Third

Common Review Mission

State Report

Gujarat

Report of the 3rd Common Review Mission Team's visit to Gujarat
(3-10 November 2009)

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1. Introduction

1.1 Introduction to the state :

PROFILE OF THE GUJARAT

2. Geography

Gujarat State

Gujarat is situated between 20°1' and 24°7' north latitudes and 68°4' and 74°4'east longitudes on the west coast of India. It is bounded on the west by the Arabian sea, on the north-west by Pakistan, on the north by Rajasthan, on the east by Madhya Pradesh and on the south and south-east by Maharashtra.

The state of Gujarat occupies the northern extremity of the western sea-board of India. It has the longest coast line 1290 km among Indian states. The state comprises three geographical regions.

1. The peninsula, traditionally known as Saurashtra. It is essentially a hilly tract sprinkled with low mountains.
2. Kutch on the north-east is barren and rocky and contains the famous Rann (desert) of Kutch, the big Rann in the north and the little Rann in the east.
3. The mainland extending from the Rann of Kutch and the Aravalli Hills to the river Damanganga is on the whole a level plain of alluvial soil.

3. History

Gujarat forms an area that housed the regions of the Indus Valley civilization and Harappan sites. Around

50 Harappan sites are found in Gujarat. Lothal, Rangpur, Amri, Lakhabaval, Rozdi etc. are some of these sites. This makes it an important territory that reveals the history of India. The Dravidian tribes were said to be the original inhabitants of this region. Even before the Aryan occupation of Gujarat it is said to have had trade contracts with Sumer, the Persian Gulf in about 1000-750BC. Rock edicts in the Girnar hills indicate that Ashoka extended his domain into Gujarat. It was during the Mauryan rule that this region witnessed the influence of Buddhism. The Mauryans also promoted trade and helped in spread of its culture. In about 150BC the Bactarian Greeks under Meander is said to have instilled their rule. Till 40AD they are said to have had trade contracts with Rome. From about AD130-390 the Scythians ruled it. After 300AD the Guptas established their reign which lasted till 460AD. The Vallabhi established their sway in between (500-700AD). After the death of Harshvardhana, the Gujjars controlled it till 746AD. The Solankis ruled over Gujarat till 1143. Gujarat attained its greatest territorial extent under the Solanki dynasty, from the 9th century. Muhammud of Ghazni attacked Somnath in Gujarat leading to the downfall of the Solankis. The conquest of Ala-ud-din Khilji king of Delhi in 1288 also influenced the conditions in Gujarat. The Sultans of Delhi had their sway over Gujarat from 1298-1392AD. Ahmad Shah I, the first independent Muslim ruler of Gujarat founded Ahmadabad in 1411. Then the Mughals ruled for about 2 centuries till the Marathas terminated their rule in the mid 18th century. It was during the18th century that Gujarat was divided among number of chiefs. From 1803-1827 the British set up their administration. The British East India company's first head quarters in India was at Surat. It was later moved to Bombay. Finally on May1st,1960, the state of Gujarat was formed from the north and west portions of Bombay state, the remainder being renamed the state of Maharashtra.

The state of Gujarat has an area of 196,024 sq. km. and a population of 50.67 million. There are 25 districts, 170 blocks and 18539 villages. The State has population density of 258 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 22.66% (against 21.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate.

3.1 Baseline of public health system in the state

3.1.1 Infrastructure and Human Resources

3.1.2

Table II: Health Infrastructure of Gujarat

Particulars	Required	In position	shortfall
Sub-centre	7263	7274	-
Primary Health Centre	1172	1073	99
Community Health Centre	293	273	20
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	8347	7060	1287
Health Worker (Male) MPW(M) at Sub Centres	7274	4456	2818
Health Assistant (Female)/LHV at PHCs	1073	267	806
Health Assistant (Male) at PHCs	1073	2421	-
Doctor at PHCs	1073	1019	54
Obstetricians & Gynaecologists at CHCs	273	6	267
Physicians at CHCs	273	0	273
Paediatricians at CHCs	273	6	267
Total specialists at CHCs	1092	81	1011
Radiographers	273	124	149
Pharmacist	1346	781	565
Laboratory Technicians	1346	897	449
Nurse/Midwife	2984	1585	1399

(Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI)

3.1.3.1.1 State : GUJARAT

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

Health Institution	Number
Medical College	13
District Hospitals	23
Referral Hospitals	409
City Family Welfare Centre	106
Rural Dispensaries	8347
Ayurvedic Hospitals	47
Ayurvedic Dispensaries	1046
Unani Hospitals	-
Unani Dispensaries	-
Homeopathic Hospitals	16
Homeopathic Dispensary	216

3.1.3 Indicators :

HEALTH INDICATORS OF GUJARAT

The Total Fertility Rate of the State is 2.6. The Infant Mortality Rate is 50 and Maternal Mortality Ratio is 160 (SRS 2004 - 06) which are lower than the National average. The Sex Ratio in the State is 920 (as compared to 933 for the country). Comparative figures of major health and demographic indicators are as follows:

