

Third

# Common Review Mission

State Report

## Madhya Pradesh



## Madhya Pradesh –Report by Third CRM Team

### REPORT OF THE TEAM VISIT TO MADHYA PRADESH

**1. Objective:** Spot Appraisal of the Health System, Policies, Strategies as per the Guidelines of the national NRHM Mission Directorate.

**2. Team Composition:** A six member team visited MP

- 1) Dr. K.R. Antony, Director, State Health Resource Centre, Chhattisgarh at Raipur
- 2) Dr. Thelma Narayan, Centre for Public Health and Equity, SOCHARA, Bangalore
- 3) Mr. Rajesh Kumar, Dy. Controller General of Accounts, Ministry of Finance, Office of the Controller General of Accounts, Lok Nayak Bhawan, New Delhi.
- 4) Ms. Moni Sinha Sagar, USAID, American Embassy, New Delhi
- 5) Ms. Mona Gupta, Technical Management Services Agency, New Delhi
- 6) Mr. Sanjeev Kumar Gupta, Finance Controller, NRHM, FMG, New Delhi

**3. Overall Process:** A very good experience for the team. Helpful and efficient technical inputs and logistic support was given by the MP State Dept. of Health & Family Welfare (DHFV), the MP State NRHM Mission Directorate and State Program Management Unit (SPMU). The state briefing was held on 4<sup>th</sup> November with a wide range of DHFV senior staff members and development partners, chaired by the Health Commissioner who is also the state NRHM Mission Director. The review team divided into two sub-groups for the field visits. One team went to Chindwara district and the other to Guna district both of which were selected or suggested by the State. Unscheduled visits were also made by both sub-groups providing different insights and a glimpse into reality. A meeting with NGOs from different districts was held in Bhopal on 11<sup>th</sup> November. This was followed by a state level debriefing with state officials, some district officials, and development partners, in the presence of the Health Secretary and the Director Health Services and chaired by the Health Commissioner. The open process of dialogue and discussion was appreciated by the review team. Both the state level meetings were lengthy, and cordial with a lot of discussion.

**4. Team visit to Gwalior Division and Chhindwara district:** One team consisting of Thelma, Moni, and Sandeep visited Guna, Gwalior, Shivpuri and Datia districts in Gwalior division from the 5<sup>th</sup> to 10<sup>th</sup> November 2009. Visits to additional districts, health institutions (even in Guna) and coverage of specific strategies (IEC and state training institutions) were added by the team to gain additional insights. To get an overview of the public health system strengthening undertaken with NRHM support and within the NRHM framework, extensive visits were made rather than an intensive focus on a smaller number of institutions. An approach of affirmative enquiry was adopted looking at strengths, progress made and challenges.

The other team consisting of Rajesh, Mona and Antony visited Tamiya district and Pipariya of Hoshangabad district.

The team interacted with a wide variety of persons ranging from women admitted before/ after deliveries and their relatives; persons suffering with TB and leprosy; ASHAs; *Dai's* who were present in the institutions; food demonstrators and NRC staff members; ANMs; Laboratory Technicians; Blood Bank Technicians; Medical Officers at PHCs & CHCs; MBBS and PG doctors on rural bond service; Block Medical Officers; Specialists in the Sick Neonatal Care Units at the three different levels; Specialists in the Departments of

OB/Gynae, Paediatrics, Emergency Care; staff from teaching/ training institutions and the IEC bureau; personnel from UNICEF, UNFPA, JICA and the DFID TAST team, NGO representation and with community members from a household on the roadside. Meetings were held with the District Collectors, Guna and Chhindwara.

## **5. Health Institutions visited:**

### **I. Health Sub Centres (HSC)**

Guna dist. (1) Bhadora (2) Chipon (3) Pgara (4)Mavan and (5) Jhagar – upgraded delivery centre

Shivpuri dist. (6) Nabli

Chhindwara dist (7)Khunachirkala

### **II. Primary Health Centres (PHC)**

Guna Dist. (1) Aavan (2) Bajrangarh,

Shivpuri Dist. (3) Khod,

Chhindwara dist.(4) Chhindi,(5) Linga

### **III. Community Health Centres (CHC) – First Referral Units**

a) 1.Beenagant, 2. Raghagarh 3. Sathanwada – Guna Dist

b) (4)Pichhor , Shivpuri District,

c) (5)Tamiya, (6)Parasia,(7) Pipariya, (8)Civil Hospital Chandameta- Chhindwara district

### **IV. District Hospitals**

1. Guna 2. Shivpuri 3. Datia 4. Chindwara

### **V. Teaching and Training Institutions:**

1. ANM Training Centre (ANMTC), Guna

2. GNM school, Chindwara

3. Regional Health & FW Training Centre (RHFWTC), Gwalior

4. State Institute of Health Management and Communication (SIHMC), Gwalior

5. Medical College Hospital, Gwalior,

### **VI. Other Meetings held**

With NGO's – Harit, Susheel Shiksha and Sonali in Guna, MP Vigyan Sabha at Tamiya.

With ANM's & LHVs at RHFWTC, Gwalior.

With Dist Collector,CMHO, and Civil Surgeon, Chhindwara.

With Psychiatrists & Civil Society groups on Mental Health at Bhopal.

**VII. VHND (Village Health and Nutrition Day)** Khajuri- at Anganwadi centre and Dhurwadhana AWC, Tamia block.

**VIII. VHSC (Village Health and Sanitation Committee) Meeting** at Nai Colony and Khunachirkala (Chhindwara dist.)

**IX. Integrated Camp** for *Sehariya's* and **Village market** at Chintipur, Tamiya station for MMU

**X. Call Centre**, Guna Hospital regarding emergency and referral transport.

**XI. Nutrition Rehabilitation Centres (NRCs) and SNCUs** (Sick Neonatal Care Units)  
Chindwara, district hospital, Civil Hospital Chandameta

## **6. Findings and Comments**

**Overall Impression:** Overall there has been progress in the strengthening of the public health system since 2005, and specifically during the last year, supported by the NRHM framework and funds, despite inherent difficulties of distance and remoteness of villages, poverty and hunger, staff shortages etc. Processes of decentralization within the health system, training of community health workers, addressing health determinants etc had been initiated in MP prior to the NRHM and in fact have informed the strategic approach of the NRHM.

Strong Political Commitment to Health agenda does exist in the state for e.g. Vidhan sabha questions like: If it is a CEmONC, why isn't a paediatrician present there? Both the Chief Minister and Health Minister are supportive to NRHM.

More recently there have been several innovations. Weekly *Jan Sunwai's* at different levels statewide initiated by the political leadership, emails to the CM, and an SMS complaint system by the Guna Collector are examples of a complaint cum grievance redressal system. Other innovations include Call Centres for referral transport of pregnant women to health institutions for delivery in Guna and Shivpuri districts, refining further the model initiated by Nivedita an NGO in Bhopal.

Realizing the importance of addressing neonatal illness to reduce IMR the state has started SNCU's (Sick Neonatal Care Units) with support from UNICEF. In Guna district there is a systematic strategy to develop well staffed labour rooms in health sub-centres and PHC's to decongest the CHC's and District hospital. The proportion of deliveries in the public sector in the district is over 90%. The proportion of deliveries in the District hospital has reduced from 36% to 26%. There is a very good documentation, data analysis and reporting in the NRC's, SNCU's, the call centre, CHC's and district hospital.

