TAMIL NADU

TAMIL NADU - 2nd CRM Field Visit

Chapter - I Introduction

The 2nd Common Review Mission Team to the Tamilnadu State consisted of the following -

1. Prof A.T. Kannan	Prof & Head of Department of Community Medicine, University College of Medical Sciences, Dilshad Garden, New Delhi – 110095
2. Dr S. K. Sikdar	Assistant Commissioner (Family Planning), 452-A, Nirman Bhawan, New Delhi - 110018
3. Dr. D. Thamma Rao	Advisor – Public Health (HRD), National Health Systems Resources Centre, NIHFW Campus, Munirka, New Delhi – 110067
4. Mr. Sushil Pal	Financial Management Group 525-A, Nirman Bhawan, New Delhi – 110018
5. Ms. Sheena Chabra	Chief, Health Systems Division USAID, American Embassy Chanakyapuri, New Delhi – 110021

The NRHM briefing on 25th November was attended by five member team. Ms. Sheena Chabra (USAID) and Mr. Sushil (FMG, MOH&FW) could not participate in the CRM visits.

The CRM team was **briefed by Ms. Girija Vydyanathan, Mission Director and Dr. Ellango, Director (Public Health)**. The representatives of the **Director of Medical Education and Director of Medical Services as well as the State level programme managers** (RCH, IDSP, NVBDCP, TB, Leprosy, Blindness control etc) and **State Health Mission Consultants** were present during the 3 ½ hours briefing session. The team was apprised of the present health sector status and the progress in NRHM activities. During the interactions the Tamilnadu officials were informed of the issues raised by various programme divisions of MoH&FW, Govt. of India.

Demography:

The 6.24 crore population resides in 31districts, 201Taluks, 385 Blocks, 161 Municipalities / Corporations, 561 Town Panchayats, 12,618 Gram Panchayats and 16,317 villages. The SC population is 11.86 % and ST population is 0.65%. The analysis of Census 2001 and DLHS –II data, and based on 13 indicators, **all the districts of the State are ranked as more developed** (Ranking & Mapping of Districts, Indian Institute of Populations Sciences, Mumbai and MoH&FW, New Delhi.

Infrastructure:

Tamilnadu State has established a **very good network of health facilities**. The health care delivery is through a dense network of 8706 SHCs, 1421 PHCs, 235 SDHs 29 DHs and 15 medical college hospitals. The SHCs and PHCs are functioning under the control of Director of Public Health. The women & children hospitals (7), district hospitals (29) and sub-district hospitals (235) are functioning under the control of Director of Medical & Rural Services. There are 44 hospitals including the 15 Government medical colleges functioning under the control of Director of Medical Education. The **existing 31 revenues districts are re-designated as 42 Health Unit districts (HUD)** on bifurcation of larger revenue districts. The large district of Villupuram was bifurcated as two Health Unit districts (HUD) of Villupuram (44 PHCs) and Kallaikurchi (36 PHCs) **as part of decentralisation process in the health sector**.

Health Care Facilities - Government

	Institutions	Facilities (Nos)	Beds (Nos)
1	SHCs	8706	-
2	PHCs (including 130 Up-graded as 30 bedded PHCs)	1421	7,191
3	Sub-District Hospitals (Taluk / Sub-Taluk)	235	12,285
4	District Hospitals	29	8,478
5	Women & Children Hospitals	7	98
6	Family Welfare Centres	27	549
7	Medical Colleges (15) & other Hospitals - DME	15	21,399
8	AYUSH Hospitals	10	-
9	AYUSH Dispensaries	451	-
10	Urban Health Centres	193	-
11	Municipal Dispensaries	668	-

All the 1421 PHCs in the state are providing 24x7 services and computers provided. The **AYUSH centres are co-located in 451 PHCs**. The up-gradation of facilities as FRUs was completed for 29 DHs and it is proposed upgrade 32 SDH during 2008-09. Since inception of NRHM, **235 PHCs are upgraded with 30 beds**, ultrasonogram, X-ray, ECG and semi auto analyser. The Bemonc services are available in 385 PHCs. The **operation theatre facilities are provided in 217 PHCs** and 451 PHCs are functioning as BEmonc facilities. The Facility surveys are under progress and scheduled to be completed during 2008-09. The average daily OP at PHCs is around 140 and Inpatients has doubled from 23 to 24 during the past three years.

Human Resources:

The **Health Workers Density in Tamilnadu is relatively high of 22.55** with 6.1% allopathy physicians, 1.4% AYUSH physicians, 0.3% dental surgeons, 10.4% nurses & midwives, 1.7% pharmacists and others 2.8 %. As per the State Government data base 10,882 doctors and 24,504 nurses are available in the Government health facilities. The State Government committed for the provision of additional staff at the 30 bedded up-graded PHCs (MOs, Obstetricians, Anaesthetists, Staff Nurses, Nursing Assistants and Radiographers). The availability of health workers as per the Bulletin of Rural Health Statistics – 2007 is as detailed below-

Human Resources - Tamil Nadu

		Required	**Available**	**Shortfall**
1	MPW (Female)/ANM at SHCs & PHCs	9864	10351	-

2	Health Worker (Male) at SHCs	8683	1503	7180
3	Health Assistant (Female)/LHV at PHCs	1181	1612	-
4	Health Assistant (Male) at PHCs	1181	303	878
5	Nurse/Midwife	2833	-	-
6	Laboratory Technicians	1417	955	462
7	Pharmacist	1417	1349	68
8	Radiographers	236	-	-
9	Doctors at PHCs	1181	1984	-
10	Obstetricians & Gynaecologists at CHCs	236	-	-
11	Physicians at CHCs	236	-	-
12	Paediatricians at CHCs	236	-	-
13	Total specialists at CHCs	944	725	219

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

Health Indicators:

The State made **rapid progress toward the RCH Goals of < 30 MMR and <100 IMR. As per SRS (2001 - 03) the IMR is 35, MMR is 134 and TFR of 1.7.** The Sex Ratio is 987 and Child Sex Ratio (0-6 yrs) is 942. As per recent SRS reports, the Still Birth Rate is 8 and Neonatal Mortality Rate is 37. Over **21.5 % girls are marrying below 18 yrs age and the 3rd order of births is 21.6%.** As per the State HMIS, the ANC registration is 99.6% and Institutional deliveries are 45 % in Government and 40.5% in private facilities.

Maternal & Child Health - NFHS I, II & III

	Indicator	NFHS			Trends	
		I	II	III	1993-99	1999-2006
	Maternal Health					
1	ANC (any)	96	98	99	+ 2	+ 1
	ANC (min.3)	-	90.9	96.5		+ 5.6
2	Institutional Deliveries	64	79	90	+ 15	+ 11
	Assisted Births	* 86.2	82.3	90.6		+ 8.3
	Child Marriages – Girls	-	24	26		+ 2
	Child Health					
3	IMR	68	48	31	- 20	- 17
4	Immunization Children (12-23 months)	65	89	81	+ 24	- 8
5	Nutritional Status – Children					
	Total	-	86	80	-	- 6
	Stunted	-	29	25	-	- 4
	Wasted	-	20	22	-	+ 2
	Under weight	46	37	33	- 9	- 4

*DLHS- I

As per NFHS –III, **54% of married women** (15-49 yrs) are anaemic, as per DLHS-III **68% of adolescent girls and 72.5% of Children (6-35 months) are anaemic**. The DLHS-3 recorded that 46.8% of pregnant women received 100 tablets of IFA. The ANC registration in first trimester is 73% and 70% in women <19 yrs age. Over 46 % of pregnant women availed complete package of ANC services. The **Immunisation of Children** has **declined to 82.6** % and Children **without Immunisation increased to 1%** (DLHS-III) from 0.2 (DLHS –II). The **Exclusive Breast Feeding increased** to 22% (DLHS-III) from 9% (DLHS-II).

As per the NFHS – III (2005-06) over 33% of children (<3yrs) are underweight, another 25% are stunted and 21.5% are wasted (total of 79.8 %). The Under 5 Mortality is less than 83 in 15

districts and between 83 to 106 in the remaining 16 districts and 508 / lakh population are suffering from TB (445 all India, 141 Karnataka and 275 Kerala).

MCH in Rural & Urban Tamil Nadu - NFHS I, II & III

Rural	NFHS			Trends		
	I	II	III	1993-2006	1993-99	1999-2006
Maternal Health ANC (Any)	95	98	98	3	3	0
Institutional Delivery	50	73	87	37	23	14
Child Health IMR	71	52	37	- 34	- 19	- 15
Immunization Children (12-23 months)	60	85	84	24	25	- 1
Urban						
Maternal Health ANC (Any)	97	99	100	3	2	1
Institutional Delivery	91	93	95	4	2	2
Child Health - IMR	61	41	23	- 38	- 20	- 18
Immunization Children (12-23 months)	73	97	78	5	24	- 19

Selected Health Indicators -Tamilnadu & neighboring States

State	**TFR** SRS 2005	**MMR**	**IMR**	#BF within hr of birth (%)	Under Weight < 3yr#	TB cases /1lakh * NFHS-III	Malaria Cases 2007 DGHS	*OP Govt. Rural (%)	In-Patients Rural Hospitals %
Tamilnadu	**1.7**	**134**	**37**	**58.8**	**33**	**508**	**17748**	**29**	**40.8**
India	2.9	301	57	24.5	46	445	1363279	22	41.7
Karnataka	1.7	228	48	56.5	29	275	1769	34	40.0
Andhra Pradesh	2.0	195	56	24.6	37	449	27406	21	27.2
Kerala	2.2	110	15	35.7	41	141	48415	37	35.6

* Includes medically treated TB–Reporting higher side –RNTCP division questions TB prevalence data, # NFHS-III 2005-06

PRI Framework:

The Village Health & Sanitation Committees (**VHSC**) were **established in 12,618 villages and 2,540 town Panchayats** and Rs. 8.03 crore released. The Patient Welfare Societies (**RKS**) were **established in 29 district hospitals, 235 sub-district hospitals and all the 1,421 PHCs**. The **untied funds** of Rs. 3.55 crore to the PHCs and Rs. 8.70 crore to the SHCs were also **released**. The mobile phone costs are paid from untied funds of SHCs at the district level. The **Annual Maintenance Grants** of Rs.8.80 crore to the PHCs and Rs. 6.35 crore to SHCs were also **released**.

1st CRM

POSITIVES	AREAS FOR IMPROVEMENT
►Good pre-existing services with admirable transparency in postings and procurement, efficiency in logistics; Public health cadre exists as well as three to five year rural posting for all on joining service.	►Janani Suraksha Yojana and Dr. Muthulakshmi Reddy scheme for SC/ST/BPL needs further inputs, poorly known/utilized and delay in payment, and no JSY incentives for Taluk and district hospitals
Consequent to NRHM:	
►Untied funds improve ambience of facilities, empower local health providers and motivation of community	►Upgrading Block PHCs to CHCs to be expedited.
►Block PHCs now working 24x7 with additional nurses (3)	► District Planning with focus on equity issues slow to take off.
►Up-gradation of PHCs to B-PHC undertaken and expedited	

►Active PRI and community participation, VHSCs functional ►NGO partnerships for emergency ambulance network.	► Urban health planning lags behind.

Chapter – II Facilities Visited

The State Health Mission identified Villupuram district for the 2nd CRM visit, and team members proposed the visits to Salem district (least Child Sex Ratio of 826) and Krishnagiri district with least Sex Ratio of 929 and ranked as the least developed district by the State Planning Commission. As suggested by the State Mission Director, the Vellore district was also visited briefly. Thus the team traversed the state from the east coast to the western district adjoining Karnataka State. In comparison to the State average of 16.3 the **higher order of births** are relatively **high in** the **three districts** visited by the CRM team (**Krishnagiri 24.3, Villupuram 21.2** and **Salem 19.6**). The three member team undertook spot appraisal of the health services delivery to identify the midcourse corrections. The implementation of NRHM and State health policies were looked at by documenting the evidence for the efforts being made at the districts and health facilities.

The 2nd CRM team was accompanied by Deputy Director and two consultants of State Health Mission. The Joint Director of State Health Mission joined the team in Salem district. The Mission Director of State Health Mission and the District Collector were also with the team during the visits to the tribal areas of Krishnagiri district. The Mission Director advised the Dr. Vasanthi, recently joined Deputy Director & Dr. Chitra (Consultant) who joined the State Mission recently and Dr. Arun (consultant) of State Health Mission to accompany the team as a learning process. The team was accompanied by Mr. Rajasekhar, Non-medical supervisor as a facilitator. In the districts, the respective Deputy Directors, MCH officers (public health nursing cadre), disease control programme officers accompanied the team members. The **team visited 16 SHCs, 19 PHCs, 3 District Hospitals, 2 Sub-District Hospitals, outreach services such as Mobile Medical Units & School health programme, Training institutions** etc. as detailed below –

Visits to Health Facilities

2nd Common Review Mission			November - December 2008	
Districts visited				
	Name	District HQ	DM	CMO
1	Villupuram - HUD 1	Villupuram	Mr. Ashish Chatterji	Dr. Krishnaraj
	" - HUD 2	Villupuram	Mr. Ashish Chatterji	Dr. Geetha Mani
2	Salem	Salem		Dr. Nirmal
3	Krishnagiri	Krishnagiri	Dr. V K Shanmugam	Dr. Ganesan
4	Vellore	Vellore		

Health Facilities visited

	Name	Location	Level	in Charge
VILLUPURAM District				
1	PHC Saram	Olakkur Block	PHC	
2	PHC Kiliyanur	Tindivanam – Pondy Road	PHC	Dr. Sudhakar
3	PHC Iruvelpattu	Villupuram-Ulundurpet Rd	PHC- Upgraded 30 beds	
4	PHC Elavanasur Kottai	Ulundurpet Block	PHC	
5	PHC Nainarpalayam	Chinna Salem Block	PHC	
6	PHC Thirunavallur	Thirunavallur Block	PHC	
7	SHC Kandhalavadi	E. Kottai Block	SHC	A.R. Selvi VHN

8	SHC Killapalayam	E. Kottai Block	SHC	
9	SHC Sempi	E. Kottai Block	SHC	
10	Kallaikurchi Hospital	Kallaikurchi town	District Hq. Hospital	

SALEM District

	Name	Location	Level	In- charge
11	PHC Sarkarkolapatti	Salem Block	Block PHC	
12	PHC Tharamangalam	Tharamangalam Block	Block PHC	
13	PHC K.R. Thoppur	Tharamangalam Block	PHC	
14	PHC Nangavalli	Nangavalli Block	PHC	
15	PHC Pagalpatti	Omalur Block	PHC	
16	PHC Valavanti	Yercaud Block (Tribal)	PHC	
17	SHC Dettampatti	Omalur Block	SHC	
18	SHC East Pavadi street	Salem Block	SHC	
19	SHC Thalavai patti,	Salem Block	SHC	
20	SHC Sarkar Kollapatti	Salem Block	SHC	
21	SHC Manjakuutai	PHC Nagalur	SHC Hill area	Ms. Shobhana
22	SHC Semianatham	Yercaud	SHC Hill area	Ms.Kaliammal
23	Mettur Hospital	Mettur	District Hq. Hospital	Dr. T. Chandra

KRIHNAGIRI District

24	PHC Kelamangalam	Kelamangalam-635113	PHC- Upgraded 30 beds	Dr. M. Palaniammal
25	PHC Thally	Thally – 635118	PHC- Upgraded 30 beds	Dr. Latha
26	PHC Anchetty	Anchetty – 635102	PHC- Upgraded 30 beds	Dr.D.Sraravani
27	PHC Rayakottai	Rayakottai -635107	PHC	Dr. P. Arunagiriraj
28	PHC Baladhoddanapalli	Debanikottai Taluq	PHC	Dr. Prasad
29	SHC Sathanur	Muthur post – 635114	SHC	VyayanthimalaVHN
30	SHC Balagoondapalli	Thai road -635114	SHC	Chadrodhayam VHN
31	SHC Sesurajapuram	Hogenkal road- 635102	SHC	Madheswari VHN
32	SHC Bathigounder	Hogenkal road- 635102	SHC	Jaya VHN
33	SHC Noganur	Noganur post- 635107	SHC	Sathiyammal
34	SHC Pennagar	Pennagar post 635107	SHC	Selvarani
35	SHC Kandakanapalli	Debanikottai Taluq	SHC	Mallika
36	Denganikottai Hospital	Debanikottai Taluq	Sub-District Hospital	Dr. Jayapal
37	Hosur Hospital	Hosur Taluq	Sub-District Hospital	Dr. Kalaivani
38	Krishnagiri Hospital	Krishnagiri	District Hq. Hospital	
Vellore District				
39	PHC Pallikonda		PHC	
40	PHC Kaveripakkam		PHC	
Others				
41	Mobile Medical Unit	Debanikottai Taluq	MMU - Tribal area	Dr. Girija Aditya
42	School Health	Debanikottai Taluq	Student Health Camp	Dr. Kalai Selvi
43	District Health Society	Villupuram	District Head Quarters	Dr. Krishna raj and Dr. Geetha Mani
44	District Health Society	Salem	District Head Quarters	Dr. Nirmal
45	District Health Society	Krishnagiri	District Head Quarters	Dr. Ganesan
46	Institute of Child Health	Egmore, Chennai	State Hospital	
47	Regional Training Institute	Egmore, Chennai	Regional	

SHCs

The team visited 16 SHCs namely Kandhalavadi, Killapalayam and Sempi (Villupuram district), Thalavaipatti, Sarkarkolapatti, East Pavadi street, Dettampatti, Manjakuutai and Semianatham in Salem district) and Sathanur, Balagoondapalli, Sesurajapuram, Bathigounder, Noganur, Pennagar, Kandakanapalli in Krishnagiri district. Most of the ANMs are committed for MCH services. There is substantial increase of deliveries at PHCs as the pregnant women are encouraged to go to PHCs and as a result the deliveries in SHCs decreased substantially. The pregnant women are accompanied by VHNs to the PHCs for deliveries. All the essential equipments such as delivery table, weighing machines, BP instrument, stethoscope, Uristix, torch light, hub cutters, The MOs are visiting the SHCs

fortnightly or monthly. The SHCs are within a travel distance of 15 to 20 minutes and farthest village of SHCs is at a distance of 4 to 8 km.