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

S. No.	Item	Gujarat	India
1	Total population (Census 2001) (in million)	50.67	1028.61
2	Decadal Growth (Census 2001) (%)	22.66	21.54
3	Crude Birth Rate (SRS 2008)	22.6	22.8
4	Crude Death Rate (SRS 2008)	6.9	7.4
5	Total Fertility Rate (SRS 2007)	2.6	2.7
6	Infant Mortality Rate (SRS 2008)	50	53
7	Maternal Mortality Ratio (SRS 2004 - 2006)	160	254
8	Sex Ratio (Census 2001)	920	933
9	Population below Poverty line (%)	14.07	26.10
10	Schedule Caste population (in million)	3.59	166.64
11	Schedule Tribe population (in million)	7.48	84.33
12	Female Literacy Rate (Census 2001) (%)	57.8	53.7

Demographic Profile		SC/ST Population (2001 Census) (in millions)	
1. Census :		a) S/Caste Population	3.59 (7.1%)
Population (2001 census) (in millions)	50.67	b) S/Tribe Population	7.48 (14.8%)
Female Literacy Rate (%)	57.8		

3.1.3.2 Average Annual Exp.Growth Rate % :		**1.2 Slum Population (2001 Census)**	
1981-91	1.92	Total Slum Pop.	1.87
1991-2001	2.03	**% of Slum Pop. to Total Population** Urban	9.90
% Decedal growth of total Population (1991-2001)	22.66	Cities/Towns (Reporting Slums)	14.70

2. SRS Estimates

	1981	1991	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
CBR	34.5	27.5	25.6	25.5	25.4	25.2	25.0	24.7	24.6	24.3	23.7	23.5	23.0	22.6
CDR	12.0	8.5	7.6	7.9	7.9	7.5	7.8	7.7	7.6	6.9	7.1	7.3	7.2	6.9
IMR	116	69	62	64	63	62	60	60	57	53	54	53	52	50
TFR	4.3	3.1	3.0	3.0	3.0	2.9	2.9	2.8	2.8	2.8	2.8	2.7	2.6	2.6
CPR	32.5	57.8	57.4	53.8	54.5	52.8	51.2	50.2	50.5	50.6	50.2	49.4		50.7
MMR				46			202		172			160		

II. Achievement under Family Planning Programme

(Figures in lakhs)

3.2 ***Method***	2004-05	2005-06	2006-07	2007-08*	2008-09*
Sterilisation	2.78	2.80	2.68	3.10	3.2
IUD Insertions	4.26	4.66	4.64	4.95	5.9
C.C. Users	11.56	10.04	10.83	12.24	12.0
O.P. Users	2.24	2.45	2.37	2.96	2.7

* Provisional ** HMIS Portal

National Family Health Survey *(Figures in %)*

Indicators	Current Use of any modern method(%)			Total Unmet Need for FP (%)	3 ANC (%)	% Births assisted by a doctor/ Nurse/LHV/ ANM/Other Trained personnel	Institutional Births (%)	Full Immunis Ation (%)	Anaemic among Children (%)	Anaemia Among Ever-married Women aged 15-49(%)
	Total	Ster.	Spacing							
NFHS – I (1992-93)	46.9	41.0	5.8	13.1	61.3	42.5	35.6	49.8	NA	NA
NFHS– II (1998-99)	53.3	45.3	8.1	8.5	60.2	53.5	46.3	53.0	74.5	46.3
NFHS-III (2005-06)	56.5	43.5	12.8	8.0	67.5	63.0	52.7	45.2	69.7	55.3

District Level Household Survey *(Figures in %)*

Indicators	% of Girls Marrying Below 18 years	% of Birth Order 2 and above	CPR	Unmet Need	3 or more ANC	% of Institution Delivery	% of Safe Delivery	Complete Immunisation
DLHS-I (1998-99)	25.3	NA	52.0	19.7	55.0	46.1	55.9	58.1
DLHS II (2002-04)	24.6	56.3	52.4	16.3	61.4	52.2	62.1	57.7
DLHS III 2007-08	19.9	40.6	50.7	16.5	56.8	56.5	62.1	54.9

3.2.1 Complete list of the facilities visited by the team

Districts visited

No.	Name of district	District HQ	Name of DM	Name of CMO
1	Patan	Patan		Dr. Babubhai Patel
2	Banashkatha	Palanpur		Dr. P.R. Sahay

