08 – 15 NOVEMBER 2011
National Rural Health Mission,
Ministry of Health and Family Welfare,
Government of India
New Delhi.
## Contents

CHAPTER 1 .................................................................................................................................. 3  
TEAM ......................................................................................................................................... 3

CHAPTER 2 .................................................................................................................................. 4

CHAPTER 3 .................................................................................................................................. 6

INTRODUCTION ........................................................................................................................ 6

CHAPTER 4 .................................................................................................................................. 7

INFRASTRUCTURE DEVELOPMENT .................................................................................... 7

HUMAN RESOURCES .............................................................................................................. 11

HEALTH CARE SERVICE DELIVERY................................................................................... 15

OUTREACH SERVICES............................................................................................................ 19

ASHA PROGRAMME............................................................................................................... 23

REPRODUCTIVE AND CHILD HEALTH ............................................................................ 25

PREVENTIVE & PROMOTIVE HEALTH SERVICES.......................................................... 34

PC- PNDT ACT ......................................................................................................................... 35

NATIONAL DISEASE CONTROL PROGRAMMES ........................................................... 37

PROGRAMME MANAGEMENT............................................................................................ 43

DRUG PROCUREMENT SYSTEM .......................................................................................... 44

EFFECTIVE USE OF INFORMATION TECHNOLOGY ..................................................... 45

FINANCIAL MANAGEMENT................................................................................................ 46

DECENTRALIZED LOCAL HEALTH ACTION .................................................................. 50

MAINTREAMING OF AYUSH ............................................................................................. 50

Chapter 5 .............................................................................................................................. 52

RECOMMENDATIONS............................................................................................................ 52
CHAPTER 1

TEAM

The Fifth CRM Team visited the State of Uttar Pradesh from December 9th to 15th November 2011. The Team consisted of the following members;

<table>
<thead>
<tr>
<th>S. No</th>
<th>Names</th>
<th>Designation &amp; Address</th>
<th>Tel/Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Badaun Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Dr. Suresh K.Mohammed</td>
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<td>011-23061333</td>
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<tr>
<td></td>
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<td>011- 23351932</td>
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<tr>
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<td>9810546495</td>
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<td>6</td>
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<tr>
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<td><strong>Jalaun Team</strong></td>
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<tr>
<td>1</td>
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<td>Joint Director, NVBDCP, MoHFW</td>
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<td>2</td>
<td>Dr. S.K. Choudhary</td>
<td>Sr.Regional Director (H&amp;FW), Lucknow</td>
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<td>Clinical Specialist, NIPI Secretariat</td>
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<td>Dr. Ritu Aggarwal</td>
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<td>6</td>
<td>Dr. Ben Rolfe</td>
<td>External Consultant (Governance Specialist),</td>
<td><a href="mailto:brolfe@options.co.uk">brolfe@options.co.uk</a></td>
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<tr>
<td></td>
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<tr>
<td>7</td>
<td>Dr. Manpreet Singh Khurmi</td>
<td>Consultant -RCH, MoHFW</td>
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<td>Dr. Pankaj Sinha</td>
<td>Joint Director, DG-Health Lucknow</td>
<td><a href="mailto:jdfw@gmail.com">jdfw@gmail.com</a></td>
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<tr>
<td></td>
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# CHAPTER 2

## 5th Common Review Mission

### 8th November 2011 to 15th November 2011

<table>
<thead>
<tr>
<th>Name of the State</th>
<th>UTTAR PRADESH</th>
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<tbody>
<tr>
<td><strong>Districts Visited</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SN</strong></td>
<td><strong>Name</strong></td>
</tr>
<tr>
<td>1</td>
<td>Badaun</td>
</tr>
<tr>
<td>2</td>
<td>Jalaun</td>
</tr>
</tbody>
</table>

### Health Facilities visited

<table>
<thead>
<tr>
<th><strong>SN</strong></th>
<th><strong>Name</strong></th>
<th><strong>Address/Location</strong></th>
<th><strong>Level (SC/PHC/CHC/Other)</strong></th>
<th><strong>Name of the Person in charge</strong></th>
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</thead>
</table>