There are however major continuing challenges in MP for public health system strengthening in several areas. These include:

- Providing universal and equitable access to good quality medical/health care in all districts. The team was taken to the better districts and centres and we appreciate the amount of work done to develop these centres which is not easy. However equitable access and quality of public sector health care still remains problematic in many other districts as reported by consultants and NGOs.
- in developing adequate numbers of FRUs, BEmOC and CEmOC Centres
- reducing staff shortages in a sustainable manner,
- developing a trained public health cadre,
- making a positive shift to addressing the issue of under-nutrition with a community based approach etc.
- developing the District Mental Health Program in a time bound, phased manner and providing preventive, promotive and rehabilitative care for Disability

**6.1 Leadership:** The present leadership is thoughtful, proactive and dynamic. However there have been about eight state NRHM Mission Directors over four years and currently there is only one Director of Health Services. Three other Director level posts are vacant.

Professional Leadership at other levels exists but needs to be strengthened. For instance posts of District TB Officers are largely not filled, or State and District health officials are holding charge of several portfolios and are finding it difficult to handle them. The quality and pace of program implementation gets adversely affected.

Public health leadership needs to be systematically developed. The Health Commissioner is trained in public health and a handful of others are similarly trained. Eight young doctors have been sent this year to the Diploma program in Public Health Management at IIPH, Gandhinagar. However the need for public health specialists can be quantified e.g. one for every Block i.e. 313, at least 2-5 at district level for every district ie100, and a small pool at state level i.e. MP would require about 450 public health specialists. Developing a critical mass of trained public health personnel is an important component of health sector reform that will help attain the goals of the National Health Policy 2002 and the MDG's

A Human Resource Development Cell is essential to plan and manage a technical Department with such a large number of clinical, public health and allied health professionals. A cadre development policy is needed to ensure a good quality, motivated workforce who can be responsive to complex medical and health needs of the population.

## **Part 1**

### **Change in key aspects of Health delivery system**

#### **1. Infrastructure**

##### **1.1 Base Line Resource Mapping**

**Connectivity-** for Health Service delivery has improved in Madhya Pradesh during the past few years. Roads are good to fairly good especially the National and State highways. But remoteness of villages & hamlets and distances are still a barrier in accessing care.

**Telecom-** good mobile connectivity generally exist, ASHA's and health workers use mobiles. But failure of networks did occur resulting in home deliveries taking place because of inability to contact the call centre.

**Electricity -** 12 hour power cuts occurred in all areas visited, solar powered systems are used in some health institutions. Issues of freedom for local maintenance, renewal of Annual Maintenance Contracts and other options (invertors/generators etc) are to be considered.

To illustrate worst scenario of infrastructure primary health care a reality, 92 out of 1155 PHCs are without electricity connection, 312 without regular water supply and 280 without telephone connection still.

**Water** – problems exist in some places like Civil Hospital Chandameta, Chindwara district. Innovations like connecting hand pumps to overhead tanks in some centres can be replicated.

*Sewage- disposal and waste management systems* are to be strengthened. In Chindwara district there was no segregation of Bio-medical waste at source, waste disposal management was poor and staff not trained for it.

**Land & Premises, Buildings** –

Institutions we were taken to had fairly good buildings. Some were undergoing construction.

Compound Walls existed in most places and in some PHCs, CHCs had even gardens. The buildings, layout, design and maintenance of SNCUs and NRCs were excellent. NRCs had a “baby-mother friendly” look.



**1.2 Overall Maintenance-**very good to fair, Guna & Datia district hospitals had grounds paved to reduce dust, vehicles other than ambulances were not allowed beyond a certain point. Animals, cows and dogs in the Datia hospital compound & dogs were roaming around in Casualty and wards in Pipariya CHC. Maintenance in Sethanwada CHC was not good. Baby warmer was coated with dust, equipment and drugs were not well organized. So also the maintenance of Burns ward of Chindwara district hospital with very poor infection prevention & control measures.

Renovated labour rooms and OTs in many places and the ICU in Chindwara district hospital were good.

**1.3 Infrastructure Upgradation:**

Only 66% of Health Sub Centres of MP are functioning in government buildings (RHS 2008). Out of 8860 HSC, only 25.4% are having ANM quarters constructed. Out of 1155 PHCs in the state, only 385(33%) have prescribed 4-6 bed wards, 607(52.5%) with labour rooms.

There are dedicated engineers for construction, but not a separate entity like *Infrastructure Development Wing*.

**96** Civil hospitals and CHCs including all CEmONC centres are taken up for facility survey and upgradation for civil works to meet IPHS norms.

**2. Human Resources Planning**

**2.1. Availability of Human Resources & Gap analysis:**

This is the most significant challenge facing the health system. As given in the reports of the State Govt. there are significant gaps in human resources at various levels. 196 out of 1155 PHCs are supposed to function without any doctors, whereas 82 PHCs have a lady doctor for the comfort of women.

## **2.2. Pre-service Training capacity:**

There are 30 ANM training centres in government sector and one in Indore under voluntary sector. Staff Nurses are trained in 10 GNM training centres. Male MPHWS are trained in 10 centres. With three Regional Health and Family Welfare Training Centres at Indore, Gwalior and Jabalpur, the infrastructure for health human resource seems adequate. But still there are 153 Health Sub centres without both ANM and Male MPWS and 1469 HSC out of 8860 in the state without a Male MPWS.

Under utilization of available infrastructure, lack of coordination among training institutions and inadequate faculty members are some of the hurdles that need to be addressed to bridge this human resource gap in primary health care.

SIHMC, Gwalior – This has a large campus and infrastructure with large teaching and conference halls, library, residential accommodation for students, a good canteen/mess. State level training programs and TOTs are conducted here. Due to a 'locational disadvantage' it is underutilized and understaffed with only three teaching staff. However it is possible to invite resource persons from Bhopal, Delhi and elsewhere. Training programs in the State seem to be fragmented, with each training institution functioning on their own, without coordination by a nodal state institute like the SIHMC.

RHFWTCS such as in Gwalior and Indore seem more dynamic having their teams and facilities that can provide more comprehensive continuing education at a higher level.

Both teams did qualitative assessment of the functioning of paramedical training; one ANM Training School at Guna and a GNM School at Chhindwara.

ANMTC Guna had only two faculty members to train a batch of 60 ANMs whereas Chhindwara GNM School had two tutors for 40 students with no Principal, the senior sister tutor is the acting Principal. The teacher student ratio needs to be according to norms. ANMTC Guna was well housed and equipped with teaching aides, but there was no course currently running. The gap between the last batches was 6 months i.e. the Training Centre was lying idle when there is shortage of ANMs. Optimal use of these facilities is required.

**2.3. GNM school attached with district hospital Chhindwara** had very poor infrastructure- one room having 4 beds to house 6-7 girls, windows kept closed all the time because of overgrown weeds on the other side. There are only two classrooms. The broken roofs revealing the open sky need urgent attention. One of the classes is organized in the mess hall. As it is because of dearth of space, hostel mess and the library is housed together. Out of three toilets for 40 girls only one seemed functional!!

The team had witnessed the very poor diet served to future nurses to teach nutrition. Budget of Rs.600 for food is too low, and the stipend is only Rs.1500.

In spite of all these limitations, the efforts to keep the place well organized by staff and students were very positive.