Health facilities visited in Patan District

No.	Name of facility	Location	Type of facility	Person in Charge
1	Sheth N.L. General Hospital	Patan HQ	District Hospital	Dr. S. Parmar
2	Lanava CHC	Lanava	CHC	Dr. Vijay Patel
3	Harij CHC	Harij	CHC	Dr. Sandip Sonpat
4	Radhanpur CHC	Radhanpur	CHC	Dr. R.N. Naulakhya
5	Abiyana PHC	Abhiyan	PHC	Dr. S.M. Patel
6	Pimpal	Pimpal	PHC	Dr. Rekha D Nayak
7	Sankheswar PHC	Sankheswar	PHC	Dr. M.B. Patel
8	Panchasar SC	Panchasar	SC under Pimpal PHC	Ms. B.R. Choudhury
9	Bolera SC	Bolera	SC under Sankheswar PHC	Ms. D. Kumawat
10	Ruppur SC	Ruppur	SC under Chanasma PHC	Ms. M.V. Patel
11	FHW Training Centre	Patan	ANM Training Centre	Ms. M.H. Chavan
12	Ronak Hospital & Maternity Service	Patan	Chiranjeevi Pvt. Hospital	Dr. Jayesh Modi
13	Dr. Devji Patel	Radhanpur	Chiranjeevi Pvt. Hospital	Dr. Devji Patel

Health facilities visited in Banaskantha District

No.	Name of facility	Location	Type of facility	Person in Charge
1	General Hospital	Palanpur	District Hospital	CMHO
2	Dhanera CHC	Dhanera	CHC	Dr. M.M. Dhabhe
3	Deesa CHC	Deesa	CHC	Dr. (Ms) N. Modi
4	Danta CHC	Danta	CHC	Dr. N.M. Patel
5	Jegol PHC	Jegol	PHC	Dr. P.R. Meena
6	Zerada PHC	Zerada	PHC	Dr. Umesh H Zaveri
7	Khimat PHC	Khimat	PHC	Dr. R. Paswan
8	Runi PHC	Runi	PHC	Ms. L. Solanki

9	Kansari SC	Kansari	SC under Zerada PHC	Ms. F. B. Pathan
10	Ratanpur SC	Ratanpur	SC under Kunvarsi PHC	Ms. Punamben Thakkar
11	FHW Training Centre	Palanpur	ANM Training Centre	
12	Ratan Maternity & Nursing Home	Dhanera	Chiranjeevi Pvt. Hospital	Drs. Rakesh & Jyoti Patel

4. Desk review

5. Findings:

5.1 Infrastructure Upgradation:

Gujarat's Project Implementation Unit (PIU) under the Health Dept. grew out of the ECSIP Project that was set up post-earthquake to strengthen and build the health infrastructure in the state. Many of the facilities visited in Patan and Banashkatha were found to be either newly constructed (under the ECSIP Project) or renovated (under the NRHM/Govt. of Gujarat fund) and conformed to IPHS.

However, the order in which facilities are selected for upgradation or renovation is not always as per need. For example, the CHC AT Lanava, Patan District, was recently upgraded despite its relatively poor patient load. The building is impressive now but there were only a handful of patients during our visit. On the other hand, the CHC at Dhanera, Banaskantha District, is a well-utilised facility that has not yet been upgraded due to delays by the PIU, even though the new construction was approved last year (as per communication from state officials). Consequently, there is only one ward which is occupied by both male and female in-patients and an overcrowded OPD.

The Civil Hospital at Gandhinagar was upgraded and received NABH/NABL approval using funds that were generated separately and especially for the purpose. Similar efforts are being made to get accreditation for another hospital and a PHC as well. These are positive efforts made by the state to strengthen public health facilities.

The upkeep of most facilities at all levels was satisfactory. However, the CHCs at Harij and Dhanera were unclean, even though the staff knew in advance that we were due to visit.

The facilities also fell short of essential equipment in some places. For example, baby warmers and resuscitation kits, which are essential for newborn care, were not available in all PHCs of both districts and in the CHCs at Harij, Lanava, Dhanera and Danta, even where deliveries were being conducted. In reverse, the District Hospitals and the CHCs at Radhanpur and Deesa had baby warmers, phototherapy and other newborn care facilities.

Most sub-centres had facilities for examining patients and conducting deliveries and had adequate seating space and working toilets. The ANMs also had BP instruments and weighing machines.

Most facilities at all levels had residential quarters and many of these were occupied. The quality

of the residential quarters varied across facilities in both districts.

Health facilities in both districts were well connected by motorable roads, and had mostly continuous electricity supply with adequate power backup and water supply. The PHCs, even those in remote areas, were provided with computers with internet through which records pertaining to the PHC were uploaded.

5.2 Human Resource Planning:

5.2.1 Availability of Human Resource & gap:

All PHCs, CHCs and District hospitals that were visited in both the districts had a shortage of doctors. Either the positions required to run the facility were not sanctioned, or the sanctioned posts were not filled. For example, most CHCs had only 2 sanctioned posts of "Medical Officer", which is far below the facility's requirement. Moreover, apart from the CHCs at Deesa and Radhanpur, most CHCs (Lanava, Harij, Dhanera, Danta) did not have any sanctioned posts for specialists. The district hospitals in both districts had vacancies among specialists. In the District Hospital at Patan, although 5 out of 6 specialists' positions were filled, there was no physician, no orthopaedic or radiologist. Instead, two General Duty Medical Officers (GDMOs) were sanctioned. At Palanpur General Hospital, only 8 out of 13 specialist positions were filled while only 19 out of 23 doctor positions were filled up.