#### BADAUN DISTRICT

<table>
<thead>
<tr>
<th><strong>SN</strong></th>
<th><strong>Name</strong></th>
<th><strong>Address/Location</strong></th>
<th><strong>Level (SC/PHC/CHC/Other)</strong></th>
<th><strong>Name of the Person in charge</strong></th>
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<tbody>
<tr>
<td>1</td>
<td>District Male Hospital</td>
<td>Budaun Urban District Hospital</td>
<td></td>
<td>Dr. Narendra Kumar</td>
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<tr>
<td>2</td>
<td>District Female Hospital</td>
<td>Budaun Urban District Hospital</td>
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<td>Dr. Rekha Rani</td>
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<td>3</td>
<td>Ujhani</td>
<td>Ujhani</td>
<td>CHC (FRU)</td>
<td>Dr. V. K. Goyal</td>
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<tr>
<td>4</td>
<td>Bils</td>
<td>Ambiyaapur</td>
<td>CHC</td>
<td>Dr. Kalicharan</td>
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<tr>
<td>5</td>
<td>Bisouli</td>
<td>Bisouli</td>
<td>CHC</td>
<td>Dr. A.K. Sharma</td>
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<tr>
<td>6</td>
<td>Wazirganj</td>
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<td>CHC</td>
<td>Dr. Pradeep Kumar</td>
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<tr>
<td>7</td>
<td>Sahaswan</td>
<td>Sahaswan</td>
<td>CHC</td>
<td>Dr. J. S. Verma</td>
</tr>
<tr>
<td>8</td>
<td>Dataganj</td>
<td>Dataganj</td>
<td>CHC</td>
<td>Dr. Manjit Singh</td>
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<td>9</td>
<td>Saidpur</td>
<td>Wazeerganj</td>
<td>PHC</td>
<td>Dr. A.K. Choudhary</td>
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<tr>
<td>10</td>
<td>Mion</td>
<td>Mion</td>
<td>PHC</td>
<td>Dr. Rajbeer</td>
</tr>
<tr>
<td>11</td>
<td>Usawa</td>
<td>Usawan</td>
<td>PHC</td>
<td>Dr. C.P. Arya</td>
</tr>
<tr>
<td>12</td>
<td>Khitaura</td>
<td>Sahaswan</td>
<td>APHC</td>
<td>Dr. Amir</td>
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<tr>
<td>13</td>
<td>Bhetaghosai</td>
<td>Bisauli</td>
<td>APHC</td>
<td>-</td>
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<tr>
<td>14</td>
<td>Paroli</td>
<td>Bisauli</td>
<td>APHC</td>
<td>-</td>
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<tr>
<td>15</td>
<td>Sisora</td>
<td>Usawan</td>
<td>SC</td>
<td>Ms. M.J. Ratnam, ANM</td>
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<tr>
<td>16</td>
<td>Bihari Pur</td>
<td>Dataganj</td>
<td>SC</td>
<td>Ms. Pushpa Saxena, ANM</td>
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<td>17</td>
<td>Gautra</td>
<td>Mion</td>
<td>VHND</td>
<td>Shashikala</td>
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<td>18</td>
<td>Narpat Ramsi Patti</td>
<td>Mion</td>
<td>VHND</td>
<td>Sushila Devi</td>
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<td>19</td>
<td>Myori</td>
<td>Mion</td>
<td>VHND</td>
<td>Kusumlata</td>
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<td>20</td>
<td>Khera Bujurg Jagat</td>
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<td>VHND</td>
<td>Dr. R. Bhatt</td>
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<tr>
<td>21</td>
<td>Nowshera</td>
<td>Nowshera, Ujhani Taluk</td>
<td>Government Primary School</td>
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<td>SN</td>
<td>Name</td>
<td>Address/Location</td>
<td>Level (SC/PHC/CHC/Other)</td>
<td>Name of the Person in charge</td>
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<tr>
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</tr>
<tr>
<td>1</td>
<td>District Male Hospital</td>
<td>Orai</td>
<td>District Hospital</td>
<td>Dr. Khemchandra</td>
</tr>
<tr>
<td>2</td>
<td>District Female Hospital</td>
<td>Orai</td>
<td>District Hospital</td>
<td>Dr. Shanti Malik</td>
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<tr>
<td>4</td>
<td>CHC</td>
<td>Jalaun</td>
<td>CHC</td>
<td>Dr. G. S. Kushwaha</td>
</tr>
<tr>
<td>5</td>
<td>CHC</td>
<td>Konch</td>
<td>CHC</td>
<td>Dr. R. K. Shukla</td>
</tr>
<tr>
<td>6</td>
<td>CHC</td>
<td>Kalpi</td>
<td>CHC</td>
<td>Dr. R. K. Shukla</td>
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<tr>
<td>7</td>
<td>BPHC</td>
<td>Bawai (Mahewa)</td>
<td>PHC</td>
<td>Dr. A. P. Varma</td>
</tr>
<tr>
<td>8</td>
<td>BPHC</td>
<td>Rampura</td>
<td>PHC</td>
<td>Dr. L. P. Shonkar</td>
</tr>
<tr>
<td>9</td>
<td>AIT</td>
<td>PHC Pindari Konch</td>
<td>ASC/VHND</td>
<td>Ms. Laksmi Yadev (ANM)</td>
</tr>
<tr>
<td>10</td>
<td>Jagamanpur</td>
<td>PHC Rampura</td>
<td>APHC</td>
<td>Ms. Gayatri Dev</td>
</tr>
<tr>
<td>11</td>
<td>Mai</td>
<td>PHC Rampura</td>
<td>APHC</td>
<td>Ms. Gayatri Soni</td>
</tr>
<tr>
<td>12</td>
<td>Niyamatpur</td>
<td>PHC Bawai (Mahewa)</td>
<td>ASC</td>
<td>Ms. Kanti Gupta (ANM)</td>
</tr>
<tr>
<td>13</td>
<td>Churki</td>
<td>PHC Bawai (Mahewa)</td>
<td>SC</td>
<td>Ms. Meena Yadav (ANM)</td>
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<tr>
<td>14</td>
<td>Navodaya Vidhyalya</td>
<td>Orai</td>
<td>Government Primary School</td>
<td>Ms. Upama Shachan</td>
</tr>
<tr>
<td>15</td>
<td>Mahiya Khash Village</td>
<td>Chiriya, Jalaun</td>
<td>Government Primary School</td>
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</table>
CHAPTER 3