The essential supplies including ORS are available in all the SHCs. The ANMs are maintaining all the registers but there are no entries for the past few months in the Out-patients register, ANM dairy, EC register etc. The register for supervisor's visits and attendance register are not opened. The drug and other stock register are not available. The EC Pills and IUD were not available and knowledge was incomplete. There is substantial reduction of work load due to relocation of Immunisation and deliveries at PHCs. The earlier focus on family planning activities is diluted.

The ANMs in the plains are more often residing in the quarters where electrical and water supply is available. However, most of the ANMs in hill area SHCs are not residing in the quarters due to non-availability of water supply, water stagnation and roof leakages. The motivation remuneration is not received by any of the ANMs.

PHCs

The 2nd CRM team visited 19 PHCs including 6 PHCs Villupuram district (Saram, Kiliyanur, Iruvelpattu (30 beds), Elavanasur Kottai, Nainarpalayam and Thirunavallur), 6 PHCs in Salem district (Sarkar Kollapatti, Tharamangalam, Nangavalli, K R Thoppur, Pagalpatti and Valavanti) and 5 PHCs including three upgraded to 30 beds in Krishnagiri district (Kelamangalam, Thally, Anchetty, Rayakottai and Baladhoddanapalli) and 2 PHCs in Vellore district (Pallikonda and Kaveripakkam).

All the PHC premises have a new look as most of the civil works were completed including provision of toilets, water supply and uninterrupted electricity including generators. The PHCs are well equipped with ILR, Deep Freezers, Sterilisers, Autoclaves, Semi/Auto analysers, Calorimeters, emergency lights, water filters etc. The PHCs are having patient's privacy by provision of curtains, cots, mattresses in good condition. The linen supplies were inadequate as three sets are provided per bed and during the rainy season these supplies are inadequate.

During the year 2008-09, there is notable increase in number of out-patients, in-patients and deliveries in the PHCs. The average daily OP attendance is 60 to 230. The average monthly deliveries in these PHCs ranged from 20 to 40. All the Postnatal women are being discharged after 2 days stay and diet is supplied through SHGs. All pregnant women are being screened by ultrasonogram and all the mothers interviewed stated that sex of the foetus was not revealed.

All the PHCs are provided with additional Staff Nurses and made functional for 24x7 services and most of the PHC are provided with an ambulance and driver. The PHCs are functioning with one or two MOs and the 30 bedded PHCs are functioning with 3-5 MOs. All the PHCs are provided with 3 - 4 Staff Nurses including three contractual, 0 to 2 Lab. Technicians, 1 to 2 Pharmacists 1 to 3 ANMs and group-D staff. In the tribal and underserved areas there are few vacancies of pharmacists, drivers etc as the incumbents are transferred without substitutes. There is general reluctance to stay in the quarters mainly due to major / minor repairs.

District Hospitals (DH) **and Sub-District Hospitals** (SDH)**:**

The team visited three District Hospitals at Kallaikurchi (Villupuram district), Mettur (Salem district) and Krishnagiri (Krishnagiri district) as well as the two Sub-district Hospitals at Denkanikottai (Krishnagiri district) and Hosur (Krishnagiri district). The assessment of Sub-district hospitals and district hospital are detailed in respective items of the report and in the annexure.

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Chapter – III Key aspects of Health delivery system

Tamil Nadu is one of the best performing states in the country presumably due to commitment to health care, relatively higher per capita financial allocations (Rs. 357), high levels of literacy, firmed up HR policies leading to HR availability, postings, accessibility through mobile phones, management systems including supply chain, close monitoring and supervision etc.,

i) Assessment of case load

Since the inception of NRHM, the PHC **case load has increased remarkably** - daily OPD by 17%, In-patients excluding deliveries by over 100% (22.5% to 45.8%). The average deliveries at PHCs has increased from4.85 % in the year 2006-07 to 9% in 207-08 and to 14.7% in the current year. During the year 2008-09, there is further increase in number of out-patients, in-patients and deliveries in the PHCs. The average daily OP attendance per PHC is 60 to 230.

The ANC registration is over 99% and ANC - 3 visits was 96.5%. The **consumption of 100 IFA tablets in pregnant women was 43.2% and 10% of women delivered at home**. 33% of infants were only **breast fed till 6 months age** in comparison to the **national average of 46%** (NFHS-III).

The average **monthly deliveries in these PHCs ranged from 20 to 40**. All the Postnatal women are being **discharged after 2 days stay** and **diet is supplied through SHGs**. The VHNs are invariably accompanying pregnant women to the PHCs. There is no apparent increase of deliveries conducted in the district and sub-district hospitals visited by the team. In almost all the PHCs and majority of hospitals, deliveries are conducted by the nurses or VHNs. The **domiciliary deliveries decreased** drastically from 3.2 (2006) to 0.52 (2008). The **PHC deliveries increased** from 7.8% (2006) to 24% (2008). There is a **decrease of deliveries in private** sector facilities from 42% (2006) to 35% (2008), in **General Hospitals** from 42.5% (2006) to 39% (2008) and in **SHCs** from 5.6% (2006) to 1.67% (2008). The decrease in the number of deliveries conducted in the SHCs visited by the team was from **30 per month to less than 3** per month following the directions to ensure 72 hours stay in the health facility. The **maternal deaths** were 1,035 for the year 2006 and 1,025 for the year 2007.

The **operation theatre facilities in the upgraded PHCs** (30 beds) were **well utilised in Salem and Krishnagiri districts**. However these facilities in **Villupuram district are underutilised** as the surgical facilities are utilised for the monthly / fortnightly sterilisation camps and other times most of the beds are unoccupied.

The **Sub-district Hospitals** are **well equipped** and provided with the essential specialists, Nurses, Laboratory Technicians and Blood banks etc. There is an apparent **shortage of group- D staff and the buildings need major repairs /renovation works** for the aged physical infrastructure. The service routine placement of specialists for long durations was often expressed by the staff as a major concern for service delivery. The specialists in Obstetrics, Paediatrics and Anaesthesia are attending to the deliveries during routine working hours. The SDHs are mainly attending to delivery cases and emergencies only. Institution wise details of patients treated, deliveries, surgeries etc are detailed in the respective hospitals as enclosed in the annexure. In the SDHs the availability of functional Ambulance, general cleanliness, shortage of group- D are some of the major issues. The concerned specialist expressed that there is no marked increase in the number of deliveries in SDHs visited by the team.

The **District Hospitals** are also adequately equipped and provided the requisite manpower of specialists, doctors, nurses, laboratory technicians, pharmacists, radiographers and other paramedical personnel. The district hospitals at Mettur and Kallaikurchi are having shortages of group- D staff and the buildings need major repairs /renovation works. However, both of the hospitals are well managed with the available resources. The Kallaikurchi DH was recently notified as a District Hospital and has not availed the RKS grant of NRHM.

ii) **Preparedness of health facilities for patient care & utilization of services**

The PHCs, Block PHCs, Upgraded PHCs, Sub-district Hospitals and District Hospitals are **adequately equipped** for the routine works and emergency situations. All the facilities are provided with **adequate number of Specialists, Doctors, Nurses, VHNs, Pharmacists, Lab. Technicians and other** supportive personnel on regular or service placement or on contractual basis. The provision of group-D staff such as ward boys and sweepers is inadequate in many facilities.

The PHCs, SDH and DH were **able to meet the requirements for laboratory investigations, X-rays, ECG, ultrasonogram** etc. All the SHCs and PHCs are **provided with requisite drugs and other supplies**. The bed occupancy in PHCs and Hospitals is higher in Salem and Krishnagiri districts and relatively much less in Villupuram district. The non-availability of doctors for emergency situations at the health centres is a matter of concern as the doctors and nurses are not staying in the quarters mostly due to lack of good residential quarters.

iii) **Quality of Services:**

Almost all the **facilities are well maintained and upkeep of facilities is to satisfactory levels.** The quality of institutional deliveries varied across the districts visited, the outstanding being Salem district where the staff are committed to do more and improve quality of the services. All **pregnant women are being screened by ultrasonogram** and all the mothers interviewed stated that **sex of the foetus was not revealed.** However the **outcome of delivery clearly indicates unfavourable gender bias for female child**. The district administration is well aware of the issue and the Deputy Director (Health) of **Salem district has filed 130 cases under PNDT Act**.

Family Health Clinics are being conducted in all the **385 Bemonc PHCs thrice a week**. The **diet is provided for pregnant women** attending ANCs @ Rs.15 per person and **Sterilisation patients** @ Rs. 30 per day. Tamilnadu State initiated non-communicable disease control programme of **Gestational Diabetes Control** by investigating **pregnant women at 16th, 24th and 32nd weeks** and providing free treatment at PHC level. During the past two years 1.31 lakh pregnant women were screened and 2,658 (2%) treated.

iv) **Diagnostic facilities:**

The essential investigation facilities are **available in all PHCs**, **Sub-district Hospitals and District Hospitals**. The **Block PHCs** are provided with **Scan** and all the **235 upgraded PHCs are provided with ultrasonogram, X-ray, ECG and Semi auto analyser**. The **blood storage facilities were established in20 PHCs by TANSACS** and 15 are proposed under State funds. There is **good cooperation amongst** the health department staff as they perform the duties of other's during leave period – For example - Radiographer & Laboratory Technician, Staff Nurses & VHNs (ANM). Many of the Sub-district hospitals are having acute shortages of supplies and many a times the RKS funds are utilised for purchase of x-ray films, laboratory chemicals etc.

v) **Drugs and other Supplies:**

Tamilnadu State developed role model supply system of TNMSC and this is a very effective in ensuring adequate supplies of drugs and other routine supplies for all health facilities. The State Health Mission utilised the TNMSC for ensuring supplies to all the health centres. The receipts, storage and disbursement of supplies are well documented by laid down procedures. All the essential equipments such as delivery table, weighing machines, BP instrument, stethoscope, Uristix, torch light, hub cutters etc are available at the SHCs.

The **drug supplies are adequate** or surplus and short expiry stocks were seen in many facilities as none of the PHCs are maintaining expiry date calendar. The **EC Pills and IUD are not available** in Villupuram district. The EC Pills and IUD are available in other districts but the **off take is very low.** The VHNs in the other two districts need to be sensitised regarding the long life of the new IUDs supplied.

There is a need to review the quality and Quantum of **TNMSC supplies** as surplus stocks are a common feature and drugs manufactured in the year 2007 with expiry date of Jan.-Mar 2008 were received in December 2008. The surgical gloves with expiry date of Dec. 2008 were issued to SHCs on 1st Dec. 2008. There were instances of equipments of lower grade (non- hydraulic type Operation table supplied in lieu of hydraulic table which could lead to disastrous incidences during operations) and red painted aseptic furniture). The surgeons, MOs VHNs stated that the items were received by them as supplied through TNMSC. In most of the centres, one the wards / X-ray room / corridors are utilised as storage space for the equipments / aseptic furniture received.

It is therefore felt that the system needs fine tuning for elimination of surplus stocks at the peripheral centres and there is a need for clearance of procured equipments and other supplies by technical experts. The supplies need to be distributed based on annual requirements furnished by the SHCs and PHCs. Then the robust system of procurement can be expanded further for ensuring supplies to the Sub-district and district hospitals for eliminating the short supplies at these levels also.

vi) **Human Resources**:

Annually 1,700 nurses from the Government institutions and 3,200 nurses from private institutions are made available. The existing seats in ten Para-medical certificate courses and DMLT course in Government institutions was increased from 2,700 to 5,000. During the last two years permission was given to establish 61 Nursing Schools as well as Colleges for Nursing - 71, DMLT- 3, Pharmacy– 4 and Dental -10.

Medical, Nursing, Paramedical Institutions in Govt. & Private sectors

	Institutions	Government	Private	Total
1	Medical Colleges	14	7	21
2	AYUSH	5	17	22
3	Dental	1	7	8
4	Nursing	23	41	63
5	Pharmacy	3	33	36
6	Lab. Technician	3	53	56
7	Physiotherapy	3	34	37

During the past six years, both undergraduate and post graduate seats in medical colleges have increased in Government as well as private sector medical colleges are detailed below-

Medical Education - UG & PG Seats

	2003-2004	2008-2009
MBBS (Govt.)	1305	1745
MBBS (Self- Financing)	360	560
Total **MBBS Seats**	**1665**	**2305**
PG Degree	324	505
PG Diploma (Clinical)	326	408
Total **P G Seats**	**650**	**913**

The details of nursing institutions in and seats during the past few years are as detailed below-

Nursing Education – Colleges & Schools

		2005-2006		2006-2007		2008-2009	
		Govt.	Private	Govt.	Private	Govt.	Private
B. Sc.	Colleges	2	39	2	40	2	40
	Seats	50	1905	50	1965	75	1965
Diploma	Schools	21	-	21	-	21	-
	Seats	1795	-	1795	-	1795	-
Total Seats		**1845**	**1905**	**1845**	**1965**	**1870**	**1965**

During the past two years, 4263 nurses were appointed on contract basis in the rural health centres. **Life Saving Anaesthesia skills imparted to 106 MBBS doctors** and posted back at block PHCs with 2 days services at the SDHs. As part of RCH outreach programme 100 contract doctors were appointed on contract basis for the 100 Mobile Medical Units and 46,174 camps were conducted. All the VHNs of the 8,706 SHCs were given mobile phones.

The State has **standardised the rules and regulations** for appointment, transfers, promotions etc. The transfers are through annual counselling and thus minimising subjective decisions of individuals. The transfer requests are forwarded through the supervisory officers on record of their views. The **compulsory service in rural areas** and **additional marks for the service in hard areas** for admission to higher studies e**nsured enhanced availability of human resources** in underserved and rural areas. The State has two service commissions one for medical services & medical education and one for health services. There is a **minimum tenure of service for transfers and promotions**.