Although the posts sanctioned for General Nurse Midwife (GNM) were filled at the CHCs, none of the 24x7 PHCs, among the 6 PHCs that were visited, had GNMs as per NRHM's guidelines. The posts for GNMs were not even sanctioned in the PHCs. The subcentres were run by single ANMs, many of who stayed in the quarters that were provided.

Laboratory Technicians and Pharmacists were available in all PHCs and routine examination of blood, urine, blood slide for MP was being done in all PHCs and CHCs. Radiographers were available in the CHCs and district hospitals; however, the Rad meter Badge was not seen anywhere.

The gaps in the availability of Medical officers in PHCs, CHCs and district hospitals in both the districts were neither properly assessed against IPHS nor resolved.

5.2.2 Pre service Training Capacity:

The state has started new schools to generate additional human resources, particularly nursing staff. Two such schools were visited - at Radhanpur CHC (ANM training) and at Palanpur District Hospital (GNM training, 20 admissions per year). The district hospitals at Patan and Palanpur already had an ANM training school each with 40 and 30 admissions per year respectively. Trainees were selected district-wise, with the expectation that this would address human resource requirements locally.
A FEW LINES ON THE ADEQUACY AND QUALITY OF THE TRAINING SCHOOLS COULD COME HERE

However, minimal caseloads in the facilities to which the training schools are attached and reduced scope of activities in the PHCs to which trainees are sent, have important consequences for the adequacy and quality of training. Both District Hospitals and the CHC at

Radhanpur had far too few deliveries: 1-2 deliveries per month in Radhanpur, and around 10 per month in Patan and Palanpur. These numbers do not match the requirements of trainee nurses, who then end up with classroom training but little or no practical experience. Additionally, the ANM trainees at Radhanpur do not get to conduct immunisation even when they are sent to the PHC, as the government has handed over this job entirely to an NGO in the area.

5.2.3 Recruitment and Cadre Management:

Despite the shortages listed in Section 3.3.1, there is no new recruitment of full-time staff at any of the facilities, apart from that of Medical Superintendent. Rather, health workers are recruited for both full- and part-time work on a contractual basis. This has led to wide disparities in the payment structure between the regular and contractual staff. For example, specialists (Physician and Ophthalmology) on contract and posted at Deesa earned around Rs. 20,000 per month which is a fifth of the salary of a non-contractual (regular) specialist. Similarly, a dental surgeon on contract earned no more than Rs. 6000 per month. These disparities have adverse consequences in terms of staff morale, motivation and tenure.

In both districts, cadre management issues were treated in an ad hoc fashion without adequate attention to system strengthening in both the medium and long-term.

5.2.4 Plan for Augmentation of Health Human Resource:

The approach adopted so far to address human resource issues has been piecemeal. Specific measures have been taken to increase the nursing cadre in the state by creating new training schools and recruiting trainees from the same district. However, there is no specific plan to address the issue of shortages among MOs, especially the 2nd MO at the PHC as per IPHS, GDMOs, and specialists at the CHC and District Hospital.

There is a general feeling that doctors do not and will not want to work in the public sector. Consequently, the approach is to contract the services of private health providers in public facilities, and more importantly, to reimburse private doctors for services provided in their own facilities, both through the Chiranjeevi Yojana under NRHM and through insurance schemes such as RSBY.

5.2.5 Skill quality of Health Human resource:

The effort to "multi-skill" MOs through training has been in place for a long time. Yet, not a single CHC functions as a FRU even when the MBBS doctors have received EMOC and LSAS training in Patan and Banashkatha districts. The CHCs at Lonava and Danta have doctors who are trained in EmOC, but no personnel who are trained in LSAS.

The development of skills by service providers at any facility depends at least partly on the utilization of the facility by the public, as skills are gained through experience. However, as noted earlier, the number of deliveries conducted in most CHCs and PHCs (barring Sankheswar PHC, where an experienced ANM conducts around 456 deliveries a month) is very low, as are IPDs. Moreover, in some remote blocks of Patan district (Sami, Santhalpur), the responsibility of providing immunization services has been handed over to an NGO, although there are now PHC staff in place who can do this. Consequently, existing staff (FHW, LHV) in these blocks are both

without preventive work and minus the experience, which can result in a depletion of their skill set in the medium term.

The level of skills gained also depends on the individual and on the quality of training received. In one of the PHCs we visited, the ANM did not know how to measure BP although she had been trained for it, and presumably conducted the Mamta Divas (VHND) regularly. There could be others like her who do not know.

Overall, there does not appear to be any clear plan to strengthen primary care at the PHC and CHC levels, and secondary care at CHC and district hospital level.