INTRODUCTION

a. State Profile

Uttar Pradesh with 19.96 crore people is the most populous State in India and contributes to 16% of the country’s population. With an area of 2.41 lakh sq.km it is the fifth largest State in the country covering 9.0 % of its geographical area. Uttar Pradesh covers a large part of the highly fertile and densely populated upper Gangetic plain and is often described as the “Hindi speaking heartland of India”. It is the second largest state-economy in India contributing 8.3% to India's total GDP in the financial year 2010-11. It is divided into four economic regions viz, Western region, Central region, Eastern region and Budelkhand. The State is organized into 72 districts, 312 tehsils, 820 blocks, 648 statutory towns and 1.07 lakhs villages.

Uttar Pradesh has a low Human Development Index (HDI) of 0.468 and ranks 13th among major States of the country. Poverty ratio at 32.8% is high, one of the most important contributory factors for this being the very high population growth rate. In the decade 2001-11, there was a net addition of 3.34 crore people in the State. Though literacy levels in the State increased from 56.2% in 2001 to 69.7% in the latest census, female literacy continues to lag behind at 59%. The sex ratio in the State increased from 898 in 2001 to 908 in 2011. However, the child sex ratio has declined from 916 to 899 in the corresponding period.

The performance of the State in terms of major health indicators is given in the table below. As can be seen, the State has a long way to go in order to catch up with the rest of the country as regards all major health indices.

b. Status of Health Indicators (Uttar Pradesh)

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Indicators</th>
<th>Uttar Pradesh</th>
<th>India</th>
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<tbody>
<tr>
<td>1</td>
<td>Infant Mortality Rate (SRS- 2009)</td>
<td>63</td>
<td>50</td>
</tr>
<tr>
<td>2</td>
<td>Maternal Mortality Rate(SRS 2007-09)</td>
<td>359</td>
<td>212</td>
</tr>
<tr>
<td>3</td>
<td>Total Fertility Rate (SRS 2009)</td>
<td>3.7</td>
<td>2.6</td>
</tr>
<tr>
<td>4</td>
<td>Institutional Deliveries (Coverage Evaluation Survey 2009)</td>
<td>41%</td>
<td>61%</td>
</tr>
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</table>
CHAPTER 4

INFRASTRUCTURE DEVELOPMENT

The State of Uttar Pradesh has made significant strides in providing adequate health infrastructure at the grassroots level. The existence of 135 District Hospitals, 602 CHCs, 2676 PHCs and 20521 Health Sub Centres in the State is a testimony to this. At the field level it was noted that there was a well-entrenched four-tier health delivery system consisting of:

1. Sub centre/ APHC
2. Block Level PHC/ CHC
3. District Hospitals
4. Tertiary care Hospitals – Consisting primarily of nine Government Medical Colleges, two central Medical Colleges and Private sector Medical Colleges.

It was also reported that there are 140 blood storage units, 195 blood banks, 7 SNCUs and 107 NBSUs, 759 NBCCs, 767 safe abortion facilities and 908 RTI/STI clinics established in the State. Details of health infrastructure in the State are as follows:

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Required as per population norms (census 2001)</th>
<th>Number of facilities functional as of 30th September 2011</th>
<th>Number of new facilities under construction</th>
<th>Total no. of facilities which will be functional at the end of the Mission period</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Hospital</td>
<td>150</td>
<td>135</td>
<td>6</td>
<td>141</td>
</tr>
<tr>
<td>CHCs</td>
<td>1053</td>
<td>602</td>
<td>93</td>
<td>762</td>
</tr>
<tr>
<td>PHCs</td>
<td>4388</td>
<td>2676</td>
<td>356</td>
<td>3692</td>
</tr>
<tr>
<td>Sub Centres</td>
<td>27344</td>
<td>20521</td>
<td>4624</td>
<td>25145</td>
</tr>
</tbody>
</table>
Some of the important gaps noticed by the CRM team as regards infrastructure development in the State are given below:

**Newly Constructed PHCs Lying Unused**

The CRM team which visited the districts of Badaun and Jalaun observed that several new PHCs constructed in the past 3-4 years were non-functional and kept locked because of lack of manpower, especially doctors. This phenomenon of locked new PHCs was reported to be there across the State. The team observed that the newly constructed infrastructure in these facilities was slowly withering away due to lack of maintenance. Compound walls were found to be damaged to allow cattle and other animals to graze in. Similarly, plastering inside these premises was slowly peeling off and cracks were developing on the walls. The State should take immediate action to post doctors and nurses in these facilities and maintain them well.

