bank accounts in most cases; separate registers maintained, being utilized as per the resolutions of the respective RKSs.

- User fee not being deposited in RKS accounts; GO not yet issued

- The untied fund, annual maintenance grant being disbursed by office of CMO in cash – not being kept in bank account at one PHC – Male Health Worker having joint account at various Sub Centre

- All facilities being well maintained with proper cleanliness, disposal pits constructed (using RKS funds) – paramedical and group D staff trained in IMEP at District Hospital

iii) Utilisation of Diagnostic Facilities and their effectiveness

- Diagnostic facilities available but at not as per IPHS. Need for upgradation. Also need for proper maintenance strategy for equipments- machines lying non-functional for long times, slow response reported from headquarters and companies.
- The state should designate a team to oversee the maintenance and "uptime" of equipment, and train them in biomedical equipment maintenance. It should also build in strong accountability of suppliers at the purchase stage, have AMC with down-time / up time guarantee, insist for Aizawl- based company engineers for large-volume purchases and have regular follow up action with defaulting suppliers.

iv) Drugs and Supplies-

- Inventory policies should be laid down and ensured to be strictly maintained and monitored at all facilities (an inspection 4 months ago showed expired drugs in stock at one facility).
- The medicines are centrally procured and distributed based on indents.
- There are shortages eg during our visit, there was a short supply of Rapid Diagnostic kits for malaria, CHC had to purchase methergine locally, etc

v) Health Human Resource Planning –

- Doctors: increase in doctors (general) due to contract appointment. Specialist mix not available in CHC and FRUs. There is an acute shortage of specialist doctors. This is because the state has limited access to train its staff through RIMS (where it cannot choose the specialities) and the national pool of govt medical colleges. The state does not have a medical college, nor does the Civil Hospital has DNB courses. There have been discussions about establishing a medical college in the state, and these need to be followed with urgency. Meanwhile, the possibility of offering DNB courses at the Civil Hospital at Aizawl should be urgently explored and actively advocated for, with the appointment of a person experienced in medical education as an advisor to speed this up and set up strong learning systems.
- Nurses:
- 2 ANMs present in subcentres that were visited, but state figures show that not full complement (2nd ANM) as per NRHM guidelines
- The state has Nursing Schools 1 for B Sc and 3 for GNM and 1 for ANM
- There is no system of nursing inservice education for the state as a whole. This is the appropriate time to set it up while the state is developing its human resources at a rapid pace.

- there is lack of clarity on role division between the two FHWs and the one or two MHWs posted at a subcentre. Outreach village or home visits do not appear to be regular or as per a defined beat programme
- Field supervision by health supervisors does not appear to follow a well defined beat programme. Hence subcentres and subcentre villages are visited a few times a year by the supervisor, who also lack mobility for reaching interior villages. The NRHM has invested in mobility for doctors and managers, but not for field supervision by non-doctors. Resources may be mobilized for providing 2-wheeler (during good weather) or 4-wheeler monility for this prupose.

- There has been an increased staffing of lab technicians (ICTC, Malaria, RNTCP, General), and therefore an increase in service availability. Mizoram has a regional paramedical training institute in Aizawl. At places, there are 2 ot three lab technicians at the PHC or CHC and their work loads are not high – this distribution may be rationalized.

vi) Infrastructure-

- For construction, the NRHM Directorate has an engineering cell comprising one exec engineer (permanent) and one asst eng and three jr engineers (contract). They are responsible for all constructions. While this has freed the NRHM from depending on other government bodies, the cell is stretched because of the volume of work, the distances involved, and limited local (on-site) capacity for construction and monitoring. Moreover, the available months for construction are only 6 out of 12, because of the rains. An expansion of the cell is not possible (it is reported) because of the cap on admin expenses to 6 % overall. The required rate of construction is not being met. It is recommended that the need be assessed and steps be taken, including contract recruitment is necessary, so as to ensure speedy implementation.
- With this restricted engineering staffing, and the limitations of monitoring that the cell can do, it is essential that alternative mechanisms be instituted to oversee quality of design and construction. One example cited was that of a local people's committee that was monitoring construction. Where feasible, the local administration could also be involved

vii) Empowerment for effective decentralization and flexibility for local action

- Village Health and Sanitation Committees:
  - operationalized in all villages visited– need to hold regular meetings on monthly basis
  - active involvement of youth, women and sr citizens groups in activities such as awareness for malaria, improved sanitation etc
  - little support from government officials others than health department
  - ASHA is a designated member in villages where no health facility exists, not in others