5.3 Assessment of the case load being handled by the Public System:

The OPD and IPD caseloads in several facilities have increased in a relatively short time, although these increases are not uniform across facilities or even within the same facility. For example, the under-utilised CHC at Lanava, Patan district showed a modest increase in its OPD caseload from 37,214 (during 2007) to 40,508 (during 2008) and to 39009 (up to October 2009). However, indoor admissions at the same facility increased more dramatically from 102 (during 2007) to 2561 (during 2008) and 1989 (until October 2009). At the same CHC, institutional deliveries continued to be low, numbering no more than 21 during 2008-09. Similarly, the General Hospital at Palanpur (known earlier as "Good Fellow Hospital") with 221 beds and a sophisticated trauma centre, among other facilities in a large and impressive structure, both the OPD and IPD caseloads were large. The OPD attendance in the hospital was 1,08,010 until September 2009, while in-patient admissions were 27,267 in the same period. Major and minor surgeries during these 6 months were 931 and 1053 respectively. However, only 16-18 deliveries were conducted on average in a month despite the availability of qualified staff and the requisite equipment, space and furniture. Until September 2009, only 112 deliveries were recorded.

The reason for the low turnout of women for delivery in these facilities is due to the competing presence of Chiranjeevi providers either in the same town or in the vicinity. Although the quality of services provided by the Chiranjeevi providers is not necessarily better (as described in Section 3.19), they are supported by a demand generation mechanism involving government workers at the village level (ASHAs and ANMs) and by a mindset that deems private sector provision better than government provision. For this reason, institutional deliveries were low during both 2007-08 and 2008-09 in the CHCs at Dhanera (9 and 36 respectively) and Radhanpur (31 and 25 respectively) and at Deesa where no more than 14 deliveries are conducted per month, of which 2-3 are C-sections.

In places where there are no Chiranjeevi providers, government facilities show increases in the numbers of institutional deliveries. For example, in Harij CHC, institutional deliveries doubled in number from 214 (in 2007-08) to 467 (in 2008-09). In Danta CHC, institutional deliveries climbed up to 202 (during 2008-09) from 59 (during 2007-08). In Sankheswar PHC, the institutional deliveries on record numbered 468 (until October 2009). These increases could be due to JSY, though the possibility of misreporting and other hypotheses must also be considered.

Overall, the total number of deliveries conducted in the CHCs of Patan district doubled from 461 (during 2007-08) to 991 (during 2008-09), while in Banaskatha district they increased from 1242 in (2007-08) to 2192 (in 2008-09). These increases were mainly accounted for by the gains made in

talukas where there are relatively lower levels of competition from Chiranjeevi providers.

In terms of other services, the records at the District Hospital at Patan (named Sheth N.L. General Hospital), showed large numbers of OPD attendees (12,8911 in 2008-09) and in-patient admissions (8,700 in 2008-09), with these numbers tending to increase. During 2009-10, OPD attendees numbered 94,134 in just 6 months. The number of major and minor surgeries also increased in the district hospitals.

5.4 Preparedness of facilities for patient care services:

Bed occupancy in the CHCs and PHCs that were visited was below 50-60%. In the PHCs, the available beds were invariably empty. In Lonava CHC, only 4 out 16 beds were occupied. In Harij CHC, 5 out of 13 beds were filled, and even these were without mattresses. Moreover, the quality of the wards and the toilets at Harij were very poor. However, In the CHCs at Radhanpur and Deesa, and the District Hospitals at Patan and Palanpur, bed occupancy was higher.

In terms of infrastructure, most PHCs and CHCs (other than Dhanera CHC) had adequate space and facilities to serve as 24x7 PHCs and as FRU CHCs. However, the 24x7 PHCs did not function as per GOI guidelines as they did not have GNMs and newborn care corners. Most CHCs (other than Radhanpur and Deesa) did not have the facilities to support services that FRUs are expected to provide, such as blood storage facilities. These CHCs also did not have the requisite personnel to run FRUs (apart from the one at Deesa). BMW management was maintained in all health facilities.

In their spaces, the facilities fared better. Most facilities had well-lit waiting areas, reasonably clean toilets, and walls displaying IEC material, Citizen's Charters and other information (such as performance boards indicating targets set and fulfilled for the facility). However, the people who accompanied patients, especially in-patients, did not have any designated spaces to stay or cook. Nor was the NRHM logo in evidence anywhere.

The 108 EMRI service was well utilized in all areas of the district we visited. Services of 108 EMRI were found useful for transport of patients to health facilities, even to facilities run by Chiranjeevi providers. Transport money to patient under JSY scheme was also provided under Chiranjeevi scheme.

5.5 Outreach activities of Sub-centre:

Functioning of sub-centres in both the districts visited was found satisfactory. All SCs had ANMs (FHWs) in position, and several of them stayed in the quarters provided. However, concept of second ANMs was not seen in the state and only few SCs had MPW (Male) functioning in SCs.

The physical spaces and equipment in the SCs were adequate for providing ANC, Immunization, and conducting deliveries. Power and water supply to each SC were ensured. However, the ANMs, especially those who were young, preferred to refer women to Chiranjeevi providers even when they had the facilities and training to conduct (normal) deliveries themselves.

The ANMs reportedly conducted VHNDs regularly through the active involvement of ASHAs (and at times, the VHSCs) and the output of sessions was good. The ASHAs tracked pregnant women

and helped the ANM develop micro birth plans that were then shared with the 108 service to reduce potential delays in transport to institutions during labour.