Locked APHC at Bhetaghosai and Parouli in Badaun District

**Slow Pace of Infrastructure Upgradation**

The CRM team noted that pace of upgradation work in facilities such as District Hospitals, CHCs and PHCs was slow. The main reasons for slow pace of upgradation were impediments to transfer of funds as a result of conditionality such as 3rd party evaluation etc. The State was given a target of upgrading 129 District Hospitals in two phases, 40 in the first phase and 89 in the second phase. Upgradation of 40 District Hospitals in the first phase was to be completed by December 2011. However, out of this only 5 were completed as on 1st November 2011 and another 7 are expected to be ready by the end of the year. Similarly, 50 CHCs were to be upgraded through NRHM funds of which only 16 were completed and work is in progress in the remaining 34. Construction of JSY wards which was taken up in 942 PHCs has been completed in 908
facilities. There are 20521 Sub Centres (SCs) in the State of which 6,468 are in Government buildings. Construction of new building was in progress for 4624 of the SCs in rented premises. For the remaining, work is expected to be taken up soon. The State informed that all Sub Centres would be housed in Government buildings before 31.3.2011. Latest status of upgradation of health facilities is as follows:

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Upgradation planned under NRHM</th>
<th>Upgradation completed/to be completed by March 2011</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Hospital</td>
<td>129</td>
<td>12</td>
<td>Upgradation of the remaining 28 in the 1st Phase. In the 2nd Phase 89 are to be upgraded for which State has requested for more allocation.</td>
</tr>
<tr>
<td>CHC</td>
<td>50</td>
<td>16 completed, 34 will be completed by March 2011</td>
<td></td>
</tr>
<tr>
<td>PHC- JSY Ward</td>
<td>942</td>
<td>908</td>
<td></td>
</tr>
<tr>
<td>SC</td>
<td>2908</td>
<td>2824</td>
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</tr>
</tbody>
</table>

**Dysfunctional Equipments**

During the visits, it was also observed that equipments such as radiant warmer, autoclave, generator which were in need of minor repair were lying dysfunctional for many months and even years. There seems to be both a lack of initiative on the part of the In Charge Superintendents/MO to repair these equipments and inadequate support and supervision from State Headquarters, particularly a lack of appropriate asset management systems.
Poor maintenance of available infrastructure

The State should ensure unhindered maintenance of these lifesaving equipments through annual/ comprehensive/ multiyear maintenance contracts. It is recommended that equipments may be divided into three categories viz. functional, non-functional but repairable and non-functional and non-repairable. Whereas, non-functional but repairable equipments can be repaired over the next few weeks or months, the ones designated as non-functional and non-repairable may be disposed off or condemned per the State Government rules.

District Priorities not reflected in State PIP

The team noted that the plan for upgradation of infrastructure made by the State in health facilities was not correlating with actual requirement on the ground. For example, it was seen that infrastructure and equipment for essential newborn care were lacking, even in District Hospitals and FRUs. These facilities should have been provided a Special Newborn Care Unit or at least a New Born Stabilization Unit. Instead, only a Newborn Care Corner was available. On the other hand the State has given priority to construction of 77 modular operation theatres which was not the need of the hour in the districts visited. Thus, the State PIP did not reflect the priorities in the district level and underscores the need for a truly evidence based and bottom up approach during the PIP formulation process.

Other Issues

The lackadaisical attitude of some Superintendents and MO-IC as regards proper maintenance of health facilities under them was noted with concern. Interviews with patients, especially, pregnant women, indicated an unwillingness to stay overnight in the hospital as inpatient due to lack of basic amenities such as clean toilets, as well as concerns about security. Another gap noted by the team was the lack of arrangements
for night stay for ASHAs who accompany pregnant mothers in the facility. The persistent shortage of residential quarters for health staff despite construction/upgradation work in several health facilities, has added to the challenge of retaining human resources in the system. The team noted that there was shortage of staff quarter in the District Female hospital Badaun while there was no staff quarters provided for CHC Bisauli. This had a dampening effect on morale of staff.