The school needs a bus needed to take the girls on field trips. There is no facility for stay so the girls have to go and come back every day. If there could be accommodation and mess near PHC/CHC, they can stay and attend to night duties.

#### **2.4. Recruitment and cadre management:**

Measures have been initiated at State level to reduce the gaps in availability of doctors, by rural posting of one year for graduate and PG doctors from government medical colleges, as well as appointment of AYUSH doctors to PHCs.

The state has also recruited contractual doctors and nurses from the available local market pool to fill the human resource gap. Even this contractual post recruitment drive still leaves 48.8% vacancy among doctor's posts of 172 and 46.5% vacancy among nurse's posts of 243 posts in Chindwara district. There is no immediate solution to this HR challenge.

Governance issues in transfers and postings were raised by some respondents but could not be explored in detail.

Timely promotion needs to be ensured to boost the morale of serving staff. To quote one example, the staff nurse of GNM School Chhindwara didn't get a single promotion in her 18 year career!

DPC meetings are not conducted for long and many senior positions are lying vacant.

#### **2.5. Plan for Augmentation of Health Human Resources:**

A health human resource development cell is required that can evolve a HRD management and training strategy including comprehensive Continuing Education of all staff. This will need to include cadre development, policies for recruitment, transfers and promotions. The MP TAST team is providing support in these areas. However the State will need to develop self reliance in these areas. Inputs are being drawn from the National Health Systems Resource Centre eg in the ISO certification of the Katni District hospital. However further collaboration can be developed for Human Resource Development including planning for nursing, ANM and Health Worker (Male), LTs and other allied professionals.

The PP Partnership with Pondicherry University for improving Nursing education in 6 Nursing Colleges is welcome step.

#### **2.6. Skill quality of Health Human Resources:**

Deficiencies were noted in the competencies of ANMs (Health Worker Female) during the field visits. They were unable to measure BP properly or to take the weight. Hemoglobin estimations were interpreted differently with a tendency to use the same needle to prick more than one person. Plotting and use of the Partograph was also found to be difficult and was done after the delivery i.e. it was not used to make a decision. On the job supervision of practices seems to be missing. In the unscheduled visit to a CHC the care of a woman just arrived for a delivery was poor right from history taking to examination. The BP apparatus was not functioning properly and necessary drugs were not available.

#### **2.7. Training:**

Compared to previous year the pace of SBA training is slow, training was given to only 55 out of 384 staff nurses and 198 ANM and LHV's out of 576 targeted.

Female AYUSH doctors are given SBA training, which is a good strategy.

Quality of SBA training needs to be looked into as many did not get adequate hands on training in conducting deliveries. There is no post training contact or mentoring by trainers.

MTP trainings given to doctors with support from Ipas, in district hospitals/CHC, two of the doctors in District hospital were found practicing the newly acquired skills.

### **2.8. Partnerships in Training:**

The development partners are playing an important role in orientation and refresher training. The UNFPA is involved in the training of recently selected Block Program Managers in batches. They also provide training on the PCPNDT Act and on RCH. JICA has modified existing training modules for ANMs and focus on the quality of training processes for ANMs and staff in the five districts of Sagar Division (Bundelkhand). They also train on Biomedical Waste Management and HMIS. UNICEF supports skill based training of ANMs in Guna and Shivpuri districts and also statewide. They support staff and institutional development of NRCs and SNCUs in a very effective manner. The DFID MP TAST team is also involved in several ways including gender sensitization, staff recruitment, training of interview boards for staff selection etc. Time did not permit a more detailed understanding.

Issues that may be considered include:

- Scale up and cross learning from these initiatives could be planned in the state to ensure wider benefit from the learning's and positive outcomes.

### **3. Assessment of the case load being handled by the Public System**

Out-patient and inpatient load is high at CHC, district hospitals and medical college hospital. District Hospitals are over stretched, overcapacity, but management has improved with Hospital Administrator and other supports and funding. The Medical College also needs hospital administrators and management systems just as in district hospitals.

The CHCs had TB, leprosy, malaria and general patients. The maternity wards were full, specialists were performing Caesarians, blood banks were operational, labour rooms and OTs had been renovated, NRCs and SNCUs were running professionally.

But the PHCs are underutilized with 8-12 patients/day, improved since past year.

The strategy for MCH in Guna district strengthening Health Sub Centres and PHCs to conduct normal deliveries, with efficient referral transport systems, and to manage newborns is well designed and implemented, with good supervision, documentation and analysis. The approach is being adopted by other blocks and districts.

Since the start of NRHM in 2005 there is an increasing trend in the annual number of patients treated (out-patient from 2.1 Lac to >3.4 Lac and inpatient from 21 to 47 thousand), institutional deliveries (3.5 to 9.1 thousand normal deliveries and 674 to 1022 Caesarean deliveries) and other services like surgeries from 1798 to 2441 and threefold increase in diagnostics/ pathology and two fold increase in blood transfusions in the Chhindwada district hospital. But there is a decrease in X-rays, ECG and TMT.

In Tamiya CHC the outdoor patients increased from 66/day in 2008 to 76 day this year, but the new admissions are the same around 40 per month. But in CHC Parasia the outdoor patients decreased from 195/day in 2008 to 120/day this year and the new admissions from 209/month to 163/month.

After the peak in August there is a uniform decrease in deliveries in district hospitals and CHCs as depicted in the table below.

### Number of deliveries:

Name of the facility	August	September	October
District hospital	842(CS 87)	692(CS 85)	620(CS 107)
CHC Parasia	211	160	146
CHC Tamia	89	68	60

#### 4. Preparedness of facilities for patient care services

There are 83 CEmONC and 397 BEmONC centres currently operational in the state and 37 MBBS doctors trained in EmOC in addition to specialists posted to take care of women with Obstetric emergencies.

40 blood banks and 56 blood storage units established.

There are only 647 beds for admission available against sanctioned 795 in the 82 peripheral institutions (15 CHC and 67 PHC & 1 Civil Dispensary) in Chhindwara district.

Post natal and paediatric wards were full in CHC Parsia revealing the popularity of doctors and nurses.

#### 5. Outreach activities of Sub-centre

Efforts are made for strengthening of the Sub-centre and the improved performance of all outreach programmes especially the utilization of Village Health and Nutrition Days and immunization coverage.

Routine Immunization Control Rooms are established at Directorate, Districts and Blocks level to *obtain Data on the day itself, regarding Sessions Held, Vaccine Pickup, Social Mobilization & Supervisors report for immunization*. RI Control Room is turning the “monitoring of sessions” into a campaign mode.

However the results are the fully immunized coverage is only 36.2% (DLHS-3) and 40.3 % (NFHS-3)

**VHNDs needs to be still better implemented and monitored to get the desired results.**

#### 6. Thrust on difficult areas and vulnerable social groups

To provide adequate services to difficult areas a compulsory 2 Years government service bond for fresh graduates and post graduates introduced. Compulsory rural posting of 255 PG Doctors and 317 MBBS Doctors enforced. Difficult Area Allowance is proposed for ensuring availability of doctors and para- medical staff, after categorizing institutions into normal/difficult/most difficult/ inaccessible areas.

Out of the 1155 total PHCs, 501 are in difficult areas, 148 are in most difficult areas and 11 are in inaccessible areas. 2908 out of the total 8860 Sub Health Centres in the State are functioning in the tribal areas.