The State has **successfully implemented contractual appointment of large number of doctors, nurses** and few other essential categories within the scope of NRHM. The main reasons for this success are appropriate remuneration for the work, preferential consideration of contractual experience for regular appointments, minimum requirement of contractual service for certain categories such as nurses etc. As per the State HMIS **all the PHCs are provided with minimum of three staff nurses** by appointing additional contractual nurses, **filling up over 99% of specialist positions at FRUs** by posting of doctors with specialist qualifications to FRUs (1842/1865), **posting out all non PG doctors to PHCs** and **98% of the ANM positions are filled**. The continued support and motivation by DMHO and district level officers is very evident in Salem and Krishnagiri districts.

The **trainings loads are assessed and distributed to the training institutes**. During the year 2007-08, the assessed training load was 1260 and 922 trainings were completed (93%). The six regional training institutes completed TOT of IMNCI for 1105 staff including 375 doctors. The trainings completed include IMNCI for 9030, SBA for 1201 Nurses and ANMs, MVA trainings for 112. The PHC doctors are imparted training for acquiring skills in anaesthesia and ultrasonogram.

vii) **Infrastructure:**

All the **PHC premises have a new look** as most of the civil works were completed including provision of toilets, water supply and uninterrupted electricity including generators. The **PHCs are well equipped** with ILR, Deep Freezers, Sterilisers, Autoclaves, Semi/Auto analysers, Calorimeters, emergency lights, water filters etc. The **PHCs are having patient's privacy by provision of curtains, cots, mattresses in good condition**. The **linen supplies were inadequate** as three sets are provided per bed and during the rainy season these supplies are inadequate.

The **up-gradation of health centres is mostly based on the assessed needs** by the district administration as the **facility surveys are to be completed** during the current financial year. The system is working effectively as the facilities are being upgraded based on local needs and in consultation with the concerned staff of the facility. The **active involvement of the district level and state level officials ensured most of the requirements**. The up-gradation of some of the facilities by the donor partners and other agencies were considered as models for up-gradation of other facilities. The **SHCs, residential quarters** at SHCs and PHCs as well as the sub-district hospitals and district hospitals **require greater attention for up-gradation**. The **building extension is the most common feature in PHCs** for 24x7 hours services. Most of the PHCs including the PHCs upgraded with 30 bed facilities are faced with the problem of **inadequate space for storage of supplies**. The **PWD is the nodal agency undertaking all the civil works**. The creation of **Infrastructure Development Wing would meet the above shortfalls** by development standards and implementation as per the local needs.

viii) **Empowerment for effective decentralization and flexibility:**

The Village Health & Sanitation Committees (**VHSCs**) were established for the 12,618 villages and 2,540 town Panchayats and some of the VHSC are covering 4 to 5 villages. The VHSCs are **meeting regularly** and the record of decisions is maintained in all the centres visited by the team**.** The SHC committees were established for all the 8,706 SHCs The untied funds to **SHCs and VHSC funds were received in time** and aptly **utilised** in all the SHCs including hill areas. The referral transport for pregnant women and for complicated cases is arranged by utilising the VHSC funds and local arrangements with community leaders/ PRI presidents. The mobile phone costs are paid from untied funds of SHCs at the district level. The Patient Welfare Societies (RKS) were established in 29 district hospitals, all the 235 sub-district hospitals and all the 1,421 PHCs. The RKS funds are mainly utilised for maintenance of buildings, cleanliness, purchase of essential drugs, x-ray films etc.

The **District Health Missions** are very active in Krishnagiri and Salem districts. In Salem district, the expenditures are incurred on file approval by chairman. The district health mission of Villupuram constituted on 4th July 2006 has met once on 10th July 2008 and the minutes of the meeting are to be approved by the chairman.

The **community monitoring** activities are visible in few of the health facilities in Dharmapuri districts as it is one of the five districts selected where in the district & block level NGOs were identified for the community monitoring activities. The team was informed that 290 orientation workshops were conducted and village report cards are generated in some areas. The Citizens charter was not being displayed at any of the SHCs, PHCs, SDHs and Hospitals visited by the time,

ix) **ASHA:**

The ASHA and Community Links Worker schemes were **not implemented in Tamilnadu**. The State **proposed to recruit 130 ASHAs during the year 2008-09**.

x) **Financial management:**

One of the **commendable achievements of Tamilnadu State is the low out of Pocket expenses incurred by rural in-patients** (Rs.637) in comparison to Rs. 2610 in Karnataka, Rs.2170 in Andhra Pradesh and Rs.2174 in Kerala.

The State Health Mission is **transferring the funds to all the districts by e-transfer**. The release of funds to the **sub-district levels is by cheques**. The **Untied funds** of Rs. 3.55 crore to the PHCs and Rs. 8.70 crore to the SHCs were also released. The **Annual Maintenance Grants** of Rs.8.80 crore to the PHCs and Rs. 6.35 crore to SHCs were also released. **All the health centres and hospitals visited by the team have received the RKS grants / annual maintenance grants / Untied Funds** as per their eligibility. All the **contractual staff are receiving their payments** on due dates. The **JSY payments** to the beneficiaries' pregnant women are made **by cheque**.

The Village Health & Sanitation Committees (**VHSC**) in the 12,618 villages and 2,540 town Panchayats were released Rs. 8.03 crore. The untied funds to SHCs and VHSC funds were received in time and aptly utilised in all the SHCs including hill areas. The referral transport for pregnant women and for complicated cases is arranged by utilising the VHSC funds and local arrangements with community leaders/ PRI presidents. The mobile phone costs are incurred from untied funds of SHCs.

The **RKS funds** are basically **utilised for** maintenance of buildings including whitewashing, cleanliness, TV and other amenities, purchasing of essential drugs, x-ray films, minor equipments etc. As per the briefing presentation by the state health mission the funds released are as detailed below-

Funds Released (Rs. lakhs)

			2006-07	2007-08	2008-09
1	Untied Funds	SHC	6.51	8.71	8.70
		PHCs including 30 bedded	3.45	3.55	3.55
2	Annual Maintenance Grants	SHC	8.03	15.15	6.30
		PHC	6.90	8.78	8.80
3	RKS Corpus Funds		8.00	18.00	8.03

The **accounts for the year 2007-08 were audited** by the auditors appointed by the State Health Mission and the audit remarks were communicated to the districts. The **districts are to furnish the replies** for the auditor's remarks. The State has posted office superintendent rank officials at the Block PHCs and the accounts are being maintained with the assistance of an accounts clerk. The deputed staff were unaware of the double ledger accounting systems to be maintained.

The ANMs are unaware of the accounting procedures and often expressed their apprehensions to withdraw cash for routine expenses. Many of the VHNs were accumulating expenditures and withdrawing cash by with drawl slips as they are unaware of cheque book facilities. Some of the VHNs were operating more than four VHSC accounts and the expenditures for civil works etc were for similar amounts for each of the VHSCs. There is an immediate **need for guidance and training of VHNs and VHSCs executive committee members in regard to accounting procedures** as well as NRHM guidelines for VHSC's and SHC's untied funds.

(xi) **HMIS and its effectiveness:**

The availability of computers and internet facilities enabled flow of data to the district head quarters and State Programme Management Unit. The IDSP data is received at district headquarters on weekly basis and the same is compiled and forwarded to the State head quarters. The data collected

under IDSP is not reviewed at the districts for initiating preventive measures for disease outbreaks, program planning and policy development. In some of the PHCs, there were no computer literates to operate the computers. The district nodal persons were unaware of DLHS or NFHS surveys and the important issues of childhood anaemia, declining immunization coverage, increase of unmet needs etc. During the briefing, it was informed that the HMIS implementation is in transitional phase and steps are being taken to furnish the HMIS data in the revised formats.

xii) **Community Processes:**

The Village Health & Sanitation Committees (VHSC) were established in 12,618 villages and 2,540 town Panchayats and Rs. 8.03 crore released. The VHS Committees are meeting regularly. The untied funds to SHCs and VHSC funds were received in time and aptly utilised in all the SHCs including hill areas. Some of the VHSC are covering 4 to 5 villages.

The community monitoring activities are visible in few of the health facilities in Dharmapuri districts as it is one of the five districts selected where in the district & block level NGOs were identified for the community monitoring activities. The team was informed that 290 orientation workshops were conducted and village report cards are generated in some areas.

xiii) **Assessment of non-governmental partnerships for public health goals:**

The Public Private Partnerships were notably evident in Krishnagiri district with the initiatives of the district collector to mobilise over Rs. 70 lakhs for the Krishnagiri district hospital. Similarly one of the PHCs visited by the CRM team in Salem district was renovated with the contribution of public sector undertaking. These instances clearly indicate the feasibility of PPPs at the local initiatives.

xiv) **Systems in place for outreach activities of SHCs:**

The State has established **100 Mobile Medial Units** by appointment of 100 contract doctors. Each of these units are functioning one doctor, one staff nurse, one driver and one group D staff on contractual basis. During the year 2007-08, the MMUs in the State conducted 63,715 camps and these services were availed by 23,59,415 people at an **average of 37 persons per camp**.

The **School total health programme**, is the other out-reach programme launched by the State Health Mission for implementation of the new initiatives of **de-worming** children and **control of anaemia in adolescents** as approved in PIP 2008-09. The visits to the schools in tribal areas indicated the commitment of health workers and teachers. The **coverage of school children is very low** as 15 to 20 % are only covered during the annual visit by the team from the neighbourhood PHCs. As per NFHS –III, 72.5% of children are suffering from Anaemias. The teams **require managerial support** in terms of provision of transport as the teams travels by public transport to reach the schools.

The **lone VHN (ANM) at the SHC is preoccupied** with mobilisation of women for ANC, PNC, Immunisation programmes at PHCs and transportation of pregnant women to the PHC for delivery. The ANMs are further engaged in the school health and adolescent health programmes and thus leaving hardly any time for domiciliary visits and other outreach programmes of SHCs. The outreach programme VHNDs at Anganwadi Centres is not visible in any of the districts visited.

The **Emergency ambulance 1056, run by NGO** were and the MOs in-charge of PHCs expressed dissatisfaction with their service as transportation of patients to the referral hospitals is more often not accepted by the NGO. The team could not assess the veracity of the facts as the log books of these vehicles were not available with the driver and the DMHOs were helpless as these services are under the control of Director of Health & Rural Services who is in-charge of Sub-district hospitals at taluq and non-taluq levels.

xv) **Thrust on difficult areas and vulnerable groups:**

The **accessibility of facilities and service is very good in the plains** for the rural, BPL and SC population. The services in tribal areas are provided through MMUs and the **residents have sought for daily availability of VHNs and weekly visits by MOs**. One of the teachers in tribal area school showed a case of dog bite wound unhealed for three months and there were cases of cancers and chronic non-communicable diseases requiring treatment as the families unaware of the facilities to obtain adequate treatment. The Tamilnadu State is also implementing the **'short stay home' for 10 days for the expectant tribal mothers** near the health facilities.

xvi) **Preventive and promotive health with reference to inter-sectoral convergence:**

The State is **Polio free** for the past four years. The incidence of other vaccine preventable diseases of Diphtheria and Pertusis is very minimal. Annually around **1,500 cases of Measles** and over **1,300 Malaria cases** are being reported. During the first seven months of 2008-09, **38 cases of Chickungunya were confirmed** (45 during the year 2007).

At the grass root levels, the **health workers were able to coordinate their activities with the teachers and Anganwadi workers**. In the tribal areas and underserved areas, the MMU staff are leaving behind stocks of emergency drugs, ORS etc with the teachers for ready availability. The teachers were also actively participating in the school health programmes and MMU programme.

Blood storage units were **established in 4 PHCs from district collector's funds**. The Public Private Partnerships were notably evident in Krishnagiri district with the initiatives of the **district collector** to **mobilise over Rs. 70 lakhs for the Krishnagiri district hospita**l. Similarly one of the **PHC**s visited by CRM team **in Salem district** was contribution by a PSU - Salem Steels.

xvii) **Effectiveness of disease control programmes:**

The cataract surgeries during the first half of 2008-09 were 40% of the targeted 6.5 lakhs. The few **Ophthalmic Assistants available at block PHCs were only able to attend to the routine works** at the PHCs and screening of school children. The **blindness registers are not maintained** and the data is mostly based on the verbal information obtained from the VHNs. There is **considerable scope for utilisation of operation theatre and in-patient care facilities in the up-graded PHCs** with 30 beds as most of these centres are utilised fortnightly only for sterilisation operations.

There are no shortages of laboratory chemicals at the microscopy centres as well as sub-district hospitals. The **case detection rate and availability of Laboratory Technicians are of concern** in tribal and underserved areas. There is **acute shortage of male Health Workers** and the services of available 400 NMS can be utilised for implementation of DCPs. In most of the upgraded PHCs, alternate arrangements are made for taking x-rays, ECGs and other routine investigations. The ICTC technicians are also providing additional support.

xviii) **Performance of MCH and FP activities**

In Tamilnadu, the Primary care was given great emphasis with innovative initiatives and achieved several of the Public Health Goals envisaged in National Health Policy 2002. The State has effectively reduced the Maternal Mortality Rate to 134 (India 301) and IMR of 37 is lower than many other States. The **easy accessibility** of health facilities, relatively **high literacy rate** in females (64.4%), **implementation of maternity picnics, bangle ceremonies** as well as the **birth companion** programmes, **free transport, mobile phones to VHNs** etc. are drawing the pregnant women towards institutional deliveries at PHCs. The set targets for RCH are as detailed below.

MCH Trends & Targets

	Tamilnadu					India	
	Trend			Target		Status	Target 2009-2010
				08-09	09-10		
MMR	**167** (SRS 2001)	**134** (SRS2003)	**92** (SMIS 2008)	92	60	301 (SRS 2003)	< 100
IMR	**51** (SRS 2000)	**37** (SRS 2006)	**31** (SMIS 2008)	23	20	58 (SRS 2005)	< 30
TFR	**2.1** (SRS 2000)	**1.7** (SRS 2005)	**1.7** (SMIS 2008)	1.7	1.7	2.9 (SRS 2004)	2.1

During the interviews with the recently **delivered women** in the health centres and hospitals, it is evident that they **prefer to stay for 2 to 3 days in the health facility** for normal deliveries; it is **generally accepted to have 2 children only even if they are girls** and that they should undergo sterilisation after the second child. Further strengthening of health sector would enable the State to achieve the status of Kerala (15) and Pondicherry (21).

The **performance in sterilisation operations declined steadily** from 4.3 lakhs / year (2003-04) to 3.53 lakhs (2007-08) **with a decrease of 11% in the hospitals** from 90565 to 80,568. The performance of sterilisation operations at the **260 operation theatres in PHCs** is 51,808 during the first half year 2008-09 i.e. **one /day / OT**. This issue is **being addressed** as the number of sterilisations performed at PHCs increased from 28,994 to 38,947 (33%) during the current year (April- Oct. 2008).

In all the districts visited by the CRM team, the **JSY payments were pending** for over a year (Villupuram district) and for over 4 months in the other districts. The JSY beneficiaries indicated their keenness for the State's Muthulakshmi Reddy scheme providing Rs.6000. The **need for the JSY implementation may need to be reassessed as the institutional deliveries are over 99%**. However, the JSY scheme needs to be continued in tribal and other underserved areas / districts.

xix) **Assessment of programme management structure at District & State levels**

The implementation of **programmes in the State is exemplary** with effective coordination of Directorate of Public Health. The preparation of **District Health Action Plans** is mostly done by the DMHOs and the DPMU staff under the active guidance of the State Health Mission. There is **planning team** at state health mission as well as single designated person in the districts visited. The preparation of district health plans 2009-10 was started in the districts visited.

The good leadership and provision of adequate space in Salem district facilitated setting up adequate working space and efficient administrative set up at the district level. In Krishnagiri district the functioning of DMHO from a rented residential building is a severe constraint. In Villupuram district, the district mission has adequate space in the government building and can upgrade the working facilities.

The **District Health Missions meetings** were not being held as envisaged in the NRHM mandate and the expenditure is incurred. The team notes that the state is **yet to fully establish the District Program Management Units and the additional Block level staff** as mandated under NRHM.