HUMAN RESOURCES

Severe shortage of human resources, which was one of the major finding emphasized in every previous CRM, persists to this day in Uttar Pradesh. The impact of this was evident in the districts visited by the CRM team. As already mentioned in the section on infrastructure, large majority of new PHCs were found to be non-functional and locked as there were not enough doctors or nurses to man these facilities. Due to non availability of data entry operators, no reporting was being done from a considerable number of the CHCs. Acute shortage of specialists such as Paediatricians was evident to the CRM team during field visits, as a consequence of which the State had failed to establish special newborn care units/stabilization units even in District Hospitals. Details on availability and shortfall of human resources in the State are presented in the table below:

### Availability and Shortfall of Human Resource in Uttar Pradesh

<table>
<thead>
<tr>
<th>Category</th>
<th>Required as per IPHS (Sep 2011)</th>
<th>In Position</th>
<th>Total In Position</th>
<th>Shortfall in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular NRHM Contractual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td>15455</td>
<td>6050</td>
<td>572</td>
<td>6622</td>
</tr>
<tr>
<td>Specialist</td>
<td>8599</td>
<td>3226</td>
<td>302</td>
<td>3528</td>
</tr>
<tr>
<td>Staff Nurses</td>
<td>31187</td>
<td>6435</td>
<td>1127</td>
<td>7562</td>
</tr>
<tr>
<td>MPW (Male)</td>
<td>9080</td>
<td>1729</td>
<td>-</td>
<td>1729</td>
</tr>
<tr>
<td>ANM</td>
<td>41950</td>
<td>21270</td>
<td>1500</td>
<td>22770</td>
</tr>
<tr>
<td>Lab Technician</td>
<td>5389</td>
<td>1836</td>
<td>208</td>
<td>2044</td>
</tr>
</tbody>
</table>

### Availability of Specialists in Uttar Pradesh

<table>
<thead>
<tr>
<th>Gynaecologist</th>
<th>Anaesthetist</th>
<th>Paediatrician</th>
<th>Pathologist</th>
<th>General Surgeon</th>
<th>Radiologist</th>
<th>General Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>481</td>
<td>338</td>
<td>554</td>
<td>217</td>
<td>403</td>
<td>184</td>
<td>315</td>
</tr>
</tbody>
</table>
The extent of shortfall depicted in the table above is of such a large magnitude that this gap cannot be bridged by normal recruitment procedures. For example, the shortfall of 8833 Doctors in the State is a gap that is too large to be addressed by conventional methods such as expediting recruitments or outsourcing of services to contractual staff as there are simply not enough doctors graduating every year to fill this gap. A restructuring of human resource policy in the State by implementing new initiatives such as 3 year trained rural medical providers, compulsory rural postings etc is the need of the hour. Such a long term policy shift was not evident to the CRM team. The inordinate delay in recruiting of new manpower to fill up existing posts has added to the woes of the State. For example, although selection of 1,900 Basic Health Worker (Female) and 4,960 Basic Health Worker (Male) was completed in 2010, results have not been declared as yet. The recruitment of ~ 4,000 Medical Officers has been similarly pending for a long time. It is hoped that current recruitment of 1500 doctors will be completed by December 2011. However, the need for an innovative HR policy as a long term solution to the severe human resource crises in the State is emphasized once again.

Despite the shortage of staff, rational deployment of scarce manpower has not been given priority by the State. It was noted with concern that SBA trained ANMs were not posted at delivery points and EMONC/LSAS trained doctors were not allotted to FRUs. The CRM team noticed that in some facilities with very less case load, there was an excess and irrational deployment of staff, possibly due to political compulsions. For example, there were 5 doctors posted in CHC Wazirganj which has an OPD load <100/day and a monthly delivery load of 50-60 whereas facilities with double or triple the OPD/delivery load were managing with a single doctor. The CRM team also noted the lack of incentive/reward for staff to serve in hard to reach and inaccessible areas as a policy gap which needs immediate attention. Another area of concern noted was the continuing deployment of Dais in some health facilities. Review of Labour Room Registers indicated that Dais are still conducting deliveries. Names of Dais were also displayed in the list of staff at some PHCs and Sub-centres. During a VHND session in Jalaun District, a few Dais approached the CRM team for payment of remuneration which is pending for last few months which implies that dais are still working in these communities. The influence of Dais was visible in some health facilities such as CHCs where labour room nurses were found using retrograde Dai kits to undertake deliveries.

Since the advent of NRHM, an increasing number of contractual employees have been posted as can be seen in the table above. However, it was noted that there was a substantial lack of motivation amongst the contractual staff. It was apparent that this was due to poor service conditions; reluctance on the part of State to depute contractual staff for longer skill based training, outdated contract renewal policies and a clear
demarcation between the regular and contractual employees. It was also noted that payments of contractual staff nurses were pending from last 6 months. Appropriate human resource initiatives are required on the part of the State to improve morale and to retain contractual staff posted under NRHM funds.