- It would improve accountability if VHSc meetings were to routinely review progress of expenditure from the VHSC fund as well as the local institutionsl (SC/PHC/CHC) untied fund and minute the same at their meetings.

- RKS:
  - Operationalised in all facilities
  - Active involvement of the Village Council Members and others is appreciated – taking keen interest in the functioning of the health facilities
  - Absence of designated vice chair in guidelines makes it difficult to hold regular meetings because of frequent travel of bureaucrat who chairs the committee
- Utilization of Untied funds and RKS funds: This is seen at all places for a number of activities including upkeep and maintenance of facilities, purchase of small items of use
- Utilisation of RKS grant and Untied funds not as per guidelines due to lack /delayed release of other funds
- E.g. JSY, expenditure of recurring nature like payment of electric bills, payment to the ambulance driver are being made from Untied Grant and RKS funds
- Need to keep provisions in State Budgets for the same
- District Health Society meetings not regular

viii) Systems of financial management

- System of financial recording in place with specific personnel at various facilities visited: But largely unsupervised and would benefit from regular facilitative supervision and quality check including physical verification of entries (since maintained by people not trained)
- Provisional UCs from State for year 2007-08 already submitted for all components of NRHM – however FMR for second quarter yet to be submitted
- JSY payments not made at the time of delivery; delay of 3-4 months due to delays in requisition, processing and payout. Therefore, need to keep timely payment of JSY as a performance parameter, and to alter system to ensure this eg requests can be made based on projected requirements on quarterly/ half yearly basis rather than after the delivery occurs. A GO needs to be issued to this effect to ensure that it is understood and done at all levels, and the DPMSU and SPMU include this in their monitoring.

ix) Assessment of non-governmental partnerships for public health goals

- A pilot 1 year project on health insurance with Reliance - need to study in details
- At the village level, active involvement of youth, women and senior citizens groups through VHSC.
- Mobile Medical Units provided to some NGOs
- Mother NGO system working to strengthen government efforts
- The Young Mizo Association, Mizo Women's Association hold promise for mobilizing VHSCs around health issues through their large state-wide cadres.

x) Systems in place for outreach activities of Sub-centre

- VHNDs held regularly once a month – health worker participating in IEC/BCC activities – need of ready made IEC material like flip charts / pamphlet/leaflets/ brochures on various programmes expressed by health functionaries. For subcentres located at the same venue as PHCs and CHCs (for example Thingsulkiah and Thenzawl), the community already had easy access to the SC or PHC / CHC itself for immunization and antenatal care, and proactively came to these locations. Hence given high awareness and initiative in such communities, the VHND did not seem to add much value for ANC and immunization coverage. Health workers too mentioned that VHNDs at several locations serve more of an educational rather than service function.

- Mobile Medical Unit operational under District Hospital – Regular operations with definite plan of action with advance intimation to the community need to be ensured. The three vehicle MMUs appear to be better suited to use by large districts in the country whereas Mizoram districts have smaller population. Besides, existing staff from busy district hospitals has to be re-deployed and this can put a strain on scarce human resources. Also given the high organizational costs of each MMU camp, the cost effectiveness in a Mizoram context may be objectively assessed.