The Block PHCs are posted with an office superintendents well experienced in government systems. The Block PHC and PHC are level management systems are to be strengthened by provision of requisite contractual staff and orientation training programmes for following the envisaged NRHM managerial patterns.

The DMHOs belonging to the Public Health Cadre are relatively much junior in the service and the district programme managers (including Family Planning) are much senior level officers leading to certain hierarchy issues. This necessarily requires reassessment for feasible corrective measures as deemed fit by the State Government for integration at the level of districts.

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The progress against the time line of NRHM is enclosed as an annexure.

The Checklist for charting the **Progress against approved PIP is enclosed as Annexure**

Chapter – IV Outstanding Achievements in Tamilnadu

- During the first 3 years of NRHM - PHC deliveries increased from 5% to 15% (2008-09), domiciliary deliveries decreased from 3.2 to 0.52%.
- 96.2% pregnant women received at least three ANC and 89.3% received PNC within 2 weeks.
- All the 1,421 PHCs providing 24x7 services by provision of additional nurses on contract
- Specialists serving in PHCs & Dispensaries, etc, were relocated to SDHs and MBBS Doctors working in Medical Colleges & SDH/DH posted to PHCs.
- Filling up of over 99% of specialist position at FRUs, over 98% of ANM posts at SHCs
- 106 MBBS doctors trained in Anaesthesia and posted at health facilities
- Untied Funds and Annual Maintenance Grants released to all SHCs and PHCs.
- Provision of semi-auto analysers, Ultra sonogram, calorimeter etc., to PHCs with 30 beds
- Appointment of regional biomedical engineers (10) for optimum utilisation of equipments.
- All the 1,421 PHCs provided with computer and internet connectivity
- High acceptance of small family norm (96%) and satisfaction with 2 daughters (86%).
- Sanctioned operation theatre facilities for 374 PHCs and 278 (74%) were operationalised.
- Sterilisations increased by 32.8% during Apr.-Oct.2009 in comparison to 2008 (28994 to 38486).
- AYUSH facilities co-located in 451 PHCs
- HIV testing for pregnant women in upgraded PHCs, SDH and DH.
- 100 Mobile Medical Units operationalised by appointment of contractual doctors and nurses.
- Transparent system of procurement and logistics for quality drugs and equipment
- Higher per capita financial allocations of Rs. 357
- Out of pocket expenses of Rs.637 for Inpatient stay (India 3238, Kerala Rs.2174, Karnataka Rs.2610))
- **Diet** provided for **pregnant women** at ANCs and **Sterilisation cases**
- **Gestational Diabetes Control** for **pregnant women** and providing free treatment at PHC level.
- Polio free status and low incidence of other vaccine preventable diseases
- Innovative measures for increasing deliveries at PHC by **maternity picnics, bangle ceremonies** as well as the **birth companion** programmes for pregnant women

Chapter – V Issues of Concern

- **Full Immunisation of Children** decreased from 91.4% to 82.6 % (DLHS- 2&3) and immunisation in children < 2 years from 88.8% to 80.8% (NFHS-2 & 3).

- **Anaemias in children** (6-35 months) increased from 57.1 to 72.5% (NFHS- 2 & 3).

- In married **women** (15-49 years age), the high incidence of **54% anaemias** and **15.4% incidence of obesity** are of great concern. The low (43%) intake of 100 tablets of IFA by pregnant women and very marginal (2.6 %) reduction in Anaemias (NFHS-2 & 3) are suggestive of the need for thrust in early detection and treatment for any improvements in MCH.

- **Maternal deaths** were 1,035 for the year 2006 and 1,025 for the year 2007.

- **Decline in** annual performance of **sterilisation operations** from 4.30 lakhs (2003-04) to 3.5 lakh /year for the last two years (2006-07 & 2007-08). **Unmet Needs** for spacing as well as terminal methods decreased from 12.7% to 13.3% and 5.4% to 6.1% respectively. The **male sterilisations** (0.2%) continue to be very low and the usage of **IUDs & condoms** decreased (DLHS-2 & 3).

- **Non-availability of IUDs & EC Pills** in Villupuram district **and very low off take** in other districts

- **32% Caesarean Section deliveries.** (43,923 for 1,80,367 deliveries)

- **Decline** in the **outreach activities of Sub-centre** and house visits of VHNs are they are preoccupied for the immunisation clinics at PHCs for two days, one day for school health visit and transportation of pregnant women and conducting deliveries at PHCs etc

- **Role of VHNs and SHCs** as the State policies advocate diversion of routine Immunisations and deliveries to PHCs (or higher level facilities).

- **JSY payments pending** for over a year in Villupuram and for over 4 months in other districts.

- **Updating of Blindness registers and non-utilisation of Operation Theatres at PHCs for cataract surgeries**

- The **HRH availability** of doctors, specialists, nurses, ANMs, lab. technicians, pharmacists **in tribal and underserved areas** where the vacancies are persisting in PHCs.

- **Short expiry drugs** at SHCs and PHCs, supply of **surgical Gloves** during the last month of expiry date and **TNMSC supply** of non-hydraulic operation table in lieu of higher cost OT Table.

- **Non-occupancy** of residential **quarters at SHCs and PHCs** due to essential repairs.

- **Convening the meetings of District Health Missions, RKS etc and expenditures as per the decisions in these meetings**

- Combination of Senior level programme managers (Family planning etc) and the junior level DMHOs (Public Health) leading to certain **hierarchy issues at district levels**

- **State has to fulfil the conditions as per ROP 2008-09:**
    1. Operationalisation of SHCs
    2. Auditing of accounts for the years 2007-08 and 2008-09

3. Utilisation of unspent balances
4. Fill up the vacancies of Health Worker (Male) at SHCs

Chapter - V Recommendations

Implementation of Programmes:

Improve nutritional status of children, adolescents and women by early diagnosis & treatment of Anaemias, reduction of obesity in women through inter-sectoral activities with teachers and AWWs.

Village Health and Nutrition Days on monthly basis with assured services for immunization.

Strengthening of School Health Programmes by providing vehicles and adequate supplies

Promote male participation for Family Planning.

JSY programme may be reassessed as the State has achieved the status of over 99% institutional deliveries. The JSY scheme needs to be continued in tribal and other underserved areas / districts.

Community Participation:

Ensuring monthly meetings of Executive Committees and ½ yearly meeting of Governing Bodies of District Health Societies

Promote community participation through awareness generation meetings for members of VHS, SHC & PHC committees.

HR ISSUES

- Provision of **rural and hard area allowance for all categories** of health workers may be considered for availability of health workers (male & female), lab. technicians, pharmacists and drivers in the tribal and underserved areas

- The **option of 2nd ANM may be reconsidered as the lone VHN is fully preoccupied** with immunisation sessions and institutional deliveries at the PHCs. The availability of additional ANM in tribal and underserved areas would facilitate easy accessibility of essential primary health care.

- **Reorientation trainings for ANMs** to facilitate decentralized preparation of Village and SHC level health action plans, control of anaemias, adolescent health, newer FP techniques/ IUDs etc

- Sustain the **availability of VHNs** (ANM) in consideration to future vacancies due to retirement etc

- **Skill up-gradation of laboratory Technicians and Radiographers** for formalising the roles practices at PHCs and facilitate continued availability of services.

- **Provision of ophthalmic assistants at all the PHCs**, minimum of **four drivers and four group-D staff** for 24x7hrs availability or outsourced as deemed fit.

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Management :

- Enhanced **intra-sectoral coordination** (Directorates of Public Health, Rural Health, Medical Education etc) for **strengthening of linkages** to **increase referrals from PHCs to Sub-district and district hospitals and optimal utilisation of available facilities**. The **up-gradation of SDHs as per IPHS** (under Directorate of Medical Services) may be taken up to avoid replication of facilities by upgrading large number of PHCs under Director of Public Health.

- **Electronic transfer of funds to sub-district levels** for decentralised activities at health facilities

- Establishing **Infrastructure Development division at State level and units at district level for high quality infrastructure**

- Further **streamlining of the TNMSC procurement and distribution systems** to eliminate short expiry drugs / surgical supplies and supply of high quality equipments

- **State Health Systems Resource Centre for strengthening of managerial skills of DMHOs, DPMUs, BPMUs etc, facilitate linkages** for effective planning and policy development.

- Strengthening of **supervision and monitoring** activities for improved HRH performance. It is suggested to undertake reorientation programmes for DMHOs, district programme managers in RCH, TB control, NVBDCP etc.

- Providing **contractual staff with the appropriate skills** in planning, data analysis and financial management at district and block levels.

- Capacity building of the six **regional training institutes for Continued Medical/ Nursing/ Paramedical Education** programmes

- **Meetings of District Health Missions, RKS (PWS) and VHSCs** to be conducted more frequently and in presence of non-official members and if needed **conduct orientation workshops**.

- Enhancing GNM seats for posting of **Nurses with Diploma at the PHCs and SDHs**.

Please incorporate at appropriate areas :
Nomenclature PHC – Addl. Block, Upgraded, Main, Bmoc
Grading of PHC – Bmoc & different Recommendation – PHC CHC, CEmonc, BEmonc
Varied Releases to PHCs on designation to different categories Bmoc -
No Norms for beds, equipments.
Authority – State - DPH, DMRS, DME,
District - Managerial conflicts – triplication of authority JD, DDH, DDFW
Beds occupied for PS 7 days (GOI - 4 hrs) & PN – 3 days
Kiliyanur – ref
No CHCs and the patients go directly from PHC to SDH or DH or tertiary hospitals.

Chapter – V Findings at Facilities

A. Villupuram District

29th to 30th November 2008

SHC Kandhalavadi

The SHC located at a distance of 8 km from the PHC is covering a population of 3,877. The OP attendance for the past 10 months was 1,067 and the SHC registered 63 ANC cases.

The SHC is provided with all essential items including drugs, BP apparatus, delivery table, weighing scale, delivery instruments, AMBU bag etc. However, no deliveries were conducted recently as the directions were to refer the cases to PHC for 72 hrs stay. The ANM is not residing in quarters. All the pregnant women advised to go to PHC for delivery. The immunisation services are discontinued at SHC.

During the community interaction with villagers and mothers it was confirmed that the ANM is visiting one a week or fortnightly. The ANM confirmed the same and the OPD attendance on the day of her visit is around 15. The villagers residing next are given stocks of ORS, paracetomol, cough syrup etc. The expiry date calendar is not maintained and the ANM is unaware of expiry dates of available drugs. The SHC has a stock of 400 tablets of B. Complex (Batch No. KBC 7058) expiry dated December 2008. The average monthly consumption is less than 50.

SHC Kilapallayam & SHC Sempi

All basic instruments are available and working conditions (BP, Stethoscope, Torch, Hub cutter, AD syringes). The SHC has adequate stocks of drugs and other materials. The VHN (ANM) knowledgeable about her job responsibility regarding MCH but her knowledge on FP methods especially the IUDs and Emergency Contraceptive Pills is inadequate. The Routine Immunisations and Deliveries are not being conducted in the SHC. The untied funds for the SHC as well as the VHSCs were received by all the SHCs and the accounts are being maintained. The VHN (ANM) is motivating patients for puerperal Sterilisation but has not received motivator's component as envisaged in the scheme.

The observations are similar in SHC Sempi except that the account keeping is poor.

PHC Saram (3 bedded Additional PHC)

The PHC is covering a population of 25,018 and the enumerated Eligible Couples were 3,919The PHC is functioning with one MO, three staff nurses (contractual), ANM, pharmacist, lab. technician and two group-D. The nurses and ANM are to undergo RCH trainings. Adequate stocks of drugs were available except IUD and EC Pills.

The PHC's daily OP is around 90 and 19 Deliveries were conducted during October and during Nov. (till 28th) 17 deliveries including 10 during nights. During the past one year, 14 delivery cases (82%) were referred to hospitals in Puducherry. There were five quarters in good condition and one quarter is occupied by ANM of SHC.

The PHC has received Rs.1.25 lakhs of NRHM funds - Untied funds Rs. 25000, AMG 50,000 and PWS Rs.50,000. The PHC committee is constituted and four meetings held. The minutes were

recorded and decision includes repairs @ Rs. 60,000, provision of gardener Rs.500/month etc. The JSY payments for the 700 beneficiaries are pending for several months due to non-release of funds.

PHC Kiliyanur (3bedded Additional PHC)

The PHC covering a population of 1,10,801 is functioning with one MO,4 Staff Nurses (3 Contractual), one ANM, PHN, pharmacist, Lab. Assistant, ophthalmic Assistant, driver and group-D staff . The MOs quarters is utilised as office. The daily OPD is around 100. During the past the number of deliveries increased considerably. During Jan. to Oct. 2008 (10 months) there were 1,817 deliveries in the PHC area population and of these 316 only were conducted in the PHC and the remaining were delivered in neighbouring Puducherry State. The ANC referrals were also relatively high of 68.Amongst the 316 deliveries, 264 were 3rd child and 37 were 4th child in the family. The Episiotomy deliveries were very high of 105. There were four still Births. The patients are kept in the PHC for 48-72 hrs as confirmed by the presence of three post delivery patients and all three of them desired to stay for 72 hrs. The diet is supplied by local SHGs.

The service of Lab. Technician and functional Auto analyser are available. The Blood grouping sera were kept outside the refrigerator and the Lab. Asst. Stated that it was kept outside from 11 AM. The generator is available but the PHC was in darkness during the power failure due to non-availability of kerosene.

The PHC received the NRHM funds of Rs. 1.75 lakh - Untied funds Rs. 25000, AMG 50,000, Bmoc 50,000 and PWS Rs.50,000. The last payment for JSY was on 28th March 2007.

PHC Iruvelpattu (30 bedded) (Villupuram HUD- II)

The upgraded PHC is covering a population of 1,37,599 and there are 6 SHCs attached to the PHC. The PHC is functioning with 5 MOs and two of them are qualified surgeon and anaesthetist. The other staff includes 3 ANMs, 2 pharmacists, Lab. Technician and Health Worker (Male). The services of Obstetrician, Paediatrician and Physician are not available.

The PHC is provided all the essential equipments including operation tables, OT lights, anaesthesia machine, ILRs, Deep Freezer etc. The male ward is utilised partly as store room and partly as a meeting hall and all the aseptic furniture including oxygen cylinder stands, bed side lockers, crash trolleys, baby warmers etc. are stacked up in the ward.

At the time of there were no patients in any of the 30 beds. Physically only one ward is utilised for in-patient stay during on sterilisation camps. During October and November, 3 camps were conducted and 13 sterilisation operations performed. As on date 175 ANCs are registered with 10 high risk pregnancies referred by the SHCs and 7 of them were referred to higher institutions.

The PHC received the NRHM funds of Rs. 1.25 lakh - Untied funds Rs. 25000, AMG 50,000 and PWS Rs.50,000. The JSY payments due in 2008-09 were released for 278 and there is a backlog of 1,918 cases. All the six staff quarters were unoccupied. The MO in-charge is a surgeon.The Emergency ambulance 1056, run by NGO was stationed at the PHC and the log book was not available with the driver for verification. The MO in-charge expressed dissatisfaction with their service.

PHC Elavanasur Kottai (Villupuram HUD- II)

The Block has six PHCs and 24 SHCs for population of 1,67,513. The PHCs in the block are functioning with 3 MOs, one AYUSH physician, 4 Staff Nurses including three contractual, 28 ANMs including 3 ANMs at PHC E Kottai, one Health Worker (male), pharmacist, two drivers and four

group-D staff. The PHC is provided with two clerical staff. The post of Lab. Technician and Accounts Manager are vacant. The PHC is provided with Labour Room, ILR, Generator, autoclave, suction machine, AMBU bag etc. The temperature chart is maintained for the ILRs.

There were 5 in-patients at the time of visit. The average monthly load of deliveries was 118. There were 10 referrals (3 to District Hospital and 7 to Puducherry) which appear to be more reasonable when compared to the PHC Kiliyanur. There was one reported case of adverse reaction after vaccination during the last 6 months. The JSY payments were made for 100 beneficiaries after discharge and there 118 pending payments.