**TRAINING**

Trainings and continuing professional development is directly related to the quality of service delivery. The CRM team noted that the sub-optimal quality of services provided in many health facilities could be directly linked to lack of trained staff or poor quality of training. Details of training conducted so far since 2005 are as under:

<table>
<thead>
<tr>
<th>Type of training</th>
<th>Cumulative achievement (2005 to Sep. 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ANM</td>
</tr>
<tr>
<td>IUCD</td>
<td>452</td>
</tr>
<tr>
<td>SBA</td>
<td>4889</td>
</tr>
<tr>
<td>FBNC/F-IMCI</td>
<td>-</td>
</tr>
<tr>
<td>BeMOC</td>
<td>-</td>
</tr>
<tr>
<td>EmOC</td>
<td>-</td>
</tr>
<tr>
<td>LSAS</td>
<td>-</td>
</tr>
<tr>
<td>MTP/MVA</td>
<td>-</td>
</tr>
<tr>
<td>NSV</td>
<td>-</td>
</tr>
<tr>
<td>Minilap</td>
<td>-</td>
</tr>
<tr>
<td>Laproscopy</td>
<td>-</td>
</tr>
<tr>
<td>Communicable Diseases</td>
<td>-</td>
</tr>
</tbody>
</table>

Some of the salient areas of concern identified by the CRM team as regards training are given below:

**Low Priority Accorded to Training**

The team noted that in the past 5 months, no training programmes were conducted in the State because of low priority being accorded to training and due to other administrative reasons. Thus, it was seen that training proposed in the PIP 2011-12 for MOs and paramedical staff in FIMNCl, BEmONC, and SBA, CCSP have not been initiated yet. SBA training which was planned for female AYUSH doctors who are undertaking delivery in PHCs and CHCs, has not been started so far. Training of ASHA in the 6th and 7th module is also yet to be initiated. It was also noted that no training calendar was available for the current year in both districts visited by the CRM team. Coordination between the State Institute of Health and Family Welfare and the
Directorate of Health and Family Welfare/NRHM was also found to be lacking. Thus, overall, it was noted with concern, that the crucial component of training remained neglected by the State.

**Shortage of Training Institutes**

The CRM team observed that the number of training institutions available was not commensurate to the requirement of the State. For e.g. there was a shortage of 6,860 MPWs in the State. Given the available training institutions the State has capacity to train only 660 MPWs in a year. Thus, the gap of training these personnel would take 11 years to bridge. Therefore, there is a need to have more training institutes to undertake this enormous task and bridge the gap. The State may enlist the support of accredited private institutes in this endeavour.

**Poor Quality of Training and Need for Mentoring**

It was evident to the CRM team during its interaction with field functionaries such as ANMs, that training quality was not up to the mark. For example, the SBA trained ANMs did not demonstrate the competency to plot partograph. Similarly, they were lacking in skills such as Advanced Management of Third Stage of Labour (AMTSL). MOs trained in MINILAP and Laparoscopic Sterilization were lacking in confidence to undertake operations as they had not received adequate hands on training. Quality assurance mechanisms such as pre and post training assessment of trained personnel, periodic assessment of quality of training by State or District level officials was also not being implemented. The team also noted the need for mentoring and support for trained staff such as ANMs and LTs. It is suggested that onsite mentoring and supportive supervision for newly trained ANMs be undertaken by mobile trainers such as the Senior Public Health Nurse or Senior LHVs. Similarly, for LTs, the STLS under the RNTCP programme could be designated this task.

**Lack of Trainers in ANM Training Centres**

The CRM team visited the ANM Training Centres in both districts. It was seen that though there was adequate infrastructure in these ANMTCs, there was a pitiable lack of trainers. The ANMTC in Badaun was found to be have just one staff i.e. Public Health Nurse, with no tutors or other supporting staff. The team noted a similar situation in Jalaun district. It was clear that these institutions were being underutilized and trainings have not been undertaken for several months. The quality of training imparted in ANMTCs was also doubtful due to lack of staff.
HEALTH CARE SERVICE DELIVERY

Quality of services was found to be below normal in most of the health facilities visited and considerable scope for improvement exists in the following areas:

Service Delivery

Though the range of services which need to be provided in each category of health facility has been clearly laid down in guidelines of the Government of India and the Indian Public Health Standards (IPHS), the State was finding it difficult to provide commensurate services at each facility. Thus, a large number of Sub Centres were not providing full range of level L-1 services. A full range of family planning services, as envisaged for an L-1 facility were also not found at many Sub Centres visited by the team. Most of the CHCs visited by the team were not providing Basic Emergency Obstetric and New Born Care (BEmONC) as envisaged for a level 2 (L-2) centres. It was observed in some of the PHCs qualified laboratory technicians were performing only peripheral blood smear examination and sputum for AFB, but were not checking up haemoglobin and urine of pregnant women.

Citizens’ Charter

The community has a right to be aware of the services available at each health facility as well as rates and user charges for the services provided. The CRM team observed that none of the health facilities visited had a citizen’s charter on display. It is strongly recommended that a citizen’s charter and a grievance redressal mechanism be displayed prominently in local language at the entrance of the health facility and also at the registration counter.