Ms. Rambhai Dubey, ANM of PHC Chhindi in Tamiya block spends two hours to walk down the valley of Pataalkot and another three hours to climb up with registers, vaccine carrier and medicines-reaching the unreached.

To what extent the thrust of government to reach out to vulnerable social groups materialized? Access of BPL families to services and facilities is reflected in the UNFPA evaluation of Janani Express Yojana which is 28%. Similarly JSY coverage for institutional deliveries is 83.8% out of which 35% goes to BPL families.

When they do not get Janani Express on time, many women are coming on their own to hospital and spends up to Rs.300. If the women come on their own they are not paid any money for referral currently, but at least they could be provided free transport to return home after discharge.

There are 91 Mobile Medical Units operational under Dindayal Chalit Aspatal scheme in tribal blocks. Mobile Medical Unit-Contracted out to an NGO KGN Welfare Society, Betul are rendering regular services with adequate staff and good supply of medicines in Tamiya block; it is coming on scheduled days with enough medicines as per fixed route chart.

## 7. Quality of services provided

NABH accreditation process is initiated in 5 hospitals to declare quality standards of government hospitals. ISO 2000-9001 Certifications also initiated in one district hospital, one civil hospital, 2 SNCU 5 Regional diagnostic centres.

Thrust on infection control and cleanliness, as well as Infection prevention was found lacking in Burns unit of a district hospital, Chhindwara. In the same hospital the ICU/CCU are maintained very well at the same time and NRC is even better.

Lack of running water supply due to damage and theft of PVC pipes by local miscreants in Chandameta Civil hospital was affecting quality of services.

Staff nurses/ANMs after SBA training were maintaining partograph in the labour rooms.

The quality of antenatal and post natal care requires greater attention and supervision in the field. While efforts have been made to improve the quality of intra-natal care the continuum

of care could improve. The role of Dai's along with ASHA's especially in health education/promotion during the ANC and PNC period to be reconsidered with adequate training and support.

**Monitoring and Supervision:**

Supervision and recommendation register in each facility may be provided, where in the supervisor would write their comments. This would be a very helpful tool for the next visit by any Supervisor, ensuring continuity in supervision.

**8. Diagnostics**

Availability of trained medical, para medical and nursing personnel is a major challenge in ensuring quality. Less than half of the PHCs in the state have laboratory technicians and pharmacists. Similarly only two third of the CHCs in the state have laboratory, O.T and X-ray machines.

At CHC Tamia and CHC Parasia new models of X-ray machines are needed. The X-ray technicians are not wearing radiation safety badges as it is not supplied.

Special investigations like USG, MRI, CT scan, Color Doppler's etc. became a reality because of RKS funds.

**9. Logistics & Supply chain management**

There are 272 drugs listed under Essential Drug List of July 2007. The Procurement Cell is having one Joint Director and two Deputy Director with an additional support of Consultant Logistics, MP-STAT. They have installed ProMIS, an inventory management software for drugs procurement and supply.

There are 27 Drug Warehouses out of which 7 are constructed by DANIDA project.

Instances of stock outs and less availability of essential stocks were not heard from the field. On the other hand media representatives angrily represented to the team of dumping of huge stocks of expired drugs in open pits in Tamiya.

**10. Decentralized Planning**

Though the district Chhindwada had made detailed presentations on achievement under NRHM they did not show a well written Integrated District Health Action Plans (IDHAP) or could describe a systematic process of developing the same. Probably the situation is the same in other districts too. The activities taken up are in concurrence with state NRHM SPMU guidelines rather than follow up of IDHAP.

CMHOs are not comfortable in taking their own decisions and resort to safety net of approvals of DCs resulting in almost each and every file going to District Collector for approval eg: Chhindwara fortunately he is quick in approvals, but need not the same in other districts. Delegation of powers needs to be enhanced at each level and CMHOs/BMOs need to be told to take decisions and depend less on Revenue Administration for their day to day functioning.

**Working of District Health Society (DHS)**

The assessed DHS was working well under the leadership of the District Collector, Chhindwara. However the working of DHS needs to be streamlined and made more focused.

Each of the District Health Society meetings chaired by DC should be used to get more NRHM activities implemented. This is particularly necessary to ensure effective use of the time spent by DC and other officers out of their busy schedule on DHS meetings.

Specific recommendations for making DHS meetings more effective:

- Detailed agenda notes to be prepared and circulated to the members well in advance, at least 2 days before the DHS meeting.
- DPM should collate all the materials for agenda and should alone be responsible for writing and getting the minutes signed, not others to take over this role.
- In the beginning of each DHS meeting, to place the 'Action taken report' on decisions of previous meeting.
- One time approval of district action plan to be taken at the beginning of the financial year and then implemented. Only in cases of change in implementation strategy or financial component should it go to the DHS again thus avoiding a lot of unnecessary procedures.
- Training in office procedure needed for better and faster implementation
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## **11. Decentralised Local health action**

Funds are released to all VHSCs and Utilization level is good wherever we checked. Meetings are held regularly, minutes written, signed by members at HSC Khunachirkala under Muhked PHC of Chhindwara district. VHSC fund utilization optimal and incurred expenditure not reported periodically. Block Accountant need to proactively collect the SOEs and monitor quality of expenditure of this decentralized spending

### **Rogi Kalyan Samiti:**

Set up in all health institutions (DH, CH, CHC, PHC) with the mandate to manage the facility with Quality of services with a greater autonomy.

All district hospitals are having an MOU with Sulabh International to ensure cleanliness, hygienic wards and toilets with RKS funds. RKS funds are also used for life saving drugs in emergency ARV, AVS, streptokinase and for critical care like cardiac ICCU, neonatal ICCU, trauma center, special investigation USG, MRI, CT scan, Colour Doppler's etc.

Utilization of RKS funds is having mixed picture of poor utilization (PHC, Chhindi, Chhindwara - 13% in 2009-10), average (CHC, Tamia, Chhindwara – 53% in 2009-10) to excellent: PHC, Awan, Guna – 80% in 2008-09), Distt. Hospital, Shivpuri – 70% (2008-09) Distt. Hospital, Chhindwara - more than 100%.

## **12. Community Processes under NRHM**

While there has been implementation and innovations in the critical **Communitisation** component, progress has been relatively slow and there are many areas of concern.

### **13.1. Village Health and Sanitation Committees:**

VHSC's have been constituted in 24,520 villages. They are reformed into '*Swasthya Gram Samiti's*' with inter-sectoral collaboration between the Mahila Bal Vikas Department and other departments. The integration was agreed to after several rounds of discussion between departments initiated by the Health Commissioner. It is to be actualized shortly.

Training modules are still being developed with many groups involved. The state VHSC consultant left some months ago and has not yet been replaced. There is confusion about the utilization of VHSC funds, about giving UCs and if funds are not utilized during previous years whether can be carried over. Disbursements are delayed and it was reported that Rs. 2000/- was given and further payment installments were not made. While state consultants say that guidelines were given to the DPMs this appears not to have been passed on in many districts from which NGOs came. There is a need for training and handholding of VHSC members, ASHAs, field staff and NGOs to provide clarity about roles, responsibilities, management of accounts etc. The ASHA samanvayaks and BPMs could play a supportive role.

The appointment of District Community Mobilisers has been discussed for 2-3 years. Appointments were recently made. Only five have joined. Low salaries were one of the reasons given.