PHC Thirunavallur (Villupuram HUD- II)

The PHC is functioning with two medical officers against the three sanctioned posts, one AYUSH physician, 4 staff nurses (3 contractual), ANM,VHN, health worker (male), laboratory technician, driver and two group-D staff.

During the month of November 2008 (up to 27th), 42 deliveries were conducted in the PHC and all the three available beds are occupied by female patients who delivered during the past two days. The surgical facilities are not available in the PHC. The diet to the in-patients is provided through self help group on payment from the PHC funds. The medical officer is not residing in the quarters.

PHC Nainarpalayam (Villupuram HUD- II)

The PHC is covering a population 43,383 with 7 SHCs. The PHC is functioning with two MOs, three Staff Nurses (all contractual), two ANMs, three Health Workers (male), one specialist in Obstetrics & Gynaecology, one Pharmacist, Laboratory Technician, driver and two group- D staff. All equipments and drug supplies are adequate. Since Apr. 2008, 52 JSY beneficiaries received their payments and 153 are pending. There were no supervisory visits.

Kallaikurchi District Head Quarter Hospital (Villupuram HUD- II)

The 108 bedded SDH was notified recently as the District Hospital. The hospital is having 11 MOs (2 Obst., 2 Anaesthetists, 3 Surgeons, 2 orthopedicians, 2 Ophthalmologists, physician, TB etc), 18 Staff Nurses, 3 ANMs, 4 Pharmacists, 4 Lab. Technicians, 2 X-ray technicians, Physiotherapist, Social Worker etc. One lady MO is on medical leave for over 6 months. There are no paediatricians and ENT specialists. The services of ortho-surgeons are placed alternatively at the Villupuram hospital.

The average daily OP is 2,264 and in-patients is 126 (> 100% bed occupancy). During the past 10 months, 141 major surgeries including 119 sterilisations and 830 minor surgeries were performed. The SDH received 18 referral cases and 123 direct cases for deliveries. The SDH referred out 5 cases due to non-availability of blood, 2 cases due to non-availability of ultrasonogram and 2 for other reasons. The SDH conducted 147 deliveries including 9 caesareans. A total of 39 newborn were < 2.5 kg and there were 3 Still Births.

The SDH attended to 38 snake bite cases and 169 dog bite cases. The SDH has referred 137 cases to higher institutions (Puducherry), The SDH is conducting weekly special clinics for ANC (70 patients), Hypertension (1585), diabetes (1465) and Epilepsy (752). The case load for x-ray technicians was 2 x-rays/day and one ECG/ day.

The lone ambulance is off road for several months. The SDH has 60 audit objections. The Sub-District hospitals are relatively neglected with lack of general cleanliness, water stagnation in low

level pockets in the campus, stray pigs/ dogs/ cattle in the campus due to non availability of security staff etc.

Salem District

SHC Manjakuutai

The SHC is functioning in government building with one ANM and two contractual staff (VHW Rs.500/month & Aya @rs.100/ month). The SHC is covering population of 3415 with 538 eligible couples. The daily OPD attendance was 15 to 20. The ANC is 44 and only one delivery is conducted in the past 11 months in the morning hours. The ANM is not staying in the quarters as there is water logging, roof leakages, and non-availability o f water supply.

Of the 36 deliveries in past 11 months 8 were third child and there were none over 3 births. The JSY payments were update for deliveries in PHC and the last JSY payment for the deliveries in the hospitals was for the delivery on 26.5.2007 (pending cases - 14).

The ANM record maintenance is very good and she could prompt in details of each family in her area even though the ANM field visits dairy is not maintained. The visitors and supervisors visits register and attendance register are not opened.

Drugs were available in surplus and IUD & EC Pills were not available. Stocks of Gloves (5prs) received yesterday with Exp. in Dec. 2008. VHSC committees is meeting regularly and fund utilised for - Rs.500x2 cases for transportation of high risk pregnancies , transportation of immunisation cases from villages to PHC Rs.500 x8, contractual VHSC attendant Rs.500x8 and Aya Rs.100x8 and milk & biscuits for VHN camps Rs.112x8.

SHC Semianatham

The SHC is functioning in govt. building with one ANM and two contractual staff (VHW Rs.500/month & Aya @rs.100/ month). The SHC is covering population of 4,278 with 684 eligible couples. The OPD attendance was 15 to 18 and not maintained after 18th Nov. 2008. The ANC is 56 and 13 deliveries conducted in the past 11 months in the SHC working hours. The ANM is not staying in the quarters as there are roof leakages.

Of the 56 deliveries in past 11 months 7 were third child and there were none over 3 births. The JSY cases were 128 and last JSY payment was on 23 May 2008. .The ANM record maintenance is not good as the ANM dairy, EC register, family registers etc were not available and no entries for past few months. The visitors and supervisors visits register and attendance register are not opened.

The drug stock register is not available. Drugs were available in surplus and EC Pills were not available. Stocks of Gloves (9prs) received yesterday with Exp. in Dec. 2008. There is a stock of over 5000 tab of IFA with exp. date of Mar. 2009 (Mfg date 2007)

VHSC committees is meeting regularly and fund utilised for - transportation of immunisation cases from villages to PHC Rs.350 on 27th Aug., contractual VHSC attendant Rs.500x8 and Aya Rs.100x8 and milk & biscuits for VHN camps Rs.112 up to Aug.2008. There were no entries in the Register even though payments were made for all the above purposes.

PHCs

The 2nd CRM team visited 6 PHCs namely Sarkar Kollapatti, Tharamangalam, Nangavalli, Iruvelpattu, K.R.Thoppur and Pagalpattu and **Valavanti** in Salem District.

All the PHCs are provided with additional Staff Nurses and made functional for 24x7 services. The PHCs are provided with 1 – 3 MOs, 3 staff nurses, pharmacist, lab. technician, ANM and driver. The PHCs are well equipped with ILR, Deep Freezers, Sterilisers, Autoclaves, Semi/Auto analysers, calorimeter and other lab. equipments. All the PHCs are provided with Generators, emergency lights, water filters etc. The PHCs are having patient's privacy by provision of curtains, cots, mattresses in good condition. The linen supplies seem to be inadequate as three sets only are provided per bed and during the rainy season the supplies are inadequate. The EC Pills and IUD are available but the off take is very low. The VHNs are to be sensitised regarding the long life of the new IUDs supplied.

The average daily OP attendance is 60 to 230. The average monthly deliveries in these PHCs ranged from 20 to 40 and there is substantial increase of over 100% in comparison to the previous year. All the Postnatal women are being discharged after 2 days stay and diet is supplied through SHGs. During the past three years, the domiciliary deliveries decreased by 30 %.

The JSY payments have a backlog of 2 to 3 months and in certain PHCs the payments are done immediately for the current month. All the pregnant women were screened by ultrasonogram and all the mothers interviewed stated that sex of the foetus was not revealed. However the outcome of delivery clearly indicates unfavourable gender bias for female child. The district administration is well aware of the issue and the Deputy Director (Health) at Salem filed 130 cases under PNDT Act.

The PHCs do not have linkages with referral SDHs and the emergency ambulance services contracted to NGOs by the Director of Medical Services. In general the staffs are reluctant to stay in the quarters as all the quarters are in need of major or minor repairs.

There is a need to review the quality and Quantum of TNMSC supplies as the upgraded PHC (30 beds) were provided with non-hydraulic OT Tables and accounted as high cost hydraulic table. At many facilities, the supplies are stocked up in the wards due to lack of storage facilities. Similarly the drugs manufactured in the year 2007 with expiry date of Jan.-Mar 2008 were received in December 2008. The surgical gloves with expiry date of Dec. 2008 were issued to SHCs on 1st Dec. 2008.

A large number of PHCs are being upgraded as 30 bedded facilities and it may be appropriate to upgrade the SDH as per IPHS (under Directorate of Medical Services) and avoid duplicating the facilities. The SDHs are invariably underutilised with very low bed occupancy and very few referrals from PHCs.

PHC Tharamangalam

The Block PHC is covering a population of 46,808 and 5 SHCs. The PHC is functioning with 3 MOs, 4 Staff Nurses (3contractual), PHN, 3 ANMs, Pharmacist, Ophthalmic Technician, Lab. Technician, driver and Group IV. The post of Lab. Technician is vacant.

The PHC is provided with all essential equipments including baby warmer, foetal Doppler, phototherapy unit pulse oximeter, generator, refrigerator, autoclaves, steriliser etc. The AYUSH clinic is collocated in the PHC. The dental services are outsourced on payment of Rs. 500 / day to the dental surgeon and Rs.250 to the Dental Assistant.

During the year 2008-09 (Jan-Oct), there is visible increased acceptability of the facility as the OP load was 59,121 (80,352 for 2007-08). The monthly average of in-patients increased from 15 (2007-08) to 21 (2008-09). The number of deliveries / month has doubled during 2008-09 from 18 to 36 mainly due to shifting of delivery cases from SHCs to PHC. Annually over 900 deliveries are conducted in the PHC, 161 pregnant women registered with in the PHC population and 6 high risk pregnancies were referred to hospitals. the year 2007-08. The JSY beneficiaries were 154 and the payments were done to 39. due to non-availability of funds. The lone ambulance is off road. The Sex Ratio is 879. The Ophthalmic Technician is visiting all the POHCs in the block on weekly basis but not maintaining Blindness Register.

PHC Sarkar Kollapatti

The Block PHC covering 50,543 populations was recently upgraded as 30 bedded facility. The PHC is functioning with one six MOs including one ophthalmologist, four Staff Nurses, one ANM, one pharmacist, one Lab. Technician, one health worker (male), one driver and two group D staff.

The OP attendance was 115. During the year 2008-09 (Jan-Nov), there is visible increased acceptability of the facility as the OP load has increased from 18,669 to 24,658. There were 21in-patients. The average monthly admission of in-patients is 123 in comparison to 69 during 2007-08. In comparison to 2007, the PHC deliveries increased by12% for the year 2008. Amongst the 495 deliveries (Jan.-Nov.2008), 418 were 1st or 2nd child, 62 were third child, 9 were fourth child and 6 were fifth child in the family. As per the records the birth weight of 495 live newborn (Jan.-Nov.2008) was

< 2.5 kg.	Female 64	Male 58
≥ 2.5 kg	Female 188	Male 188
Total	243	252

Even though the pharmacist is posted, the expiry date calendar for drugs is not maintained. The pharmacy main store short expiry stocks of drugs e.g. 1700 tablets of Acyclovir 200mg expiry date Mar. 2009 and the monthly consumption of less than 30.

All the VHN from the SHCs assembled in the PHC for the weekly immunisation day as the routine immunisation is discontinued at all the SHCs. The JSY payments for August onward are pending due to non-availability of funds. The contractual staff nurse was unaware of the temperature settings for the baby warmer made available at the PHC.

PHC Pagalpatti

The PHC is functioning with 2 MOs, 3 Staff Nurses, ANM, 3 Health Worker (male) pharmacist, Lab. Technician, driver and 2 Group IV staff.

PHC K.R. Thoppur

The PHC is functioning with 2 MOs, 3 Staff Nurses, ANM, 3 Health Worker (male) pharmacist, Lab. Technician, driver and 2 Group IV staff.

PHC Nangavalli 3 SHC Available 2 ANM

The PHC is functioning with 2 MOs, 4 Staff Nurses, PHN, 6 Health Worker (male) pharmacist, and 5 Group IV staff. Lab. Technician and driver are not available.

District Hospital Mettur (Salem)

The District Hospital (est. 1927) at a distance of 65 km from Salem is mainly catering to the urban population of Mettur town and the underserved inaccessible hilly areas.The 200 bedded hospital is functioning with 143 staff including 15 MOs with specialist qualifications – Obst. & Gynae. 3 + 2 contractual, Paediatrics 2+1 contractual, Anaesthesia 2, Medicine 1, Surgery 2, ENT 1 and Ophthalmology 1. There are 36 Staff nurses including four contractual, 2 x-ray technicians, 5 Lab. Technicians including two for AIDS control and one for RNTCP. The Lab. is adequately equipped with Semiautomatic Analyser, Electrolyte Analyser, Cell counter, calorimeter, Hot air oven etc. During October 2008, 11,418 investigations (381 / day) were done. All the lab. equipments and both the X-ray machines (300MA & 100MA) are in good working condition. The Blood Bank is fully functional and at the time of the visit a young patient was being given blood transfusion for thalasemaia. The pharmacy has adequate supplies and the MOs expressed that there were no shortages. There were 4 ambulances, one mortuary van and two other vehicles. The generator is also functional. The hospital premises were kept very clean with meagre 10 sweepers. The Nursing supervisor expressed that the 36 nurses are adequate.

The daily OP attendance is around 1,300 and the annual OP is 5.18 lakhs. The daily admissions is 29 -32 / day. There were 170 in-patients and the patients were fully satisfied with the services including diet and emergency transport. Annually 4,000 operations are performed. Annually the hospital receives over 500 snake bite cases and over 1500 dog bite cases.

There were three patients in the Labour room. During the last month 94 deliveries were conducted and 32 of them were Caesareans and 32 were Episiotomy deliveries. The low normal deliveries are due to the high load of patients coming from hill areas inaccessible by road. One of the patients was carried in a basket for 3 hours down the hill. Of the 98 delivered women, 16 were anaemic and four cases of PPH. As per the records the birth weight of the 94 live newborn was

<	2.0 kg.	5
2.0	- 2.49 kg.	4
2.5	- 2.99 kg	19
3.0	- 3.49 kg	48
3.5	- 3.99 kg	14
>	4.0 kg	2

Amongst the 94 live births there were 55 male babies and 39 female babies indicating very adverse sex ratio in the newborn. During the past eleven months (Jan.-Nov.) 129 cataract operations were performed. The NRHM funds were fully utilised for purchase of cots, mattresses, aseptic furniture, IEC boards, minor civil works etc.

Krishnagiri District

3rd December – 5th December

The Krishnagiri District is the westernmost district of Tamilnadu with large tribal population in the relatively underserved hill areas. As per 2001 census, the total population is 15.46 lakhs with a rural population of 12.92 lakhs residing in 2464 villages. The rural population constitutes 15 % of the district population. The sex ratio is 944.

Health facilities

1	District HQ Hospital	1
2	Sub- District Hospitals	5
3	PHCs (all PHCs are 24x7)	37
	Upgraded (30 Bedded)	4
	Upgraded (24 Bedded)	3
	PHCs with functional OTs	6
	PHCs with AYUSH facilities	10
4	SHCs	238
5	Blood Bank	1
6	C Em O N C	2
7	B Em O N C	10
8	Mobile Medical unit	2

As per the state HMIS, the institutional deliveries are 91%, Full Immunisation (0-12 months) is 98 %, IMR is 26.5, Still Birth is 10.5, MMR is 26.5 and Couple Protection Rate is 42.8 As per the NFHS – III, the IMR is 45.7, Still Birth is 19.0 and MMR is 1.5. The number of deliveries increased considerably during the year 2008-09 except in one PHC as detailed below -

The Private health sector facilities include 23 hospitals / nursing homes, 32 clinics, Nursing School and four paramedical institutions (2 each for pharmacy & Lab. Technician courses).

SHCs

The team visited seven SHCs namely Sathanur, Balagoondapalli, Sesurajapuram, Bathigounder, Noganur, Pennagar, Kandakanapalli in Dharmapuri district and the following are the observations.

The referral transport is arranged for complicated cases by utilising the VHSC funds and local arrangements with community leaders/ PRI presidents. The stocks are adequate or surplus for drugs, ORS, delivery table, weighing machines, BP instrument, stethoscope, Uristix, torch light, hub cutters, IUD, Condoms. In few of the SHCs surplus drug stocks are noticed (3 to 10 year's stocks). The eligible women were being motivated and referred to the PHCs. The MOs are visiting the SHCs occasionally.