Barriers to Accessing Services by Marginalized Communities

During the course of visits by the CRM team, barriers were found to exist for marginalized sections of populations to avail health services at government health facilities. For e.g. in the month of October 2011, a total of 5063 tests were conducted at the hospital laboratory of District Hospital (Male) Badaun; however, only 60 tests were conducted without any user charges (excluding prisoners, sent from the district jail), that too with prior written approval of the CMS of the hospital. Number of free beneficiaries would reduce further if number of government officials and public personnel availing the laboratory facility ‘free’ were to be discounted. Thus, it was observed that utilization of services by marginalized populations was very low. This needs immediate attention of health department and if required, enabling instructions / Government Order may please be issued.
Feedback from Patients

Health facilities should have a system of collecting feedback from the patients who availed services there. This system was not found in existence at any of the health facilities visited by the CRM team in the districts of Badaun and Jalaun and this is a crying need of the hour. SCs, STs, women and BPL beneficiaries should be adequately represented in such a feedback mechanism. Structured questionnaires, separately for OPD and IPD patients, can be administered to the patients and their feedback should be discussed in RKS meetings. The State may develop a system to this effect.

Poor Quality of Labour Rooms

The number of deliveries taking place in public health facilities has increased considerably across the State during the recent times, more so, after the launch of JSY. However, the status of labour rooms at every level of the health facility was found to be far from satisfactory. Though the CRM team met a number of extremely dedicated personnel, they did not have requisite knowledge and enabling environment to deliver the range of services, which are expected to be available at a particular location. The team was informed by Labour room nurse at CHC Daatagunj and doctor (AYUSH practitioner) at Jagat PHC in Badaun District that they had used episiotomy occasionally, when perineal tear was anticipated. However, none of the locations had episiotomy tray or instruments to undertake the procedure.

Poorly maintained labour room, absence of essential drugs and equipments

The following gaps were noticed in almost all the labour rooms visited by the team:

- Non-existent functional newborn corners
- Inadequate illumination
- Absence of essential drugs such as Injectable Antibiotics, Oxytocin, Magnesium Sulphate, etc.
- Absence of required skill-sets.
Bio-Medical Waste Management

Management of healthcare waste was found to be grossly inadequate at all visited health facilities. Collection of the waste had been outsourced to a Common Waste Treatment Facility (CWTF) operator at the District Hospitals and a few of the peripheral health facilities. However, the schedule of their visits to peripheral locations for collection of biomedical waste has been erratic to the extent that they visited few locations only once in a month (Primary Health Centre Jagat, Badaun). After launch of the JSY, quantum of human tissue waste at public health facilities (constituted of placenta & product of conception) has increased considerably. Some of the common areas of concern in the area of Biomedical Waste Management were;

1. Lack of awareness on correct segregation scheme
2. Non-availability of puncture proof containers for collection of SHARP waste
3. Plastic waste being thrown after its usage without mutilation
4. Non-usage of chlorine solution for ‘on-site’ disinfection, and
5. Absence of pits for disposal of human tissue waste.

For ensuring proper management of healthcare waste, it is proposed that the State needs to undertake following actions:

1. Periodical training of the staff of hospitals, CHCs, PHCs and Sub centres on hospital waste management practices. The recommended topics for the training could be segregation as per colour coding, usage of needle cutters, mutilation of needles & syringes, and usage of chlorine solutions
2. Provision of puncture proof containers for collection of SHARP Waste
3. Mutilation & disinfection of plastic waste – to ensure its disinfection and to prevent its repackaging and circulation
4. Dissemination of information from State to districts and facilities, regarding outsourced waste management (if any) and terms & conditions of the contract. The
State may also evolve a monitoring system for services to be rendered by CWTF operator.

5. The peripheral health facilities should identify an area within their premises for digging two pits – one for burial of SHARP waste and second pit for the burial of human tissue.

6. Issue of Personal Protective Equipment (PPE) & Personal Protective Clothing (PPC) to all waste handlers and full immunization of all of them.

**Strengthening of Disinfection Procedures & Protocols**

During the course of the visit to districts and health facilities, it was observed that disinfection protocols were not in place at the user’s end. Procedures which directly influence hospital disinfection, were weak e. g. lack of running water supply, non-availability of elbow operated taps, inadequate awareness on hand-washing, etc. It is suggested that programme officers and health/ hospital administration may strengthen following domains –

1. Hand washing;
2. Availability of liquid soap and dispensers at users points;
3. Connecting hand-wash basins and sinks with over-head tanks to ensure availability of 24-hours running water at the users’ point;
4. Training on correct hand-washing practices (six steps over 2 minutes);
5. Display of protocols for hand wash;
6. Operation Theatre;
7. Installation of elbow operated taps;
8. Usage of colour change strip to monitor autoclave procedure;
9. Standard Operating Procedures (SOP) for weekly cleaning of floors and wall with disinfectant and water;
10. Supervision of the construction work for ensuring better quality of construction (seamless joining of tiles and avoidance of dead spaces);
11. Monitoring of disinfection in the operation theatre by periodical swab testing;
12. Use of mask and gloves.