Records were maintained and these could be seen during each visit to a SC. The ANMs also provided services linked to NVBDCP. Blood slides were being collected and treatment provided.

5.6 Utilisation of untied funds:

In all of the health facilities that were visited, untied fund were used to augment resources required for the upkeep of facilities and records were well maintained. However, untied funds for 2009-10 were released as late as October-November, 2009, and even this was a part-payment for maintenance, and the untied and RKS funds. Lumpsum amounts were released to facilities at all levels (e.g., 1-1.5 lakhs to PHCs and CHC). Most of facilities were using untied funds left over from the previous years. This year's release is subject to submission of Utilization Certificates of earlier releases. So, many institutions are yet to receive funds for the year due to unspent money with them.

No institution-specific plans were evident in any of the facilities which guided decisions on how the funds (maintenance, untied and RKS) should be used. The MOs in charge of the facilities were utilizing the funds in combination with the user fees that were collected.

5.7 Thrust on difficult areas and vulnerable social groups:

It was not possible in the space of a short visit to assess either the adequacy or the effectiveness of measures currently being taken to improve access to care among vulnerable social groups or those living in remote areas. However, such an assessment would be necessary if health inequalities are to be meaningfully addressed, and all forms of social exclusion tackled.

The state has instituted incentives for SC, ST and BPL populations for services such as delivery care (through JSY, Chiranjeevi Yojana), and enables access to both public and private providers through health insurance via the RSBY. It is also working with NGOs to improve the uptake of services in its remote areas.

The coverage of services among SCs, STs and minorities were the same as in other areas in both the districts. Facilities located in these areas were adequate to deliver services and quality of services provided in tribal and minority areas of Patan and Banaskatha were satisfactory. Records of BPL utilizing Chiranjeevi and RSBY were seen in the districts that were visited. Increase of Chiranjeevi Scheme deliveries in the state indicates utilization of institutional care by BPL families.

5.8 Quality of service provided:

In the facilities visited, Female Health Workers were available in all SCs, at least one MO was available with 3-4 FHWs in PHCs and 2-3 MOs and 7 GNMs in CHCs visited and all were qualified. However, quality of service provision in terms of maintenance of partograph etc. was seen only in Deesa CHC of Banaskatha. In health facilities service provision as per 24X7 guidelines, FRU guidelines were not seen because of shortage of manpower and equipment.

Regarding quality of services of RCH, like stay of postnatal period for 48 hours etc was not followed in the districts. Patients are leaving health facilities after delivery within 6 hours also in few facilities. However, efforts to keep the patients for 48 hours were seen in few CHCs. In a PPP institution in Dhanera patients were leaving after 4 hours of delivery as per record. Newborn care corner concept is not seen in PHC level though as per 24X7 PHC it is must. In few CHCs, newborn care corners were not seen.

Gender perspective care were missing in Dhanera CHC where Male and female patients were kept in one ward and labour room was located in front of toilet for wards.

Quality improvement of health facilities in the state is a good initiative and Gandhinagar hospital has been certified by NABH already. In second phase of initiative, Palanpur and Patan district General Hospital are being included. However, accreditation of PPP hospital under Chiranjeevi is an urgent need in the state to improve quality of services provided.

Women friendly services are being seen in health facilities in CHCs (except Dhanera) and district hospitals. Privacy of wards, labour room, clinics were adequate in the CHCs and District hospitals.

RTI/STI service clinic could not be seen separately except in CHCs and district hospitals where ICTC centres were functional with counsellors.

5.9 Diagnostics:

Diagnostic services were available up to PHC level in both the districts and Laboratory Technicians were found in all PHCs, CHCs and district hospitals. X-ray facility in all CHCs was available and utilized by public. Lab facility for Urine, Blood for Hb, ABO grouping and MP were available in PHCs visited. Malaria diagnosis was available in all PHCs.

Ultrasound facility was available in Deesa CHC and all District hospital visited.

User charges are levied on lab test, x-ray etc and are used by RKS.

It was observed that, safety measures of radiographers of CHCs and district hospitals were not taken care of providing Rad meter in facilities.

Reports of diagnostics were utilized in the facilities for patient care and quality of services was adequate.

5.10 Logistics and Supply chain management:

Gujarat Health system has central procurement system with effective inventory control using HIMS from districts. The supply of drugs and logistics are done in regional basis to Regional warehouses and supply to districts is being done from Regional Warehouses. The Patan Warehouse located in the District Hospital Complex had newly constructed modern Warehouse having racks and pillets, lift etc.

The inventory of drugs is being maintained in the warehouse electronically and registers are maintained. However, stocking of drugs were seen dumped in floors without using racks and pillets due to shortage of lifter for racks. The quality control of drugs testing is done from warehouses and 6 monthly supply of drugs are being done to regional warehouses. The Regional Warehouses are online with Gandhinagar DHO office centrally.

Supply of drugs to facilities was regular and stock maintenance was seen proper. The system of dispensing of drugs and keeping stock for distribution daily seen in proper boxes with display of names for identification.