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

- Antenetal care: ANC care and monitoring done in community and at all facilities.
- Deliveries: delivery facilities at SCs are limited, though home deliveries are being conducted by health workers in the same villages. PHC's and upwards providing adequate delivery facilities with doctor present. For SCs to take on facility deliveries, will need upgradation of equipment and renovations.
- The incidence of low birth weight is very low in most institutions visited – we were informed that it comes to only 8% in some institutions. Besides, a large proportion of babies weighed 3 kilos or more at birth. This phenomenon probably helps to ensure better newborn and

child survival in the state. More birth weight data and perhaps a research study on this would help to better understand this fortunate situation in Mizoram. There might be lessons in this for other states.

- Newborn care facilities in labour rooms of primary and community health centres are deficient – at places there was no mucus sucker (improvised suction pumps were being used instead) or facilities for keeping the baby warm. A distinct newborn corner was not seen. This situation can easily be rectified.
- Immunisation: Immunisation provided regularly on fixed days at each centre. List of families and under –5 children maintained at some centres. However, DLHS-3 shows approx only 50 % coverage, and this lack of coverage is not perceived by the health workers. "Tickler" bag present in all centres, but not maintained accurately. In terms of design, there are now labelled with one pocket for each vaccine. It may work out better if each pocket represents one month, and all due immunisation cards for a month are placed in that pocket. Evidently, it also does not form part of the supervisor's checklist
- Family Planning: All centres have list of eligible couples. Mizoram has very high uptake of the oral pill as evidenced from the NFHS-3 (10% of ECs) and the DLHS-3 (12%). Large numbers of women are on the oral pill records of health workers, but the quality of service is wanting. Counseling is cursory, and an extra pill packet is not given (to prevent stock-out at the level of the user); drop-outs are not methodically contacted. Going by the records, it is possible that several women run out of pill supplies. Given the unique opportunity of ensuring very high oral pill coverage, health workers and ASHAs could be better trained to promote them. This would benefit from a more focussed approach where the emphasis is on keeping couples on regular pill usage rather than numbers distributed.
- Condoms are by and large distributed by ASHAs and female health workers to the wives of users. The large contingent of male health workers does not appear to be distributing condoms. However, since AIDS control efforts are active in parallel, it appears that condoms are being promoted among men more as an AIDS prevention measure, and among women as a FP measure. Hence male health workers should be given an active role and their performance monitored directly.
- Emergency contraceptives were made available once and are now not available. EC pills should be made widely available, in particular because there might be social or religious objections to abortion as an option for women with unwanted pregnancy.
- Several young doctors have been trained to carry out minilap and regularly offer the service in PHCs and CHCs. This is a positive feature and should be sustained..
- Quality of IUD services could be improved. The state lacks training mannequins, hence FHWs who had completed refresher IUD training had received adequate opportunity to develop practical skills.

- JSY payments being made with delays of as much as 3-5 months due to non-availability of funds at the facility

- The existing working of the healthworker system (and its supervision) is very facility-oriented. It is not a practice to make regular home visits and be familiar with the families and their home situations. Supervisory visits are limited to checking of records and registers, and do not include visits to homes. In any public health system, this home based approach is the foundation and is crucial to success. With the recruitment of new ANMs, doctors and

other staff, and as part of the NRHM thrust, the state must seize the opportunity to re-orient the grassroot healthworkers and the supervisory system towards this end.

- Systemic constraints: delay in renovation / upgradation/equipment purchase and repair, delay in JSY payments

xii) HMIS and its effectiveness –

- The peripheral facilities are given the formats for information HMIS, in a booklet form, and submit the information monthly to the district where the date is entered in the computer, reports generated, and sent to the state. Also, most of the data reporting is as aggregates, and is not analysed at the household level. There is no evidence that the data is used at each level for informing operational decisions, identifying gaps etc.