The number of deliveries at the SHC reduced drastically to less than 20 % to that of previous year. The male Health Worker is not available at the SHCs. Most of the SHCs are locked as they are away to the PHCs or accompanied the pregnant women or on other duties. The ANMs are available in their respective SHCs for one or two days only at the SHCs. The ANMs expressed that there is not much work to do at the SHCs as the Immunisation services and deliveries are shifted away to the PHCs and they have to accompany the pregnant women and children to the PHCs. The ANMs staying earlier at the SHCs are no more residing in the quarters.

There is substantial increase of deliveries in the PHCs as the pregnant women are encouraged to go to PHCs and as a result the deliveries in SHCs decreased substantially. The pregnant women are being accompanied by the VHNs to the PHCs for the deliveries. The SHCs are within a travel distance of 15 to 20 minutes. The farthest village covered by the SHCs is at a distance of 4 to 8 kms.

VHSC committees are constituted but meeting are held as when funds are available. The untied funds to SHCs and VHSC funds were received but partly utilised. Most of the ANMs are unaware of the guidelines and accounting procedures. The ANMs are maintaining all the registers but entries are delayed by months in the OPD register, ANM dairy, EC register etc and no entries for past few months. The supervisor's visits register and attendance register are not opened. The drug and other stock register are not available. The earlier focus on family planning activities is diluted.

SHC Sathnoor

The SHC is covering a population of 5,498 residing in 12 villages. The EC is 956 and 650 have adopted permanent methods, 192 EC are having less than two children. 22 women have undergone sterilisation operation during Jan. - Nov 2008. The SHC has a stock of 8138 tablets of paracetomol and the monthly consumption is over 400. The SHC has stock of 176 tablets of Methergin and for monthly consumption of 11. The VHN is convenor of three VHSCs and each one of the VHSC are covering over four villages. All the VHSC met two to four times in the past eleven months. Each of these VHSCs incurred the expenditure of Rs. 1500 for repair of drainages, Rs. 800 for procurement of phenyl, Rs. 300 for spraying operations, Rs. 2000 for cleaning of water tank in the village, Rs. 1000 for procurement of bleaching powder.

SHC Belagoodapally

The SHC is covering a population of 7,562 residing in 9 villages. The EC is 1572 and 1136 families have adopted permanent methods and 42 women have undergone sterilisation operation during Jan. - Nov 2008. During the year 2007-08, the ANM conducted 27 deliveries in the SHC and during the current year 3 deliveries only were conducted as all the patients were advised to go to PHC for ensuring the 72 hours stay during postnatal period. The ANM stated that she incurs an expenditure of Rs, 5000 and subsequently claims the amount as advised by Block PHC. The money is drawn from the bank through with drawl slip. She was advised to obtain cheque book from the bank and payments can be by cheques. The statements of income and expenditure are not maintained. The VHSC has met regularly on monthly basis.

The SHC has surplus stocks - 8,138 tablets of paracetomol for monthly consumption of around 400 and 176 tablets of Methergin for monthly consumption of 11. The VHN is convenor of three VHSCs and each VHSC is covering over four villages. All the VHSC met 2 to 4 times in the past eleven months. Each of these VHSCs incurred uniform expenditure of Rs. 1,500 for repair of drainages, Rs. 800 for procurement of phenyl, Rs. 300 for spraying operations, Rs. 2000 for cleaning of water tank in the village, Rs. 1000 for procurement of bleaching powder.

PHCs

The 2nd CRM team visited three Upgraded PHCs with 30 beds (CHCs) and two PHCs namely Kelamangalam, Thally, Anchetty, Rayakottai and Baladhoddanapalli. in Krishnagiri district. All the PHC premises have a new look as the minor civil works were attended, new tiles laid, water supply ensured and generators provided.

The PHCs are functioning with one or two MOs and the 30 bedded PHCs are functioning with 3 to 5 MOs. All the PHCs are provided with 3- 4 Staff Nurses including three contractual, 1-2 Lab. Technicians, one pharmacist. The vacancies of pharmacists, drivers etc are in the tribal area PHCs as the incumbents are transferred without substitutes.

All the PHCs are provided with adequate Lab. equipments, Generators, water filters, ILRs, deep freezers sterilisers, autoclaves etc. The drug supplies are adequate in all the facilities and surpluses are a common feature and none of the PHCs are maintaining expiry date calendar. The EC Pills and IUD are not available.

During the year 2008-09, there is notable increase in number of out-patients, in-patients, deliveries in many of the PHCs and this is mainly due to the diversion of the cases from SHCs to the PHCs. All the Postnatal women are being discharged after 2 days stay and diet is supplied through SHGs. The JSY payments are pending for 3 months except that the payments are done at the time discharge during the CRM visit.

Deliveries - 2007 & 2008 (Jan. to Nov.)

	PHC	Number of Deliveries Jan. – Nov.			Monthly average Jan.– Nov.		
		2007	2008	Increase	2007	2008	Increase
1	Rayakottai	145	214	69	18	27	9
2	Kelamangalam	546	484	160	41	61	20
3	Thally	282	374	92	35	47	12
4	Baladhoddanapalli	73	138	65	9	17	8
5	Anchetty	228	356	128	29	45	16

The out-patient and In-patient load in the PHCs visited by the team (2007 and 2008 - Jan. to Oct.) are as detailed below -

	PHC	**Out-Patients (Nos.) Jan. –Oct.**			**Monthly average Jan. – Oct.**		
		2007	**2008**	**Increase**	**2007**	**2008**	**Increase**
1	Rayakottai	23845	24947	1102	114	119	5
2	Kelamangalam	48864	63471	14607	233	302	69
3	Thally	18669	24658	5989	89	117	28
4	Baladhoddanapalli	12869	15740	2871	61	75	14
5	Anchetty	29683	29378	- 305	141	140	- 1
	All PHCs in District	891889	970604	78715	115	125	10

	PHC	In-Patients (Nos) Jan. – Nov.			Monthly average Jan. – Nov.		
		2007	2008	Increase	2007	2008	Increase
1	Rayakottai	263	295	32	38	42	4
2	Kelamangalam	517	1965	1448	74	281	207
3	Thally	483	859	376	69	123	54
4	Baladhoddanapalli	110	306	196	16	44	28
5	Anchetty	361	496	135	52	71	19
	All PHCs in District	12501	20662	8161	48	80	48

There is general reluctance to stay in the quarters as the quarters require major or minor repairs. There is a need to review the quality and Quantum of TNMSC supplies as surplus stocks are a common feature and drugs manufactured in the year 2007 with expiry date of Jan.-Mar 2008 were received in December 2008. The surgical gloves with expiry date of Dec. 2008 were issued to SHCs on 1st Dec. 2008.

A large number of PHCs are being upgraded as 30 bedded facilities and it may be appropriate to upgrade the SDH as per IPHS (under Directorate of Medical Services) and avoid duplicating the facilities.

PHC Anchetty (Tribal area)

The PHC covering a population of 51,348 with 20% tribal and the catchment area includes the neighbouring areas of Karnataka State. The PHC building was renovated and upgraded as 30 bedded facility and is functioning with 4 MOs (2 posted one week back & one returned from maternity leave), 4 contractual Staff Nurses, one CHN, one driver and 2 Group IV staff. The posts of Pharmacist and Lab Technician are vacant. During November 2008, the PHC was functioning without any doctor. The knowledge of IUDs & EC Pills is poor and there is underutilisation of available stocks.

The PHC is having adequate supply of drugs except Mesoprestol and provided with equipments including x-ray machine and ultrasound machine. The PHC building is recently renovated and maintained very clean.

The OP services were utilised by over 29,000 per year during the past two years. There is considerable increase in of in-patients during 2008 (monthly average of 71 from 52 during 2007). The monthly deliveries at the PHC have also increased from 29 to 45 and the increase is primarily due to shifting of delivery cases from SHCs to PHC for ensuring 72 hrs stay in health facility. During the last one month doctor was not available and the services including deliveries were being conducted by the Nurses.

The ultrasound machine available and the MO trained in scanning. The MO I/C popular with the clients and well respected. The X-ray facility is available with trained personnel for exposing the films. The Sex ratio is 937 which is much better than the tribal districts of the state.

The Untied funds were well utilised and accounts maintained. The JSY backlog is 2 months only and payments are released for new cases along with backlog cases.

PHC Rayakottai

The PHC is covering a population of 33,042 and 6 SHCs with one MO (MD general medicine), three staff nurses including 3 contractual, one ANM, one pharmacist and one Lab. Technician. The MO, ANM and Hospital Worker are staying in the quarters.

The OP attendance was 135 and 30 deliveries are conducted per month. The PHC is conducting weekly clinics for ANC (Tuesday), Immunisation (Wednesday), Hypertension & Diabetes (Thursday) and RTI (Friday). The PHC was sanctioned for six beds and there were nine beds in place. There were three inpatients including two admitted for delivery. The average monthly admission of in-patients is 42. The sterilisation are not performed and no IUDs as well as Oral Pills,

The deliveries during Jan. - Nov. 2008 in the PHC increased from 153 to 272. During the November month, 30 deliveries were conducted including three episiotomy deliveries. The child births were 16 male and 14 female. There were 9 cases of third child births and one fourth child in the family. The birth certificates issued and JSY payments made at the time of discharge. The JSY payments are pending for 3 to 6 months.

PHC Kelamangalam

The Block PHC is covering a population of 78,916 and 14 SHCs. The PHC is functioning with 5 MOs, 4 Staff Nurses, ANM, 2 Pharmacists and Lab. Technician. Both the X-ray machines (300 MA and a00 MA are functional. On an average 4 – 5 X-rays are only taken by the Radiographer. The X-ray machine room is also a make shift store room for old cots, mattresses, new pillows, IV stands etc. There is lack of general cleanliness

During the year 2008-09 (Jan-Nov), there is visible increased acceptability of the facility as the OP load has increased from 48,864 to 63,471. The in-patients increase by 300%. The average monthly admission of in-patients is 281 in comparison to 74 during the year 2007-08.

The pregnant women registered with in the PHC population were 156 and 12 high risk pregnancies were referred to hospitals. As per the district data, during the period of Jan. - Nov. 2008, the deliveries in the PHC increased from 324 to 484. The PHC records indicated the number of deliveries were 546 for the year 2007-08. The JSY beneficiaries were 718 and the payments from August onward are pending (209) due to non-availability of funds.

PHC Thally

The 2nd CRM team visited the PHC along with Mission Director of Tamilnadu and the District Collector and other state / district officials. The Block PHC covering 50,543 population was recently upgraded as 30 bedded facility. The PHC is functioning with one six MOs including one ophthalmologist, four Staff Nurses, one ANM, one pharmacist, one Lab. Technician, one health worker (male), one driver and two group D staff.

The OP attendance was 115. During the year 2008-09 (Jan-Nov), there is visible increased acceptability of the facility as the OP load has increased from 18,669 to 24,658. There were 21in-patients. The average monthly admission of in-patients is 123 in comparison to 69 during 2007-08. In comparison to 2007, the deliveries in the PHC increased by12% for the year 2008.Amongst the 495 deliveries (Jan. – Nov.2008) the 418 were 1st or 2nd child, 62 were third child, 9 were fourth child and 6 were fifth child in the family.

The JSY payments for August onward are pending due to non-availability of funds. The contractual staff nurse was unaware of the temperature settings for the baby warmer made available at the PHC. As per the records the birth weight of 495 live newborn (Jan.-Nov.2008) was

< 2.5 kg.	Female 64	Male 58
> 2.5 kg	Female 188	Male 188
Total	243	252

Even though the pharmacist is available, expiry date calendar is not maintained. The pharmacy main store short expiry stocks of drugs e.g. 1700 tablets of Acyclovir 200mg expiry date Mar. 2009 and the monthly consumption of less than 30. All the VHN from the SHCs assembled in the PHC for the weekly immunisation day as the routine immunisation is discontinued at all the SHCs.

PHC Baladhoddanapalli (Thally Block)

The PHC is covering a population of 25,507 residing in 86 villages and supervising 5 SHC. The PHC is functioning with two MOs, 3 Nurses and one ANM. The Lab. facilities and services of pharmacist are not available. There is frequent and long spells of electricity failure. At the time of visit, the ILR temp. was $+6^0$ C, a clear failure of Cold Chain maintenance. The blood grouping sera are stored in refrigerator, however the temperature was too high due to power failure. The low capacity generator is adequate for emergency lighting only. The Ambulance is off road and the driver post is vacant for long time.

The OPD attendance was 127 and drugs are adequately supplied. The drugs are being dispensed by ANM as the pharmacist was transferred several months ago. During Nov. 2008, 2491 out-patients were attended to and 22 deliveries were conducted. All the deliveries were normal deliveries. The adverse sex ratio was apparent with 13 male babies and 9 female babies. During Jan.-Nov. the outcome of deliveries was 102 male and 87 female children. Of the 165 deliveries, 165 were 1^{st} /2^{nd} child, 16 were third child, 5 were fourth child and 3 were fifth child in the family.

Patient Welfare Society was constituted and the meeting were held by MO with 3 or 4 PHC staff members only. The amount of Rs. 2.5 lakhs received was fully and aptly utilised for purchase of cots, arresting ceiling leakages, civil works, painting, purchase of essential items such as autoclave, generator, motor for water supply, nebuliser, water filter etc. However, the accounts of untied funds, annual maintenance grant and others were maintained as a single account and expenditure incurred. The MO and Nurses were delivering services effectively in-spite of constraints lack of ambulance, pharmacist services etc.

Sub-District Hospital Denkanikottai (Krishnagiri district)

The 62bedded Sub-district hospital is functioning with 6 MOs possessing PG qualifications. There are no obstetricians and physicians even though anaesthetist, ophthalmologist, two surgeons, paediatrician and ENT specialist as well as dental surgeons were made available. The hospital is provided with 15 nurses (9 contractual), Lab. Technicians, Pharmacists and other health workers. The SDH buildings were completely renovated and equipped by utilising HSP and NRHM funds.

The lab. is adequately equipped with semiautomatic Analyser, cell counter, calorimeter, Hot air oven etc. During November, 4807 investigations (160/day) were done and 4 new HIV cases were detected. All lab. equipments and X-ray machines (300MA & 100MA) are in good working condition. The pharmacy has adequate supplies, expiry date calendar maintained and the MOs expressed that there were no shortages.

The In-patient facilities are underutilised as there were only 23 inpatients for the 62 beds. During the past 11 months 53 patients absconded without completion of treatment. During the past eleven months 373 deliveries were conducted with the adverse sex ratio (195 male and 178 female). There were five infant deaths.

Patient Welfare Society was constituted on 22.1.2007 and two meetings were held since then. The PWS (RKS) has Rs. 1,49,735 including public contribution of Rs.41,290. The total expenditure was Rs. 56,290 only for purchase of bed sheets, emergency lights, stethoscopes, water filter etc as the hospital has been provided with most of the equipments & other supplies through HSP.

Sub-District Hospital Hosur (Krishnagiri district)

The 270 bedded Taluq hospital is located on the National Highway - Chennai to Bangalore. The SDH is functioning with 113 staff including 15 MOs possessing PG qualifications in Obst. & Gynae. (4), Anaesthesia (2), Paediatricians (2), ophthalmologist and Dermatology. An additional four MOs were provided under HSP. As per the midnight census 129 patients are in the hospital. However there were 93 patients only available. The hospital is provided with 24 nurses including 8 contractual, 4 ANMs, 3 Lab. Technicians, 6 Pharmacists and others. The SDH lacks general cleanliness.

The laboratory is adequately equipped with Semiautomatic Analyser, Cell counter, calorimeter, Hot air oven etc. During November, the lab load was 16850 investigations including 146 sputum examinations with 17 being reported as sputum +ve for TB. Both the X-ray machines (300MA & 100MA) are in good working condition and the daily load was 5 per day. The pharmacy has adequate supplies, expiry date calendar in not maintained.

The In-patient facilities are grossly underutilised as there were only 93 inpatients in the 270 beds. On the day of visit 36 patients were absconding without completion of treatment. During Nov. 167 deliveries were conducted including 55 caesarean sections and 51 episiotomy deliveries. During the last one month, there were 89 minor surgeries, 19 cataract surgeries and 55 caesarean sections.