### **13.2. Community Monitoring and Planning (CMP):**

The pilot phase undertaken in 4 districts has not been expanded. This independent social accountability mechanism that is written into the NRHM Framework of Implementation has been valuable. While the term Monitoring is changed to Community Action for Health, including monitoring by the NRHM-AGCA there is a need to enhance the budget in the PIP, utilize it and expand the program as has been done by other states such as Maharashtra, Karnataka, Rajasthan etc. At state level the Asha Mentoring Group and the CMP mentoring group can be combined.

The **Seharaiya integrated camp** was a good innovative initiative offering a single point at which members of the Seharaiya committee could avail multiple services including health care. A medical camp was conducted as part of the integrated camp

### **13. ASHA and the ASHA support system**

ASHAs were seen/met in all the health facilities visited. They had accompanied women for deliveries. They knew about early starting of breast feeding and had ensured that it happened. They also knew about immunization.

A decision was made and a GO has been passed to increase the number of ASHA's in the state according to the number of Anganwadi's thus increasing community access to ASHAs in *Majra's* and *Tola's*. This means an increase from about 44,832 ASHAs to 62,253. 98% of original target of selection ASHA's has taken place in the state. However the selection process has not always been following the guidelines.

ASHAs have not completed the 23 days of training planned and budgeted for the first year. Ongoing training of 23 days per year is also not being done.

There is no system at state level of knowing who the ASHAs are or tracking them, though payments are being made to them regularly by cheque and many have received IDs at district/block level. While they had ID cards most had left it at home.

Refresher training, 5<sup>th</sup> module training though decided upon several months ago is not taking place.

#### **ASHA Resource centre – non functional**

- ❖ ASHA support system – ASHA *Samanvays* (one facilitator for 15-18 ASHAs) were selected but were not given joining letters due to a change in policy. There is therefore no functional support system for ASHA. While ANMs and LHV's are supposed to play this on the job training and supportive role, it is widely felt that this will not be practically possible.
- ❖ ASHA Mentoring group- field visits by AMG members have not been undertaken because of non release of funds.
- ❖ NHSRC community facilitator – not retained, recently left.
- ❖ **ASHAs could be developed as health promoters over a two-five year period with a comprehensive approach including IEC/health education for non communicable diseases.**

### **14. National Disease Control Programmes**

#### **Overall Effectiveness of NDCPs**

The NDCPs are yet to be integrated well within the overall NRHM framework. Programme Management support requested and available to the disease control programme from the PMU is not as much as for MCH or JSY. Mainly guidelines come from National level and the State units implement the activities as per given norm

#### **14.1 NLEP**

Prevalence rate has come down from 4.4 in year 2000 to 0.73 last year. Similarly Annual Case Detection Rate of 55.28 in 2000 has also come down to 8.99 last year. The state needs concentrate its attention on 7 blocks with PR more than 2 per 10,000 populations with priority monitoring of 51 blocks in 11 districts.

#### **14.2 NVBDCP**

Malaria Positive Cases reduced from 2.16 lakh( in 1998) to 1.05 lakh cases ( in 2008), a reduction by 57.98%. API is 0.69% and Pf is 17.34%.

516 Male workers, 48 Malaria Technical Supervisors and 20 Lab Technicians appointed with GoI funding will boost the programme.

67 blocks are identified as Hot Spots for Malaria in the state and high API sub centre areas will be specially targeted for focused intervention.

Village Health & Sanitation Committee from Untied Fund can give incentives for induction of Larvivorous fish, conduct larva survey & destroy larvae by getting containers emptied for control of Vector Borne Diseases.

#### **14.3 RNTCP**

Though the sputum conversion rate and cure rate is high the Case detection rate is low in the state.

Vacancy of contractual staff is crippling the programme eg; most of the key posts of State TB Cell and 14 Senior Treatment Supervisors, 20 Senior TB Lab Supervisors and 12 lab technicians are to be appointed. The state has 7 TB Hospitals, 142 Treatment Units, 736

Designated Microscopy Centres and 16384 DOT's Centres.  
72 DMC's out of a total of 730 DMC's were identified to be non-functional due to lack of LT/MO. Low involvement of Private Practitioners and NGOs is another limiting factor  
ASHAs not clear on their incentives on DOTS. More Lab technicians need to be urgently recruited. Capacity building of Medical Officers on categorization of cases for DOTS needed.

#### **14.4 NBCP**

Good achievement (above 84%) in Cataract operations and IOL implantation. There is only one Eye Surgeon against requirement of 59 in rural areas and another one in tribal areas.

#### **14.5 NIDDSCP**

16 out of 50 districts are endemic areas for the Iodine deficiency related disorders. IDD Survey conducted only in 4 districts. No reports available on collection of salt samples for testing Iodine content.

#### **14.6 IDSP**

Surveillance units have been operationalised at 4 medical colleges and 45 district hospitals. But the value addition being made by the epidemiological data collected and collated under IDSP is questionable.  
No evidence of data leading to detection of early warning signals of impending outbreaks and helping the state initiate an effective response in a timely manner. Nor it has led to improvement in the efficiency of the existing surveillance activities of disease control programs or facilitated sharing of relevant information with the health administration, community and other stakeholders for decision making at district and state levels.

### **15. RCH II**

#### **(Child Health, Maternal Health and Family Planning Activities)**

Bal Suraksha Mah is a good strategy implemented biannually to clear the backlog of coverage in immunization, Vitamin-A supplementation, de-worming and promotion of iodized salt and iron supplementation.

#### **Family Planning:**

With a birth rate of 28.5 and TFR of 3.12 above national average the achievement in CPR (52.8%) for Family Planning is not satisfactory.

The increasing number of institutional deliveries due to JSY offers a very good opportunity for post-partum family planning counseling. However, this seems to be an area that has low focus as of now. During interactions with many of the expecting mothers as well as mothers of new born, it was observed that they seemed to have not received any family planning advice. Even though the state is undertaking training of ANMs for insertion of IUDs in the post-partum period using Zoe models, the ANMs need a lot of confidence building and

assurance. The ASHAs as well as ANM capacities for counseling on Family Planning methods need to be strengthened- some of them on being asked about contraceptives could not explain their correct usage.

### **Janani Sahyogi Yojana-a PPP model:**

207 private institutions have taken up Janani Sahyogi Yojana, for increasing access for Emergency Obstetrics services. They provide a package of services during 100 deliveries for Rs.185, 000/-

The scheme which has been revised recently has seen a very low uptake by private providers. It was reported that the package rates being offered by the government for 100 deliveries, seem to be not clearly understood by the private providers and hence uptake may be low (as earlier the scheme offered different rates for normal and Caesarian deliveries). The scheme needs to be more aggressively promoted, explaining the basis for arriving at the package and marketing the business case to the doctors of increased client flow. Involving private provider associations like FOGSI and IMA may be worthwhile. If the uptake continues to be low, the state may have to look at arriving at a package rate in consultation with the private provider associations so that the facility can be extended to more providers, thus increasing access to the people.

313 blocks are having free transportation models to reach a health facility for maternity services with 10 call centres.

100 remote Health Sub Centres upgraded in the state for 24x7 services for Safe deliveries. ASHAs are creating demand and making referral to the facility for MH, CH and FP services.

Adequate funds are available everywhere under Janani Suraksha Yojana, a major improvement over previous year. Payments are being made mostly on time through bearer's cheque both to beneficiaries and ASHAs.