Crash Cart seen utilized in District Hospital and trauma centre.

Kit-A and Kit-B seen all SCs visited in the districts.

5.11 Decentralised Planning:

The District Action Plan for 2009-10 was seen in both districts. However, the involvement of PRI and General Administration could not be ascertained, as in both districts, PRI and DM did not attend any meeting with the team. Their participation in the planning process of the integrated plan needs to be reviewed by the state team, as their absence was an area of concern during the team's visit to the districts. In Palanpur, the team learnt that it has been difficult for the health department to get the District Health Society to hold regular meetings. Consequently, the responsibility for both planning and implementation of the district plan seems to rest entirely with the health sector without the involvement of the PRI.

However, RKS meetings at the health facility-level involving PRI members have been seen on record and during visit of facilities.

5.12 Decentralised Local health Action:

VHSCs were constituted nearly 2 years ago in all SCs that were visited. ANMs, ASHAs and PRI members were involved in the Committee's formation. These committees were meeting periodically. Untied funds were also released for their use. Records of these meetings and of the utilisation of the fund could be seen in all SCs visited.

Although the VHSCs have received some orientation, they are not fully oriented to their role. At present, they assist the ANM, who controls them. The members who were met reported being involved in village sanitation, in facilitating the paperwork for JSY and Chiranjeevi beneficiaries, and in "any other activity indicated by the ANM". They were not involved in preparation of village plans, or on addressing local health issues either through direct action or through their use of untied funds.
The separation of the VHSC's funds from that of the SC is at present blurred. With the ANMs convening both Committees, there was a tendency for the VHSC's funds to be used for SC activities and upgradation. Local needs of the village were hardly addressed in the VHSC's utilization of untied funds.

5.13 Community Processes under NRHM

The ASHAs are in place in many villages, despite difficulties in finding suitable candidates and retaining them. Many of these women were selected by the gram panchayat. However, the eligibility criteria specified in the guidelines are not always adhered to: in some places, the ASHAs were not daughters-in-law in the village, but young daughters who lacked experience and confidence. Moreover, in bigger villages, where there were two ASHAs, they did not always belong to different sections of the community. In at least two villages, the ASHAs were related to each other.

Most the ASHAs who were met reported delays in their payments: they were being paid once every 3-4 months. However, they were not at liberty to speak openly about it in the presence of state officials and the ANM to who they are obliged. This dependence on the ANM and the health department also prevents them from becoming voices for the community in matters pertaining to the non-delivery of services or breaches of trust. These issues do arise and should be resolved if the objective of (public health) system strengthening is to be met.

Like the ASHAs, the VHSCs are also not true representatives of the community that can take village needs on board and force issues of accountability in service provision and in the disbursal of benefits. The Committees are formally constituted bodies that, at present, lack a clear sense of their own role, power and responsibilities in the village. The Community Monitoring Initiative is not underway anywhere, although a training manual has been prepared and the training of Trainers is due to take place soon.

The VSHCs and RKSs have teachers, private practitioners, members of self-help groups and local farmers, among their members, who seem to participate in meetings that are regularly organised by the health staff. The quality of their involvement could not be ascertained in the team's brief visit. However, from discussions with members wherever possible, it was clear that they lacked a clear sense of their own identity, beyond that of belonging to a group that ratifies spending priorities which are set by the health worker/Medical Officer.

Meeting of the District Health Society were infrequent at best in Banaskantha, reportedly due to the indifference of its (non-health department) members. There is little or no evidence of NGO involvement in any of these citizen's groups, although they are present in many places as service providers (e.g., Bhansali Trust in Patan) or as facilitators who seek to improve the uptake of RCH services in remote areas.

5.14 ASHA

Many ASHAs present themselves as vibrant, confident women who have gained support from their own families and from other residents. They had varying levels of knowledge corresponding to differences in their training and tenure. They reported performing a range of tasks, notably mobilising pregnant women and new mothers before the Mamta Divas (VHND), facilitating institutional delivery, popularising the use of contraceptives, and assisting in other national programmes such as RNTCP, Malaria, among other. In this respect, they were valuable assistants to the ANMs, who clearly benefited from their presence. The ANMs were also the ones who supervised the ASHAs.

5.15 National Disease Control Programmes

5.15.1 Overall Programme Management

5.15.2 NVBDCP

5.15.3 RNTCP

5.15.4 NBCP

5.15.5 NIDDSCP

5.15.6 IDSP

5.16 RCH II

The number of institutional deliveries has increased in the state in both the private sector and in government run facilities. JSY and the Chiranjeevi Yojana have certainly played a role here, though the interplay of the factors that have led to these increases should be examined in detail to eliminate the possibility of misreporting. The ASHAs and ANMs play an active role in referring women needing delivery services to Chiranjeevi providers, even if the deliveries can be done at well-equipped sub-centres.

JSY payments are made in Gujarat in two instalments: the first instalment of Rs.500 during the last trimester and a second instalment of Rs.200 after delivery, if it takes place in an institution outside the village. Although the team could not investigate into the possibility of denied

All maternal deaths are audited in the state using a verbal autopsy form by Block Health Officer and RCH Officer. The data thus gathered is sent to the state and then analysed.