Patient Welfare Society was constituted on 7.4.2007 and four meetings were held since then, the last one on 25th April 2oo8. . The PWS received Rs.100000 and 19,900 public contributions. The funds were utilised for purchase of x-ray films, chemicals, kitchen vessels, torch lights, plastic buckets, surgical gloves etc.

District Hospital – Krishnagiri :

The daily average of out-patients is around 1500. There are 28 doctors of different specialities but there is no radiologist, pathologist and ophthalmologists. The Drug supply is from the TNMSC thorough monthly indents. The User charges for CT scan provides by TNMSC are collected directly by them. The DH has outsourced the sanitation of the hospital to an NGO with 10 workers round the clock. The maternity wards are all spick and span with the average number of deliveries of 15 to 20 per day. About 1/3rd end up in caesarean sections because of the high rate of referrals. PS @ 125/ month built keeping the acceptors for up to 3 days which is a sheer waste as the GOI manuals stipulate just 4 hrs post surgical stay There is no residential accommodation for any staff members.

The District Hospital established additional welfare society (KGHWSF) initiated by the collector by raising funds from the community and the monthly interest of Rs. 45000 on the fixed deposits is utilised for the hospital.

Mobile Medical Unit - (Thally Block, Krishnagiri district)

The Mobile Medical Unit is providing the outreach services in 50 tribal villages. The MMU is provided a Swaraj Mazda ambulance and only the MO and Staff Nurse are travelling with two cartons of medical supplies. The supply of a jeep or Maruti Gypsy vehicle would be adequate for this purpose. The MMU allocation of supplies was exhausted and the Block PHC is providing the drugs etc.

During past 11 months, 392 outreach camps were held and 10791 patients were attended including 5912 women. The local teachers and ICDS organiser were available as the camps are held in the local schools or Anganwadi centres. The respiratory infections constitute 27 %, fever case 10%, Diarrhoeas 15%. The MMU is leaving stocks of essential medicines with the teacher coming on week days. The population is underserved as the transport to PHC is by occasional bus service. The villagers have sought for weekly visit of MO or LHV in lieu of the monthly camps.

School Health - (PHC Baladhoddanapalli, Thally Block, Krishnagiri district)

The school health visits are scheduled on Thursdays for annual visits by MOS from the concerned area PHC. The Jalavagiri school health camp was held last year on 20th De. 2007 with a coverage of 15% of children (worm infestations -3, URL -4, anaemias – 3, scabies – 3, dental caries-4). The school has 193 children on its rolls and 166 were present on the day of school health camp. he Medical officer of PHC Baladhoddanapalli is conducting the camp and the services of CHN, attender and Anganwadi worker are utilised along with the VHNs in the SHCs are utilised. During the 2nd CRM visit on 4th Dec 2008, the MO examined 26 children till 11.30 AM and the disease pattern is same (worm infestations -7, URL -6, anaemias – 4, dental caries- 2). The drug supplies were adequate. The team was not provided with transport and presumably the team concluded the camp prior to the arrival of the infrequent bus service to the village. The PHC covering these schools does not have an ambulance and the driver.

UTTAR PRADESH

2nd Common Review Mission

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UTTAR PRADESH

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Introduction

a. Introduction of the state.

Geography

Uttar Pradesh is bounded by Nepal on the North, Himachal Pradesh on the north west, Haryana on the west, Rajasthan on the south west, Madhya Pradesh on the south and south- west and Bihar on the east. Situated between 23° 52'N and 31° 28 N latitudes and 77° 3' and 84° 39'E longitudes, this is the fourth largest state in the country. (A part of Uttar Pradesh has been separated and formed into a new state Uttarakhand on November 9th 2000. The details given here are before the separation).

Uttar Pradesh can be divided into three distinct hypsographical regions:

1. The Himalayan region in the North
2. The Gangetic plain in the centre
3. The Vindya hills and plateau in the south

History

Uttar Pradesh forms a major area of the Northern fertile plain or the Indo-Gangetic plain. This area is said to have been occupied by the group of people referred to as "Dasas" by the Aryans. The main occupation of these inhabitants were agriculture. Till BC 2000, the Aryans had not settled in this region. It was through conquest that the Aryans occupied this area and laid the foundations of a Hindu civilization. The regions of Uttar Pradesh was said to have been the ancient Panchala country. The great war of the Mahabharata between the Kauravas and Pandavas was said to have been fought here. Besides the Kurus and Panchalas, the Vatsas, the Kosis, Hosalas, Videhas etc formed the early region of Uttar Pradesh. These areas were called Madhyadesa. It was during the Aryan inhabitation that the epics of Mahabharata, Ramayana, the Brahamanas and Puranas were written. During the reign of Ashoka, works for public welfare were taken up. Having rich resources there was active trade within and outside the country. The rule of the Magadha empire brought Buddhism and Jainism into this region. This period witnessed administrative and economic advancement.

The Kushanas exercised their power over this region till 320AD. The territory passed into the hands of the Guptas during whose rule, the Huns invaded this region. After the decline of the Guptas, the Maukharis of Kannauj gained power. During the rule of Harshavardhana, Kannauj was an important city. After his rule political chaos set it. It was amidst this confusion that the Muslims invaded into Utter Pradesh though the society was dominated by the Rajputs, jats and other local chiefs. In 1016AD Mahmud of Ghazni laid his eyes on the wealth of Kannauj. He was followed by Mohammad Ghori. Throughout the rule of the Delhi Sultanate and the Mughals, the territory progressed. After the Mughals, the Jats, the Rohillas, and the Marathas established their rule. By 1803 the British controlled this region and annexed it by 1856. It was in the Uttar Pradesh (The period between 1857-58) that the first struggle

for liberation from the British yoke was unleashed. The revolt was suppressed and from then till independence it remained under British dominance. In 1950 the state was organized and named as Uttar Pradesh.

The state of Uttar Pradesh has an area of 240,928 sq. km. and a population of 166.20 million. There are 70 districts, 813 blocks and 107452 villages. The State has population density of 689 per sq. km. (as against the national average of 312). The decadal growth rate of the state is NA (against 21.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate.

Base line of Public Health System in the state

i. Infrastructure

Health Infrastructure of Uttar Pradesh

Particulars	**Required**	**In position**	**shortfall**
Sub-centre	26344	20521	5823
Primary Health Centre	4390	3660	730
Community Health Centre	1097	386	711
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	24181	21900	2281
Health Worker (Male) MPW(M) at Sub Centres	20521	5732	14789
Health Assistant (Female)/LHV at PHCs	3660	2128	1532
Health Assistant (Male) at PHCs	3660	4061	-
Doctor at PHCs	3660	NA	NA
Obstetricians & Gynaecologists at CHCs	386	123	263
Physicians at CHCs	386	123	263
Paediatricians at CHCs	386	13	373
Total specialists at CHCs	1544	413	1131
Radiographers	386	NA	NA
Pharmacist	4046	NA	NA
Laboratory Technicians	4046	NA	NA

Nurse/Midwife	6362	NA	NA

(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	16
District Hospitals	70
Referral Hospitals	
City Family Welfare Centre	
Rural Dispensaries	
Ayurvedic Hospitals	1771
Ayurvedic Dispensaries	340
Unani Hospitals	209
Unani Dispensaries	49
Homeopathic Hospitals	8
Homeopathic Dispensary	1482

HEALTH INDICATORS OF UTTAR PRADESH

The Total Fertility Rate of the State is 3.8. The Infant Mortality Rate is 69 and Maternal Mortality Ratio is 517 (SRS 2001 - 03) which are higher than the National average. The Sex Ratio in the State is 898 (as compared to 933 for the country).

S. No.	Item	Uttar Pradesh	India
1	Total population (Census 2001) (in million)	166.20	1028.61
2	Decadal Growth (Census 2001) (%)	NA	21.54
3	Crude Birth Rate (SRS 2007)	29.5	23.1
4	Crude Death Rate (SRS 2007)	8.5	7.4

5	Total Fertility Rate (NFHS-III)	3.8	2.7
6	Infant Mortality Rate (SRS 2007)	69	55
7	Maternal Mortality Ratio (SRS 2001 - 2003)	517	301
8	Sex Ratio (Census 2001)	898	933
9	Population below Poverty line (%)	31.15	26.10
10	Schedule Caste population (in million)	35.15	166.64
11	Schedule Tribe population (in million)	0.11	84.33
12	Female Literacy Rate (Census 2001) (%)	42.2	53.7

ii. The complete list of the facilities visited by the team shall be compiled in the following format to permit overall collation :

2nd Common Review Mission				
25th November to 5th December 2008				
Name of State			UTTAR PRADESH	
Names of Districts visited				
Sno	Name	District HQ	Name of DM	Name of CMO
1	Unna	Unnao		Dr. Sahni
2	Bahraich			
Health Facilities visited				
Sno	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	FRU	Nawabgunj	CHC	Dr. Chaudhary
2	District Hospital for Women	Unnao	Distt. Hospital	CMS
3	District Hospital for Men	Unnao	Distt. Hospital	CMS
4	Block PHC	Safipur	PHC	MO I/C
5	Block PHC	Fatehpur Chaurasi	PHC	MO I/C
6	Block PHC	Achalgunj	PHC	MO I/C
7	Addl. PHC	Roop Pur Chandel	PHC	MO I/C
8	Addl. PHC		PHC	MO I/C

9	SHC	Jamalpur	SC	ANM
10	Village	Dhannapur	--	Villagers
11 12	Village Village	Pichauda Sarai Katha	--	Villagers Community
13	Block PHC	Asoha		MO I/C
14	Addl. PHC	Kalukhera	PHC	MO
15	Sub centre	Kalukhera	Sub-centre	ANM
16	Block PHC	Hiloli	PHC	MO I/C
17	Sub centre	Kardhaha	Sub Centre	ANM

Chapter on the Mandate of CRM

The state team shall draft the mandate of CRM for respective state keeping in mind the overall mandate of 2nd CRM (as detailed in preceding paras in this note) and state specific issues which come up during the initial briefings and discussions with state officials. The state specific components in the mandate should be conscious of field realities and overall transactional capacities in the respective state. The mandate should

The following points were highlighted during the state presentation by the mission director:

Janani Suraksha Yojana: A significant increase in the number of beneficiaries over the three years of implementation but the presentation was silent about quality of care. No explanation available for reasons of poor performance by some of the districts, neither was it highlighted in the presentation.

First Referral Unit: Out of 108 functional FRUs in the state, 55 are in CHCs and 53 are in District Women's hospital. However the blood storage facilities are non existent at these FRUs. Anaesthetists and gynaecologists have been made available at the FRUs . Data not presented regarding the services delivered by the FRUs.

24x7 Delivery Sites: Similar to FRUs, 615 facilities have been made functional by the end of Oct. 2008. The criteria is that the facility is reporting night deliveries. But the during the

discussion regarding quality of care, the Mission Director agreed that there is no mechanism available to judge quality of care and he is not sure about it. However, in order to meet the short fall of doctors at these PHCs, particularly Lady Medical Officer (LMO), the mission has decided to recruit 428 lady doctors from Indian System of Medicine in order to post them at the 24x7 facility and given them adequate training in EmOC.

ASHA: ASHA scheme is the flag bearer of NRHM in Uttar Pradesh. 1,34,000 ASHAs recruited against a target of 1,35,0000. 79038 ASHAs completed 2nd phase of training. ASHA quarterly news letter, ASHA sammelan and annual ASHA awards are the highlights of the ASHA related activities. ASHA support system and ASHA mentoring group is being formulated. The problems of ASHA program are: demand by the ASHAs to be converted to regular paid employees. Overburdening of ASHAs with additional work is perceived. At present 16 specific tasks are assigned which is considered as beyond the capacity of an ASHA.

PRI participation: Regarding community ownership of the health program, several issues were highlighted. The panchayati raj system is not responsive enough particularly due to political appointments and corruption among the Gram Pradhans. Mechanism of social audit is extremely difficult to be implemented due to non existence of local level NGOs.

Routine Immunization: The state of immunization of under five children against vaccine preventable diseases is abysmal. The reasons identified are:

- Over enthusiasm and excess deployment of health personnel for Pulse Polio Immunization activity
- Too many rounds of pulse polio program is leading to lack of time for RI activities
- Irregular Vaccine Supply by Govt. Of India
- Reporting is of extremely poor quality
- There was no DPT vaccine available for 4 months and TT for 3 months in the previous year.
- Poor micro planning

Management of funds: Funds transfer to district level has been tied up with State Bank of India and being done electronically.

Findings of the 2nd CRM in the state based on the districts visited

DISTRICT: UNNAO

Infrastructure

District Hospital: The DH at Unnao is well maintained, immaculately clean. The campus is also well maintained with plenty of greenery. There was no littering of hospital waste in the campus. Even the wards were clean in spite of large patient turnover particularly in women's hospital. The DH has a patient load of about 400-600 per day. The women's hospital has 10 consultants and men's hospital has 9 consultants at present. About 10-20 deliveries are conducted per day; because of JSY, the number of deliveries has increased 3 folds in last on year. It has facilities like baby warmer, blood bank, laboratory with auto analyzer and X-ray and ultrasound facility. The disbursement of funds under JSY is very smooth and methodical. But the new born children were not given zero dose of polio and the BCG vaccine within 24 hrs of delivery.

Community Health Centre: We visited the Nawabgunj CHC in Unnao district. The CHC has adequate space, wards and manpower for its functioning. The OPD case load is about 65-70 per day. Bed occupancy is 70-80% on an average. Record maintenance and documentation is not proper at the ICTC and the laboratory except for the TB lab register.

Primary Health Centres: Uttar Pradesh has two types of PHCs. The PHCs situated at block are called block PHCs which currently are catering to about 1 20 000 to 1 50 000 population. In the districts we visited, these PHCs are run by MO I/C and an AYUSH LMO. The third MO is not posted. These PHCs function as 24x7 facility. Mostly deliveries are conducted by Staff Nurse and ANMs of the attached SC. The laboratory facility is grossly underutilized as only basic clinical investigations are carried out. Eventually all block PHCs will be converted into CHCs. Construction work is in progress.

The Additional PHCs are housed in new buildings with plenty of space and availability of facility. The OPD attendance is 10-15 per day. Further, the laboratory facilities are not utilized adequately.

Sub Health Centers: Sub centers are physically in bad shape, maintenance of old buildings is poor. However using the untied funds, repair and maintenance is likely to be taken up soon. Electricity and water supply are not adequate. Some of the sub centers, not having been able to meet the accreditation standards are not eligible for JSY scheme and hence are performing poorly.

Electricity supply is very poor and erratic across the state, thus hampering delivery of health care. Though generators are available but cannot be total replacement for regular power supply. Similarly improvement in public transport and water supply are important issues to be addressed.

Manpower:

ASHA: The visiting team interacted with ASHAs who had collected at the CHC, Nawabgunj, about 60 of them. The ASHAs were positive in their approach and were contributing significantly to implementation of JSY. But active involvement in other programs like routine immunization and family planning is relatively less. The ASHAs were not aware of maternal and infant mortality in the area. Two ASHAs could recall three maternal deaths in last two years. Infant deaths were not known to them. It appeared that the entire focus of ASHAs is on implementing JSY. ASHAs have started demanding for regular jobs instead of being voluntary workers. Most of the ASHAs were very motivated and carrying out their work sincerely.

In some places a conflict is arising between TBAs, ASHAs and AWW regarding institutional delivery. The AWW and TBAs rue the loss of financial benefit from conducting deliveries.

ANM: The ANMs were appointed mostly in 1980s. With 20 years of service, this work force is ageing and not able to perform as efficiently as they used to earlier. Some of them suffer from arthritis and other disabling ailments, thus reducing their work efficiency. Further, 2000 ANMS are going to retire in next three years, thus creating a huge deficit of ANMs.

Doctors: Medical Officers were available at all the facilities visited, namely PHC, Block PHC, CHC and District Hospitals. However not in full strength. For example at the Block PHC, Achalgunj one MO I/C and one ISM lady doctor were present, same was the situation at PHCs of Fatehpur Chaurasi and Safipur. However the Nawabgunj CHC and the district hospitals had adequate number of doctors.