Occasional delays in JSY payments to ASHAs need to be avoided at any cost and BMOs are to be instructed on this.eg: second JSY installment to ASHAs (Rs.200) delayed at Tamia: 67 out of 100 payments pending for Apr, 09, 46/76 for May, 43/78 of June. We need to bear in mind that ASHAs work purely on incentives with JSY as their mainstay.

### **16. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health**

There was involvement of Panchayat members in Village Health and Sanitation Committees, but higher up the system there were little evidence of convergent efforts at addressing malnutrition, vector-borne diseases, age of marriage, school health etc. Linkages with the Rural Development department for safe drinking water and sanitation and Women and Child development department were minimal.

### **BCC:**

One important strategy for health promotion and disease prevention is an integrated IEC approach towards achieving behavior change.

The IEC strategy for the state has been prepared through a consultative process and 8 key behaviors related to RCH issues have been identified in order to streamline BCC planning. The districts are being guided to develop their communication plans aligned to these 8 key behaviors and at the same time having freedom to respond to the local challenges and issues.

The districts are also encouraged to identify the 'high alert' blocks and villages, which have the worst indicators, and plan specially focused IEC activities in those areas. The criteria and process of selection of the 'high alert' areas has been clearly defined. Each of the districts has been given very comprehensive formats for preparing the district level IEC plans in a decentralized way.

In district Guna, with UNICEF support, the state has also done a formative research to look at behavioural determinants and barriers to behavior change. Subsequent to this study the tools for carrying out a similar formative research in other districts have been prepared and sent to the district IEC officers. But capacity building of IEC officers in using this "barrier analysis tool" has not taken place.

The state has also developed a BCC implementation and monitoring MIS software, planned to be piloted in two districts. Establishment of a BCC Cell at the district level, as a single umbrella cell to promote inter-sectoral synergy on BCC activities with the IEC unit of different departments like health, ICDS, rural development, Panchayati raj etc is another initiative supported by UNICEF.

In discussions with many of the expecting and breastfeeding mothers at the facilities, it was observed that they were well informed of the benefits under JSY and about the call center numbers for transportation. They were also aware of the importance of early initiation of breastfeeding and most of the mothers had initiated breastfeeding within one hour of birth. However, exclusive breastfeeding till six months was an issue not yet understood by many of the mothers and there is need to have focused IPC on this issue.

### **The challenges:**

#### **Capacity enhancement for IEC bureau**

MP has a separate IEC bureau building which is quite huge but grossly underutilized, understaffed and lacks modern information technology equipments

#### **Lack of IPC materials;**

There is an urgent need to develop interpersonal communication tools like job aides, flip charts. After development of these tools, a training of the ASHAs and ANMs on how to use these should also be done.

#### **Needs-based resource allocation**

All the districts are given equal IEC budgets irrespective of the size of the districts or the number of high alert blocks. Similarly the budget for each block is the same, irrespective of them being identified as high alert blocks.

#### **Handholding for decentralized BCC planning and monitoring**

Decentralization in planning has been done, without the capacity building that should have accompanied it. There is no system in place for monitoring the district IEC plan implementation.

### **Capacity building of functionaries at all level**

The SIHMC (State Institute of Health Management and Communication) , Gwalior is also mandated to be the institution responsible for capacity building of the IEC staff as well. However, it has not been fulfilling its role to a great extent in the past.

### **17. Nutrition**

Under NRHM, steps are being undertaken by the state & district to improve early & exclusive breast feeding, especially among institutional delivery cases as well as identification of early malnutrition and management of moderate to severe malnutrition with complications.

Chhindwara District hospital is capturing the data on initiation of breast feeding within one hour of birth.

Responding to the occurrence of severe acute malnutrition to the tune of 27% (NFHS-3) and under-nutrition among a large proportion of under-five children the state has developed 189 Nutrition Rehabilitation Centres (NRCs) including 50 district hospitals. 24,614 cases have been treated and discharged in 2008-09 which is more than three-fold rise compared to the first year of functioning of Bal Shakti Yojana.

Apart from therapeutic diets, mothers are well trained in preparing and feeding the child correctly by Nutritionists. Unfortunately post discharge very little linkages are established by these NRC staff with the ICDS staff of the village where the child comes from.

It is recommended that a state specific module on nutrition and child care for ASHAs be developed to enable this large number of women in each hamlet and village to support mothers in nutrition and child care at community level. There will be no overlap but a complementarity with Anganwadi workers and the ICDS which tends to focus on the 3-6 year olds. The ASHAs can focus on children from birth to two years.

### **18. Non-governmental partnerships:**

There have been partnerships that are well managed with NGOs through the Community Monitoring and Planning (CMP) component of the NRHM in four districts till 2008-9. However after the pilot phase, this has not been continued or expanded despite a small budget in the 2009-10 PIP and a positive national level external evaluation report. This avenue to strengthen VHSCs and through them to promote community participation which is essential for comprehensive primary health care and CMP for independent social accountability has been closed. This needs to be reconsidered.

Partnership with NGOs, facilitated by UNICEF in Guna district, has led to strengthening ASHAs and VHSCs in the project areas. Similarly Mobile Medical Unit of Tamiya block operated by KGN Welfare Society, Betul is a good example of Civil Society partnership.

MNGOs complained that their 3 year projects were suddenly closed, after one year, adversely affecting work in the community. This decision was taken after a review meeting chaired by Health Minister, reportedly due to unsatisfactory performance and alleged corruption by some NGOs. NGOs assembled prior to CRM teams' debriefing admitted that they lack accounting experience and fund management capacities. An evaluation of MNGO's has been completed in ten districts. Further payments have been kept pending till the evaluation report is published.

This raises the issue of capacity to select, manage, nurture and monitor NGO partnerships by the state and calls into question the fairness of sudden decisions that affect all NGOs though only some may be unsuitable for the task.

NGOs also desired more representation in RKS of various hospitals, than the currently occupied traders and businessmen to better represent needs of and amenities for patients.

## **19. Programme management Units**

The programme management structures recommended by NRHM i.e. State Programme Management Unit, District Programme Management Units and Block Programme Management Units are in place. Their role as professionals functioning in the health sector team which is essentially inter-disciplinary needs to be recognized and valued for their full potential to be realized.

The effort to integrate the directorate and the existing officers with the new NRHM staff at the State level is a positive development. The current structure is functioning well because of the forceful and able leadership of MD, NRHM. Periodic evaluation of programme management arrangements can help the State in making the structures more effective in long term.

Currently 14 out of 50 DPM positions are vacant. UNFPA is helping the state in recruitment. Due to high attrition rate, recruitment seems to be an ongoing process. The last CRM had also commented on PMU and were told that recruitment was in process. The state needs to advertise for all the SPMU, DPMU and BPMU posts and make a waitlist which should be valid for at least 2 years in order to maximize the returns from such resource and time intensive recruitment exercise. The newly inducted programme management /finance personnel needs to be well oriented and mainstreamed for better utilization of these professionals.

The coordination between the State and District programme management teams and between District and Block programme management teams seemed lacking at places e.g. what was the hand holding given to BPM of Pipariya by DPM of Hoshangabad ?

The State level team need to hand-hold the new district and sub-district teams and help them establish at district and block levels. The SPMU also needs to be supported from the national level through periodic meetings (at least biannual) and refresher trainings which would promote cross-learning from other states and keep the motivation level high. Support for DPMU and BPMU training to state needs to be provided from the national level too. Though the state level presentations stated that DPMs and Block programme personnel being reoriented every quarter, the interaction with field level personnel showed that there was lack of such orientation and training and support from state and district level.