5.17 Preventive and promotive health aspects with special reference to inter-sectoral convergence and converge with social determinants of health

5.18 Nutrition

A major concern for the state is the high prevalence of anaemia among women, as evident in consecutive rounds of the NFHS. In response, the state plans to address the issue by initiating Nutrition Supplimentation and Treatment in few selected blocks. Danta has started alreadt CNBC.

5.19 (Selected) non-governmental partnerships / public-private partnerships

5.19.1 Chiranjeevi Yojana

The Chiranjeevi Yojana, which has been described in numerous publications, is credited with

giving a boost to institutional deliveries in a state where private providers seem to enjoy greater credibility in the public imagination. An allied scheme – the Extended Chiranjeevi Yojana – is now due to be rolled out in which private obstetricians who are willing to set up practice in remote areas will be provided monetary incentives to do so, in addition to being reimbursed according to the number of deliveries conducted. The number of deliveries conducted by Chiranjeevi providers in both districts is indeed impressive; however, a closer review of the scheme is required in terms of the services currently being delivered and in terms of its impact on government services both in the medium and long-term.

Quality of care is a big issue in the Scheme in terms of the physical standards of care, the upkeep of facilities, and follow-up of women after delivery. Most women do not stay in the facility for more than a few hours after delivery. Moreover, the facilities that were visited in Patan district were unhygienic, cramped, ill equipped, and housed in makeshift premises in market areas that compromise both quality and safety. The facilities also lacked basic facilities required for newborn care (e.g., Baby Warmer, Phototherapy). Steps should be taken to assure quality to beneficiaries, even though BPL families do not come with high expectations to the facility. Greater oversight is required by the government than is now evident. The extent of the government's oversight is limited to ensuring that Chiranjeevi providers receive their payments and to handling patient's complaints if any.

While we were repeatedly told that people should be allowed to go wherever they want to for delivery; in practice, these choices were not made in a vacuum. There is an elaborate demand-generation mechanism at work involving the ASHAs and ANMs and village women seem to go by what is recommended to them. This demand generation mechanism needs to be reviewed carefully to ensure that the best interests of women are retained in these referrals, and that they are not skewed by commercial interests.

There were no attempts to make beneficiaries aware of their entitlements in the scheme. For example, the innovative toll-free number service run from Patan District hospital that provided details about the whereabouts of Chiranjeevi providers and their contact numbers, did not spell out the services that women could expect to receive for free. This is an important omission, given that research in one of the scheme's pilot districts – Dahod – showed that BPL women who availed of the Chiranjeevi scheme in Dahod district did end up making payments, albeit at a lower rate compared to non-beneficiaries.

5.19.2 Bal Sakha

Bal Sakha scheme for New Born Care services under NRHM. ……

5.20 Overall Programme Management:

Programme Management Unit was seen functional at state and district with DPC and RPCs. At block level and PHC level, accountants were functional under NRHM. BHO offices are functional with are BHO and account and MIS person. Record keeping of facilities at BHO and facility level including financial records was adequate and updated. MIS is updated up to facility level monthly including financial reporting.

PMUs were functional and records of district, block and states were available to users.

5.21 Financial Management:

Financial authority has been delegated in both districts. District level account keeping and tracking of funds were evident in both districts down to the PHC, SC and VHSC levels. Financial reporting to the district and from the district to the state takes place on a monthly basis through the MIS. However, the utilization of funds and tracking of records needs time.

Audit reports and Management Report of the Audit were seen in both districts. At the district level, the disease control audit is merged with NRHM audit.

Release of funds to the districts has been delayed in 2009-10 and unspent funds are beginning to be tracked now. Money is being released in lumpsums to the districts and not for specific activities. In the district also, fund releases to facilities is not against approved activities, but in a lumpsum fashion and adjusted against the available balance in accounts of the RKS/Facility accounts.

Untied funds for 2009-10 have not yet reached all facilities in Patan district; these releases have not been uniform. Unspent funds are currently being tracked up to the facility level in Patan district; only later will funds be released.

5.22 Data Management:

Data management in the state and district levels seen effectively. MIS is regular from facility. Data entry at BHO level and individual facility reports are entered there. MIS are seen utilized by state officials and district level /PHC level Data were available to state.

6. Recommendations

- Selection of facilities for upgradation and renovation should be based on (1) their caseloads; (2) location wherein preference is given to facilities in remote and tribal areas), and (3) assessment of their requirements against IPHS.
- The Chiranjeevi Yojana should be re-assessed in terms of its impact on the public sector (especially the morale of existing staff, their skill development, on the uptake of services) and its sustainability in the medium and long-term.
- The state needs a clear human resource policy to address its biggest challenge in the health sector.
- The state needs to provide better oversight over public-private partnerships, and there are many of these in Gujarat.
- Plans underway to train VHSCs for community action should be put into place as soon as possible, as capacity building takes time and considerable effort.