However, multi skilling was not available, therefore any operative procedures could not be carried out in spite of having specialists (ophthalmologist, orthopedician) posted there. Doctors at block PHC and additional PHC had less experience in public health issues and managerial activities. Lack of anesthetists at all facility levels was a serious drawback. The ISM LMOs were not trained in conducting instrument assisted deliveries and repairing episiotomy. The LMOs pointed out that drugs of ISM are not available, they are prescribing allopathic drugs, which is unlawful. Private practitioners are not being approached for partnership with government health facilities.

Paramedical Staff: All facilities had pharmacists and lab technicians posted. Lab technicians are trained in RNTCP. Their work as well as record keeping is very efficient. At the same time

the record maintenance and documentation was very poor among ICTC counselors and lab technicians.

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

Village: It is about 2 years that ASHAs have been recruited. In all the villages that we visited (having a health facility as well as not having a health facility), ASHAs are well recognized faces. But their role is viewed as some one who will help get Rs. 1400/- per delivery at a health facility. The villager are aware of this monetary benefit but mostly do not know how institutional delivery is better than home delivery. The monetary incentive is the key factor here. Even the ANMs and Anaganwadi workers are well recognized in the villages.

Village Health & Sanitation Committees: VHSCs have been constituted and are meeting regularly. Several measures for improving the functioning are being taken.

Rogi Kalyan Samitis: RKS are functional at the district, CHC and block PHC levels. Minutes of the meeting suggested that several developmental measures are initiated by the RKS using the RKS funds, for example: waste management in the premises by hiring daily wage workers, plantation and greening of campus and maintaining the generator.

Project Management Unit: The process of setting up of project management unit has been slow in Uttar Pradesh. However, in both the districts, DPMUs have been established. PMUs have been created at block level as well, but the functioning is likely to take some time.

GLIMPSES OF HEALTH FACILITIES IN BEHRAICH DISTRICT

District hospital at Behraich is clean and well maintained. The ambience of the campus is good including plenty of greenery and also comprises of a committed team.

There has been improvement in health facilities during the last one year. The hospital is in process of accreditation by NABH (National Accreditation Board for Hospitals). Bed occupancy rate is more than 100%.

Disbursement of the funds under the *Janani Surakha Yojana (JSY)* is functioning very smoothly. Indoor patients have increased in manifolds and at the same time the institutional deliveries have also increased drastically.

Community health Centre i.e. RISIA has adequate space and manpower is also adequate. The OPD case load is about 150-200 per day, nevertheless the bed occupancy rate is quite low. Even the institutional deliveries are as low as compared to the block PHCs in the same district. No ICTC Centre, Immunization Services and DOTS Services are being provided in this Health facility.

CHC - Nala Para (FRU) is having no blood storage facility and moreover the power supply is erratic for which generator and invertors are available. Immunization sessions are not conducted at health facility, microscopy center for the TB is available under RNTCP but no DOT drugs are distributed at the facility. Diabetes, Hyper-tension and cancer service screening are not available. RTI and STI are also not available. Integrated Counseling Centers (ICTC) are not established at FRU. MTP services are not available. Family planning services need more focus.

PPC Nala Para mainly providing the ANC Services and Immunization Services is 500 meters away from the Nala Para FRU.

New PHC Jalwar Road is a New PHC. Infrastructure is well maintained. Two bedded hospital. Electric supply is erratic. Generators available in the PHC. Bio medical waste management services are not updated. There is shortage of staff nurses. There is no male health worker. Delivery load is more than the capacity available at the hospital. The capacity of the hospital and laboratory services is being strengthened. Adequate drugs are available. No ISM drugs were available. Laboratories are poorly equipped. Re-agents and consumables are in short supply. For the new PHC, funds are blocked at the block level. JSY beneficiaries are receiving payments in time. There is Inadequate utilization of funds at PHC (RKS untied and maintenance fund).

Primary Health Centre Kaisarganj: Here the infrastructure is old and requires repairs. New building is under construction. OPD patient load is very high. No referral transport services are available. Drug supply is adequate, institutional delivery load is very high. However the capacity of the PHC is having only 4 beds which require to be augmented. Laboratory services are inadequate. Male Health Worker posts are vacant. Bio-medical waste management facility is available.

Block PHC, Jalwar Road. Rogi Kalyan Samiti is established. There is shortage of human resources, particularly male health worker and staff nurse. No bio medical waste

management at the PHC. No referral transport system for the patient. Power supply is erratic. Institutional Delivery is very high but health facilities are inadequate for staying of the patients. Post partum care and follow up services, family planning and laboratory services are not adequate.

Services for basic non communicable diseases such as diabetes, hyper tension are not available. RTI, STI and ICTCs are also not available. Timely payment made to JSY beneficiaries. Electronic transfer of funds is available up to block level.

PHC Phakkarpur Infrastructure well maintained. Two bedded hospital. Electric supply is erratic. Generator available at the PHC. Bio medical waste management services are not available. The shortage of human resources. There is no male health worker. Delivery load is more, however, the facility at the hospital for stay is inadequate,. The capacity of the hospital needs to be strengthened. Laboratory services need to be strengthened. Adequate supply of drug, but no ISM drugs were available. Laboratory services are poorly equipped. Lack of re-agents and consumables. For the new PSC funds are blocked at the block level. Timely payment of JSY beneficiaries. Inadequate utilization of funds for PHC (RKS untied and maintenance fund).

Sub Centre, Kanchana has its own building. Delivery room is available and used for conducting deliveries. ANM is providing the outreach services and conducting the immunization and help in observing Village Health and Nutrition Day (VHND). Drugs are adequately available. Untied funds are available with ANM but not adequately utilized.

Villages. ANMs and ASHAs are well accepted and respected in the community. RKS formed up to Block PHC Level. RKS funds for new PHCs are held up at block level. Panchayati Raj Institutions (PRIs) are not uniformly involved in Village Health & Sanitation committee (VHSC). VHSC recently instituted but not yet active. Steps are being taken to activate VHSCs which is a good initiative. Immunization and nutrition services are provided twice in a week.

iii.iv. Comment of various ToRs of the 2nd CRM detailed in preceding chapters in this note.

CONCLUSIONS

- Mostly clean, green and well maintained dist. hospitals and CHCs and committed team
- Committed District Magistrate
- Excellent improvement during the last one year
- Very spacious HSC buildings .Lack electricity supply in some HSCs
- SHCs and PHCs need more maintenance
- Power supply is erratic. Generators and inverters available in most places
- Bio Medical Waste management needs attention

- Mobile medical Units not operationalised
- Accreditation of Bahraich DH for NABH is in process but not in Unnao
- Transport constraints for field workers and patients
- Shortage of Human resources at all levels
- Those in position work hard to deliver health care
- Acute shortage of MPW (M)
- Training process need fast tracking :multi skill training for doctors, IMNCI, IDSP, SBA training, ASHA training
- Limited promotional avenues for doctors and para medicals
- Post delivery stay in the facilities is very short- need monitoring system
- Shortage of space leads to compromise with quality
- Delivery load is more on few facilities
- New Born care services need strengthening
- Passive screening for communicable diseases needs to be strengthened
- Active screening for communicable diseases (Malaria) needs more attention
- Postpartum care and follow up of FW operated cases in the field.
- Integrated vector control measures and surveillance of diseases - weak
- Basic non communicable disease screening fixed day services needed at District Hospital level/ FRU – Diabetes , Hypertension clinic, cancer cervix screening
- RTI/STI clinics
- Integrated counseling and Testing Centres needed in all 24 x 7 facilities
- Poor voluntary blood donation – insisting on relative donor
- Institutional deliveries improved
- Awareness on MCH services very high in the community
- Adequate drug supply but no ISM drugs
- Poor availability of MTP/ MVA services
- FP services- focus needed for mini lap/ counseling for puerperal sterilization- more centres needed for provision of tubectomy services
- Convergence needs more attention
- Lab services at peripheral centers poorly equipped – Lack of reagents and consumables

- ANMs and ASHAs are well accepted and respected in the community
- RKS formed up to Block PHC level. RKS funds for new PHCs held at block level
- PRIs not uniformly involved for VHSC
- VHSC recently instituted but not yet active
- Steps taken to activate VHSCs – 2nd October- good initiative
- Clear Guidelines for the use of funds
- Electronic transfer of funds up to block level
- Timely payment to JSY beneficiaries
- Inadequate utilization of funds in some health facilities (RKS, Untied and maintenance funds)- Dental clinic in Kaisarganj hospital

RECOMMENDATIONS

1. Manpower deficit should be addressed urgently. Mapping of human resource and redistribution is required. More doctors, staff nurse, Public Health Nurse, Pharmacists need to be recruited. General duty medical officers with public health expertise and management skills are to be posted at primary care facilities. For this creation of a public health cadre is very justified. As the clinicians and specialists currently posted at various facilities are neither able to provide specialist services due to lack of facilities not able to implement national health programs and provide leadership to public health team due to lack of managerial skills.
2. The doctors posted at most of the facilities are either specialists or MBBS with clinical orientation. They lack understanding of public health perspectives and integrated approach to health care.

   ANMs recruited in 1980s are old now and not able to deliver with efficiency of young women. A large number of them are going to retire in next couple of years. It is the right time to tackle this issue before a new human resource crisis emerges in this segment. ANMs having become an experienced work force, require to be promoted to supervisory levels and new young ANMs need to be recruited in order to improve field work.
3. It is recommended that public health specialists and specialists in community medicine/family medicine should be posted at the primary health care facilities. They will be able to take care of primary health care needs of the community, implement national health programs and provide managerial/administrative leadership to his team of primary health care. Creation of a separate public health cadre will be able to fulfill this need of public health managers at various levels of health care facility.
4. Training program for MPW(M) and diploma courses for nurses in Maternal and New born care as well as career progression scheme for them may improve their functioning.
5. The working conditions and incentives for working in rural area should be so rewarding that it does not make the incumbent feel disadvantaged compared to his/her counterpart working in urban areas and private sector.
6. Provision of interest free loans for buying moped/two wheelers or providing mopeds may improve out reach service delivery component of primary health care.
7. Community participation and community ownership is grossly lacking. People are not aware of their rights and responsibilities. Sensitization and awareness generation among the people need to be improved, particularly in rural areas. The signage showing citizens charters and informing people about salient features of programs like *Janani Suraksha Yojana* or *Saloni Abhiyan* should not be restricted to health facilities. These need to be displayed in villages and prominent market places as well.
8. Monitoring and supervision is another area that needs to be improved. With aging and retirement of LHVs, supervision process is diluted. Through promotion of ANMs and recruitment of new LHVs, this can be taken care of.
9. Shortage of Male Multi Purpose Worker also need to be addressed.
10. Political interference in manpower recruitment as well as in day to governance is a great hindrance in smooth functioning of health care system. Even the involvement of *Panchayati Raj Institutions* has proved counterproductive in some areas, particularly when it becomes a key determinant in recruitment and transfer of workers, protection of erring workers. Mass media campaigns should also be used to inform the community about the facilities created under these new programs and their benefits.

11. Safety and security of ANMs and other female workers is a matter of concern in some areas. There are plenty of instances of manhandling and molestation of single female workers in the field area and the culprits getting away with.
12. Rationalization of services at different levels following IPH standards is recommended.
13. Neonatal referral units to be provided in all district hospitals and basic new born care units in all CHCs and 24x7 facilities should be made available.
14. Postpartum care need to be strengthened and closely monitored.
15. Mortuary facility and postmortem services to be provided in more facilities in a phased manner.
16. Establish modern blood bank with blood component separation units.
17. Rapid implementation of IDSP should be ensured.
18. Some of the facility buildings are located far from the villages, in a remote isolated corner, thus making it less accessible and a deterrent for ANM to stay there.
19. With the financial incentives being paid to the beneficiaries for services availed, an opportunity presents itself: availability of validated output indicators. A major deficiency of public sector programming, namely availability of only process indicators, can now be overcome. The ability to determine performance of individual providers and centres can become a very useful management tool for strengthening the programs in the time ahead.
20. With JSY gaining rapid acceptance, the number of obstetric emergencies being brought to the institutions will also go up. The system needs to get itself ready for these cases.
21. Non communicable diseases control program and vector borne diseases control programs are not yet being implemented at the peripheral level. This needs to be strengthened.
22. Nutrition supplementation, nutrition rehabilitation and provision of food for mothers after delivery and after tubectomy operations should be made at all facilities where these services are being provided.
23. NABH accreditation of district hospitals and CHCs should be done in phased manner.
24. Better monitoring and supportive supervision of all programs should be ensured by monthly review by district magistrates, use of structured inspection forms and follow up schedules.
25. Rapid grievance redress for staff and beneficiaries should be ensured.
26. Community participation and social audit should be encouraged.

2. Chapter on other State Specific issues

This chapter may include observations, suggestions on issues not covered in any other chapter of the report .

The State has taken following new initiatives and innovative programs within NRHM framework.

A. **Saubhagyavati Yojana:** This a Public Private Partnership, in which 133 nursing homes have already been registered in peri urban and rural areas. For every 100

deliveries conducted by any nursing home of BPL beneficiaries, Rs. 1.85 lacs will be paid. So far 2230 such deliveries have been conducted including 317 cesarean section.

B. **Comprehensive Child Survival Program:** Under this scheme IMNCI training is being given to ASHAs, ANMs and other workers with the help of FOGSI. Currently this scheme is operational in 17 districts spread over 17 divisions. So far 458 MOs, 812 ANM/HV & 4068 ASHAs have been trained. Training in Infant & Young Child Feeding is also conducted under this program in all the districts.

C. **Bal Swasthya Poshan Mah Strategy:** This is a month long program to be conducted twice a year. The first such program will be held in December 2008.

D. **ASHIRVAD School Health Program**: In this program, 50 lac children will be covered. The program launched on 1 October 2008 will cover 40 schools per block in all 813 blocks. This will comprise of health check up, health card for every student, and distribution of deworming drugs and Iron Folic Acid Tablets.

E. **Village Health & Nutrition Day:** To be observed twice a week at each health facility on Wednesday and Saturday. The activities will have emphasis on routine immunization and nutrional rehabilitation.

F. SALONI: Swasth Kishori Yojana: This scheme is being launched from 12 December 2008 which will cover 10 lac school going girls and 5 lac non school going girls in 10 to 19 years age group. The non school going girls will be covered by locally selected NGOs. The package will consist of counseling and personal hygiene and distribution of Iron & Folic Acid tablets and deworming drugs.

G. Scheme for Adolescent Counseling for Health: In order to provide information and counseling to 15 to 19 years of adolescents regarding reproductive & sexual health, nutrition and personal hygiene. The scheme is currently being implemented in 18 districts. The counseling centers will be opened at sub center level as Youth Information Center, at block level as Youth Information and Counseling Center (1 male and 1 female counselor), and at district level ICTCs will carry out this function.

Problems and constraints specific to the state of Uttar Pradesh

- Late start of implementation of NRHM in the state
- Large amount of allocated fund remained unspent
- IDSP has yet to take off. Training not provided at block and lower levels.
- Routine immunization is extremely poor
- The family welfare campaign is not performing up to the mark in terms of IUCD insertion, condom distribution and oral pills promotion.
- The panchayati raj institution system is not very supportive of the health programs
- The doctors at the grass root level are not trained in managerial skills and do not have enough knowledge of public health activities.
- Most of the peripheral staff are clueless about where to use the untied funds, RKS grant and annual maintenance grant.
- Record keeping and documentation is extremely poor at all levels
- Gross deficiency of staff at all levels
- Political interference in transfers
- Feeling of insecurity and vulnerability of female staffers living alone in rural areas
- Erratic and inadequate electric supply

- No Mobile Medical Units
- Lack of promotional avenues and rewards for working in rural areas are demoralizing for rural staff
- Communication with the community is poor
- No MTP services available
- Poor convergence, funds are still received under various vertical programs instead of unified funding
- Even presence of three separate funds, namely RKS fund, untied fund and annual maintenance grant increase confusion
- Non communicable diseases control program are not even started