GOI's advice on roping in an institution of repute for training to DPMU and BPMU staff on programme management including finance & accounting needs to be implemented soon.

## **20. Financial Management**

**State level:**

Fund flow was found efficient at all levels. E-transfers to all Districts are taking place from Bhopal with the help of State Bank of India. Although the centralized uploading of Sanction letters are not taking place on the SHS's website, Sanction letters are e-mailed to Districts so that the Districts can start using the funds received through e-transfers.

Financial approvals of District Action Plans have been clearly communicated to Districts and, thus, there is clarity at the District level as to what has been finally approved in the PIP. Delegation of Financial Powers have been done and communicated to all districts.

A new post of Joint Director (Finance) has also been created which will give further boost to the financial management issues and especially the internal control mechanism.

### **Suggestions for improvement at the State level:**

State Bank of India is providing e-transfer facility to the State Health Society. However, going by the present definition of e-Banking, the facility provided by SBI is elementary. After 2-3 years of getting all the bank accounts up to village level under NRHM, SBI should have provided a comprehensive Financial Management Information System to the State Health Society. ***To begin with, the bank should be asked to immediately start providing MIS of bank balances of each bank account held by it in the system. The bank account details of all the Sub-Centres, PHCs, CHCs and DHS should be structured in a hierarchy so that district-wise bank balances can be available to management both at the District as well as at the State level as decision support system.***

***The vacant posts of SAM and SFM should be filled up without any further delay*** as in a large state like Madhya Pradesh the requirement of quality finance and accounts related manpower cannot be overemphasized.

***Huge advances amounting to more than Rs.200 Crores are lying in the books of the State Health Society.*** Although the Mission Flexible Pool mechanism by the virtue of its design cannot do away with the advances, focused attention needs to be given on liquidating these balances. Efforts on getting the reports of utilization from lowest level health institutions, especially pertaining to Annual Maintenance Grant, Untied Grant and Corpus Grant to RKS, will go a long way in solving this problem. Any attempt towards this will bear result as in the field utilization of these funds was found at the optimal level.

***Utilization of funds both under the Mission Flexible Pool and RCH Flexible Pool was low up to second quarter*** and stood at 13% and 26.32% respectively. In the case of RCH it acquires special meaning as out of the funds utilized almost 72% is on Janani Suraksha Yojana only.

### **Field level:**

The quality of book keeping has improved by leaps and bounds in the field. This was evident at all levels, including at the Sub-Centre level. The concurrent audit mechanism pioneered by Madhya Pradesh seems to have been a major factor for this improvement. The CRM Team was impressed with the financial management system put in place by the State. However, in this report generally only those areas that are being highlighted where there was some scope for improvement. The report, thus, should not be read as complete picture.

## Rogi Kalyan Samities

Utilization of RKS funds was generally at the optimum level. However, at a few institutions the utilization was low, e.g., in Sector PHC, Chhindi, Chhindwara – 13% (2009-10). On the other extreme the utilization in the District Hospital, Chhindwara was more than 100% as compared to the earning during the year.

### What RKS Funds can do..

At most of the institutions visited it was observed that the RKS funds have been utilized for the purpose for which they are meant and the effect of these funds was there to be seen.



### What RKS funds cannot..

However, during an unscheduled visit to CHC, Pipariya, District Hoshangabad, the team found that the hospital was in a bad shape. Not only the building looked dilapidated, there was no provision for lighting the common areas, cleanliness seemed to be an alien idea, waste disposal was not being done at all, patients were lying on bare iron beds with torn plastic mattresses with no bed covers provided by the hospital, bathrooms were in pathetic condition, and the minor OT was being dirtied by stray dogs.

One must admit that the picture here was in total contrast with all other hospitals that the team visited. In other hospitals, the patient load was high but upkeep of the hospital was much better, and at several places it was excellent. Patient load was high in Pipariya as well which was evident seeing the bed occupancy. However, the sheer neglect by the hospital administration seemed to be the reason behind the situation at this institution.





The most surprising fact was that, going just by the expenditure figures, the utilization of RKS funds here as well was excellent. A snapshot of fund utilization in the CHC is given below:

### CHC, Pipariya, Hoshangabad

#### A. Status of Income & Expenditure of Rogi Kalyan Samiti:

S.No.	Year	Income (In Rs)	Expenditure (In Rs)
(1)	07-08	1,00,000	1,00,000
(2)	08-09	1,00,000	1,00,000
(3)	09-10	1,00,000	-

#### B. Status of Income & Expenditure of Untied Fund:

S.No.	Year	Income (In Rs)	Expenditure (In Rs)
(1)	07-08	50,000	50,000
(2)	08-09	50,000	50,000
(3)	09-10	50,000	22,949

#### C. Status of Income & Expenditure of Maintenance Grant Fund CHC Pipariya:

S.No.	Year	Income (In Rs)	Expenditure (In Rs)
(1)	07-08	1,00,000	1,00,000
(2)	08-09	1,00,000	1,00,000
(3)	09-10	1,00,000	74,122

Note: Current A/C Status of RKS: Rs 32,638=00 in account

This experience brings us to the next level of realization: *Money spent cannot be a yardstick to measure patient welfare or fulfillment of RKS objectives in all cases.* The quality of decision making in the community forum established by RKS perhaps need to be our next focus area. Mere representation of community members may not be enough to ensure proper utilization of funds, especially the outcome of the funds spent. *Time has come when the utilization details of RKS funds need to be put in public domain through local newspapers and circulars to Panchayati Raj institutions which will facilitate social audit. And this is*

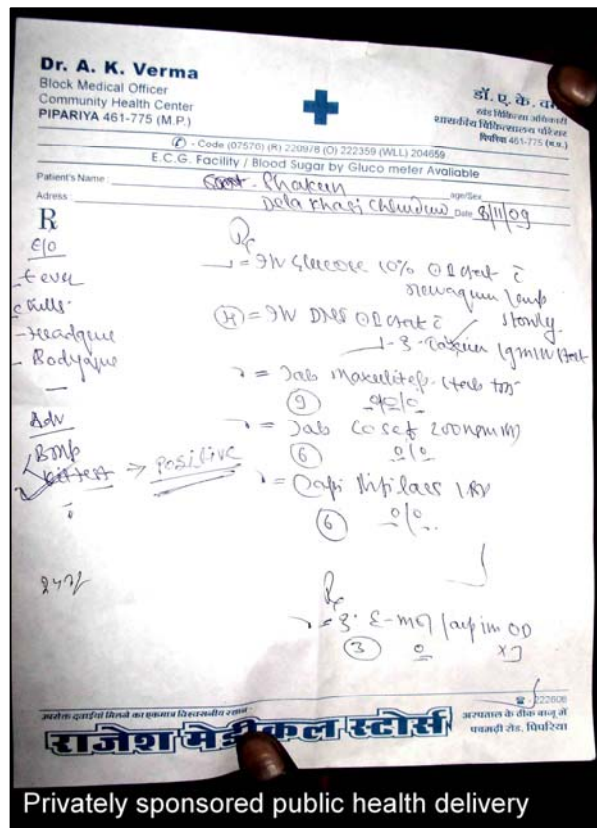
*not just for Madhya Pradesh. RKS mechanism has been in vogue in almost all States for quite some time now. All States should start monitoring the RKS mechanism through a process of social audit.*

### Annual Maintenance Grant and Untied Grant not under RKS purview

The AMG and Untied Grant are not credited to RKS account and are being operated separately through a separate bank account. Decisions to use this fund are taken by doctors with bank account often operated through a single signatory. ***It is strongly recommended that, aligning with the GOI directives, these grants are put under the purview of the Rogi Kalyan Samities so that a larger body with community participation has a say in utilizing these grants.*** Madhya Pradesh is in the process of bringing in a major reform in the RKS mechanism. This is perhaps the right time to merge these funds with RKS.