- As the systems are being established and new staff are employed at all levels, there are the usual problems of untimely submission of data and reports though report submission dates are clearly laid out at each level. There is also a poor understanding of data at the local level and errors in updation.
- Steps: Training done at different levels by NHSRC and RRC, however there is need for more clarity on training in the overall context of HMIS. New data formats prepared, effective field management put in place and compliance assured, feedback provided to one-down levels and disseminating with the district/sub-district level functionaries.

xiii) Community Processes under NRHM-

ASHA

- ASHA was in position in all visited facilities. In the state, that had a single training of 7 days, in which all the first 4 modules were completed together. No subsequent training.
- Need for refresher training of the modules, duration of training needs to be adhered to, training in fifth module to be done (and not by the government)

- The ASHAs were usually invited by VHSCs based on education, commitment, enthusiasm. They were well accepted by community, and had a closer connection with families than the health workers

- The Roles of ASHA and differentiation from Healthworkers was not clear to community.

- ASHAs uniformly expressed need to have training in deliveries. While this might not be feasible, some ASHAs expressed the wish to be trained on postpartum management of women, especially, on dealing with issues like breast engorgement and supporting mothers through this phase.. Hence postpartum maternal and neonatal care (perhaps IMNCI + a maternal component) might be considered, starting with a pilot exercise

- State level ASHA mentoring group convened once so far. This must meet quarterly, and it is advisable to have district mentoring groups, and district and block facilitators This is crucial as the ASHAs need to have a support system outside their reporting to Government.

- ASHAs are not designated as members of VHSC and so are not invited for VHSC meetings in PHC and SC villages. This needs to be addressed. They also need to see themselves as inter-sectoral facilitators and activitists rather than just interacting with the health department

- Integrated compensation package for ASHA need to be put in place for all activities ensuring regular availability of funds at the periphery

- The ASHAs have been quickly identified and put in place. They are well accepted because they are meeting a felt need in the absence of adequate health infrastructure.

- However, they are in a way "orphans". They are often doing the work that the healthworkers should be doing, without getting paid for it. After the initial excitement, there may be a disillusionment (an anxiety also shared by the mission staff).

- To sustain and maximize their effectiveness, there needs to be all-round clarity for the work of ASHA and of the healthcare workers as per already established guidelines rather than present practice. The ASHAs also need a support system outside the SC-PHC government hierarchy. This is especially crucial as the health infrastructure and staffing improves.

VHSC (Village Health and Sanitation Committees):

- VHSCs have been operationalized in all villages visited– there is a need to have a regular meeting schedule eg on monthly basis

- There is active involvement of youth, women and sr citizens groups in activities such as awareness for malaria, improved sanitation etc. The involvement varies from village to village, but mostly there is a high degree of involvement. The VHSCs are very much local efforts, guided

by the healthworker / ASHA. Facilitation and encouragement from 'higher' levels could greatly strengthen these efforts, eg block level meetings, awards for most active VHSC, etc. There would be value for the NGOs (Youth, women, sr citizens) to take this up as their state level initiatives to be implemented locally, to encourage further participation.

- There is a little interaction with and support from government officials others than health department; need for intersectoral facilitation eg sanitation efforts like cleaning up some streets is done by the youth, without asking the responsible govt department to take it up or work with them.

- The active community ownership that comes naturally to the people of the state provides a very real opportunity for the public health programme to be a truly community-based. The fact that people are willing to be involved, and that various structures (secular as well as religious) exist is a great strength that is present in few other states in India. Even as the NRHM presents an opportunity to quickly upscale the access to health across the state, it also provides an opportunity to build a robust community basis for initiation and action leveraging the active community participation and ownership. The state's NRHM leadership has the vision, and needs to plan and monitor strategically towards this end.

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

- Measures for vector (malaria) control are good, with involvement of VHSCs, but a coordinated intersectoral thrust was not present at the grassroots.

- Convergent efforts are evident in the VHN day. But other issues such as Tobacco and drugs, which are major problems, do have programmes but do not seem to be getting as much coordinated attention.

- Members of the community also expressed a need for dental services. Health staff also mentioned a large problem of dental caries, especially among children. Hence based on a more systematic assessment of oral disease burden, oral health interventions might be consideredby the state.

xv) Effectiveness of the disease control programmes including vector control programmes

- The malaria control programme is the most well known, community-involving and effective programme.