### Private practice by Government Doctors

Private practice by Government doctors is allowed in Madhya Pradesh, excluding the CMHOs, Jt. Directors, Directors, etc. who hold administrative responsibilities. ***However, there must be some riders to this dispensation. For example, the State may consider not allowing private practice by doctors from their residential quarters situated inside the hospital campuses.*** This practice presents peculiar situations. One of which is that patients are found admitted in the IPD wards of the hospitals taking consultations at residential clinics of the Government doctors which increases the out of pocket expenses of people. In one case the patient in the IPD ward was holding a prescription issued at the residential clinic of the BMO with the following printed on the bottom of the prescription: “Above prescribed medicines are available in the medical store situated just outside the hospital”. The prescription was actually sponsored by the said medical store. This perhaps does not gel well with the idea of a proper public health delivery system.



### Concurrent Audit

Madhya Pradesh is the pioneer in starting the mechanism of concurrent audits at the District level under NRHM. Based on this experience, the Government of India has prescribed similar mechanism of concurrent audit in all States. However, it was observed that the mechanism of concurrent audit has been stopped in the State since April, 2009. During discussions it came to notice that the mechanism of concurrent audit is being centralized at the State level.

However, in the process the first causality has been the very mechanism which is being 'strengthened'. It has been almost 8 months that the concurrent audit mechanism has stopped taking place. In the field at all levels functionaries were enquiring about the status of this mechanism as in the past it has helped in streamlining the system of book keeping and voucher maintenance at health institutions, including the Sub-Centres.

*It may be a matter of debate, but the concurrent audit was perhaps best done in a decentralized manner as it gave assurance to the field level functionaries that this audit was more for keeping their house in order than an oversight mechanism of the State<sup>6</sup>. Centralization may arguably bring in more objectivity, however, it also brings problems of logistics, coordination, and foremost of all, delays.*

### **Delegation of Financial and Administrative Powers**

Based on the framework provided by GOI, the State has circulated a comprehensive Delegation of Financial and Administrative Powers to the Districts. However, it was felt that the CMHOs and BMOs could be vested with enhanced powers so that their dependence on the Revenue Administration for day to day approvals is minimal. In Chhindwara, for example, it was observed that almost all files were being sent to District Collector for approvals. There are two discernible reasons for it: (1) the delegated powers themselves are limited; and (2) CMHOs and other health functionaries have become used-to to the safety net of getting the signature of higher authorities for each and every decision.

*Thus, there is a need to bring in reform in the system so that health administrators take their own decisions and be prepared to be held accountable for the same. This will go a long way in developing a robust health administration which does not only treat patients but also decides for itself. This will also reduce pressure on revenue administration in the field where it is already overstretched due to other pressing demands on it. The revenue administration can still monitor the health delivery through periodic meetings of Executive and Governing bodies of the District Health Society and lower level samities.*

### **Janani Suraksha Yojana (JSY)**

Madhya Pradesh should be complemented for excellent implementation of JSY. CRM Team studied the implementation of JSY in remotest of the areas. Everywhere the JSY funds were being disbursed through bearer's cheque and on time. Fund was available at all levels and the fund flow was excellent.

*The only area where some improvements are needed is the second installment of JSY payments to ASHA. At CHC, Tamia, Chhindwara the payment of second installment of Rs.250 to ASHAs was badly delayed with payments pertaining to even April 2009 pending till now, i.e, November, 2009.*

### **Internal Control Issues**

At some places it was found that payments of significant amounts were being made in cash or through bearer's cheques. This needs to be stopped immediately for accountability purposes. *All payments must be made through Accounts Payee cheques, unless otherwise specified under the guidelines, e.g., under JSY where payment through bearer's cheque is allowed for operational purposes.*

It is also desirable that the finance and accounts staff of various NRHM components such as RNTCP, NVBDCP, NBCP, IDSP, etc. are brought into a **common DPMU structure**. This will not only strengthen the DPMU structure, but will also bring in a system of checks and balances in the system with more than one person dealing with payments and accounting matters. The creation of the post of Jt. Director (Finance) in the State Health Society is a welcome step in this direction.

### **Good utilization of Divisional PMU Structure**

The Divisional PMU set up under NRHM is a welcome addition to SPMU and DPMU structures. In a large State like Madhya Pradesh the Divisional PMUs are valuable and they are doing a good job of monitoring the programme and giving feedback to the State. This system should be replicated in other large States.

**Overall the State may be complemented for having put in place a very good financial management system with very few concern areas.**

### **21. Data Management**

New HMIS formats are being introduced, Hindi translation done. State and divisional level training completed. There is a further capacity building training plan on new formats at district and block level. Programme Managers are initiated to GIS mapping, NRHM web portal and DHIS-2. Apart from routine programme reporting, there is a central monitoring system for financial allocation/utilization. JICA supported GIS maps were shown on institutional delivery, JSY beneficiaries, labour room performance etc.

### **Key Recommendations:**

- **National level meetings of SPMs and State level meetings of DPMs needed**
- **Improvements in systems for increasing effectiveness of DHS/meetings**
- **Need for linking up the training institutes and monitoring of the quality**
- **Comprehensive Continued Medical Education & training plan should be developed by SIHMC**
- **Have public health training institute in the state**
- **Better utilization of specialists, power to post doctors and other staff may be given to districts**
- **Display of essential drug stock on the walls**
- **Helpline for post-SBA training ANM/MOs as a handholding**
- **Expansion of Community monitoring from pilot districts to rest of the state in a planned manner with budgetary allocation through NRHM PIP**
- **ASHA support structure & ASHA resource center needs to be strengthened**
- **ASHA selection and deployment needs to be looked into- norm of same village candidate and not related to any government post holders may be included**
- **Strengthen community based nutrition and train ASHAs on nutrition and new born care**
- **ANM training manuals developed by JICA may be used state-wide**
- **Emphasis on family planning, specially spacing methods, needs to be increased**
- **IEC bureau infrastructure and staffing needs to be strengthened for BCC**

- **IPC tools, job aides for ASHAs/ANMs needs to be prepared at the state level and training given for their use.**
- **Enhancement of Delegation of Financial and Administrative Powers to the Districts and lower institutions.**
- **Public disclosure of RKS funds and institution of social audit mechanism.**
- **Creation of a combined SPMU and DPMU structure for all components of NRHM.**
- **Bringing Untied Grant and Annual Maintenance Grant under the purview of RKS.**
- **Leveraging the core banking solution of State Bank of India to get more value added services.**

**Concerns of the State government to Govt of India:**

1. For creating additional infrastructure for better health service delivery more fund allocation under NRHM
2. SRS estimation of MMR is currently for undivided old Madhya Pradesh, which needs to be separated for Chhattisgarh and MP.

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