- Fever and malaria cases have come down, and the community acknowledges that it is because of their efforts. All the interviewed community members not only knew about causes, but could also intelligently discuss the various activities, and how to make them more effective (eg one VHSC member asked whether the DDT spray can be mixed by the govt assigned and trained person, but sprayed by a family member under supervision, because they would be most interested to protect their area). The strong point of the programme is that,
- in almost all VHSCs, it gets the women's groups, youth groups and senior citizens to indentify and take up possible solutions.

- The RNTCP is reported to be doing well as per programme parameters. However, the fact that this is a mountainous area with many areas unreached is an indicator that the state needs to be looking actively for uncovered groups and areas, and not go by nationally-determined indicators of performance. HIV-TB co-infection is appropriately emphasised, but should not become the overarching priority. There is also a need to integrate this programme into the SC and VHSC activities. At places, there seemed to be a proactive role by *district* level TB workers in providing DOTs directly through village level ASHAs to TB patients, and directly monitoring their compliance. This led to a situation in which local subcentre based health workers remained unaware of TB patients in their jurisdiction and progress in treating them. This anomaly should be resolved through information sharing and by making health workers (especially male health workers who currently appear to be under-utilized) responsible for successful completion of DOTS treatment within their areas.

- The Blindness Control programme is reported to be less active because of lower awareness, longer distances and limited ophthalmologists. This is one of the states where outreach surgical camps are still being conducted because of geographic remoteness and shortage of staff. Scaling up must include emphasis on awareness of the benefits of IOLs, making access easier, improving quality and number of operating facilities, and community involvement in mobilisation. Formal training in research-backed large scale mobilisation and high-volume high-quality techniques as has been facilitated by CBM and Sightsavers, would help the state make more rapid progress in this area.

xvi) Assessment of programme management structure at district and state level –

The programme management team is to consist of a state programme management support unit (SPMU) with a district programme management support unit (DPMU) at each district.

- The DPMSUs are in place. The DPMs were appointed in September 2007, had two trainings in action plan development in March and June 2008, and had their job orientation in September 2008. This job orientation done by RRC
- The SPMSU does not have a team leader, the state program manager (SPM), who is to be from management or social work background.(one is expected to join in early 2009)

- The Programme management structure at the state and district levels is just 1-1/2 years old and is evolving. In this situation, not having a SPM for 1-1/2 years (running) after the DPMs were appointed has put the programme management structure at a great disadvantage for several reasons.
- The DPMs have had no leadership at the state level. DPMS have had no technical mentorship or sounding board to help them learn to do their work analytically and in a way that introduces managerial skills to the health system
- The programme management structure has not had a champion to help it evolve into a professional management supportive structure

- The result has been
    - a muddling through by the DPMSUs of what their roles and responsibilities are
    - inadequate use of the resources and the data they have access to, to make strategic analysis and decisions at the district and state levels
    - preoccupation with clerical details of data management rather than programme support

- Nevertheless, their presence has been a strong support to the district health administration, and a fair amount of the credit of the forward movement of the NRHM should no doubt go to them. The State Unit and the strategic and operational importance of the PMSU structure needs to be quickly established otherwise it will be difficult to bring it back on track.

Chapter 5. Recommendations

- Progress under NRHM has been significant and has achieved considerable impact in revitalising the system, enhancing staff availability creating locally responsive facilities, community mobilisation and increasing public and staff satisfaction
- Some areas slower than others; this needs to be analysed, and corrective steps taken
- Systems have not been developed and assimilated at the same pace: potential for major long term difficulties if this not addressed
- Need to define and ensure performance and accountability at each level
- Need to move from service delivery orientation to “has the community received services / undergone change” and ensure home visits by health workers
- Need to invest in improve quality of primary healthcare services beyond the clinical care by doctors
- Need for further decentralisation

- Need for revitalisation of the Supervision System and the dissemination proces