**Maternal and Infant Death Audits**

The CRM team did not find any evidence of conduct of maternal death audit and review of infant death at any of the health facilities, which were visited. The team members also got a perception that there has been a kind of apprehension about the aims and objectives of the audit process. It is recommended that the State may conduct awareness workshop on Maternal and Infant Death audit as part of a rollout of a robust system for its implementation.
Defining Time Norms for Service Delivery

No evidence was found that the health facilities are adhering to time limit in terms of delivery of services – such as time limit for availability of laboratory reports, radiological investigations, waiting time in OPD & dispensary, etc. It is recommended that the State may define the time-line for availability of services and it should be displayed at service delivery point, together with details of appropriate recourse mechanisms for patient, where they find services lacking.

Protocols and Procedures for Departments

Labour room protocols, referral protocols or emergency room protocols were not found at any of the locations visited.

State Quality Cell and District Quality Cell

The State had issued an Order No. 1860/5-9-05-05 {5}/2003 dated 14th July 2005 for formation of State level and district level quality assurance committees, which were primarily meant to ensure quality assurance in sterilization programmes. However, minutes of the same were not found in the districts visited by the team.

OUTREACH SERVICES

In general, the CRM team found significant outreach activities being undertaken in the State, which was providing a foundation for further expansion and broadening of scope. The team noted that Sub Centres were providing vital cold chain support which was rather well managed, although some minor deficiencies were observed in record keeping. Support from the Sub Centre level to community outreach activities was rather limited to immunisation, and this needs to be diversified and strengthened further. The CRM team could not find a second ANM posted in any of the Sub Centres visited. The addition of a second ANM would help bolster outreach services substantially.

Well maintained equipments in Sub Centre Sisora
**Village Health & Nutrition Days**

Village Health and Nutrition Days were being conducted across the districts and were visited by the CRM team. It was noted that VHNDs are an important vehicle to take preventative services down to community level and it was seen that ASHAs were proving their potential in facilitating these events.

**VHND session in Jagat & Myori Village**

At present, VHNDs appear to be very effective in promoting immunisation but as the 4th CRM also observed, their potential for delivering other preventative services was yet to be realised. The lack of privacy, high caseloads, narrow focus of ASHA incentives, limited training and support, were all leading to inadequate focus on family welfare, ANC, home based new-born care, ARI, Diarrhoea, nutrition and disease prevention. Routine aspects of check-ups such as growth monitoring and blood pressure were being neglected while waste management needed improvement. VHNDs were often located in schools at the periphery of villages and this was seen to be a significant barrier to pregnant women and lactating mothers who had to find time to attend VHNDs leaving demanding household chores.

**Village Health Sanitation and Nutrition Committees**

These committees have in many cases been constituted, with for example 564 registered in Jalaun. However, their contribution to public health was at present limited. The CRM team found little mentoring support, financial support or involvement in planning processes by these committees. Further work and support is required to realise their full potential. In particular, their potential to provide an oversight role to ensure local ownership, access to quality services and health entitlements was not being realised. Links to Panchayati Raj Institutions (PRIs) and
greater involvement in decentralised planning and community monitoring should be further strengthened.

**Mobile Medical Units**

Significant proportions of the population have inadequate access to appropriate levels of care, with physical access playing a major role. Mobile Medical Units have the potential to increase access to primary care only where the mobile infrastructure, staffing, tasking and community/health service integration is appropriately managed. In the State of Uttar Pradesh, it was reported that 133 Mobile Medical Units are functional in 15 districts. The CRM team were able to observe one such unit in Jalaon District. The vehicles provided are constructed to a high standard, but their large size makes potential penetration into remote areas questionable. Whilst the vehicle observed was conducting valuable outreach work, the cost effectiveness of such a resource intensive intervention requires further analysis.

Records within the unit were well maintained and appear to indicate that beyond vaccination, the focus of operation is on minor curative care. In Jalaon district visited by the CRM, the planned coverage of 105 locations a month, with only two hours in each, raises questions over how accessible these units are for the rural poor. Some local stakeholders opined that better use of existing community infrastructure, perhaps augmented with smaller and more versatile vehicles may be a more cost effective basis for outreach services. A review of barriers to service access and a cost effectiveness analysis of a range of outreach solutions would support better decision making on the role of MMUs. It is also suggested that local ASHAs be informed at least a week prior to the visit of MMU, so that she can spread the message in the community, thus increasing the utilization of this service.

A significant investment has been made into MMUs and it now falls to the State to provide the necessary evidence based guidance to optimise their public health impact; this should include an analysis of their role in reaching underserved populations and strategies identified to serve those unable to access fixed or mobile services.

**Saloni Swasth Kishori Yojana**

At present a relatively small number of school-based outreach services under Saloni Swasth Kishori Yojana are provided, offering Iron Folic Acid (IFA), de-worming and general check-up. The potential for this intervention has yet to be realised at a significant scale. Integration with other outreach activities could be improved. A district
wide BCC strategy bringing together preventive and promotive initiatives would further support the objectives of this initiative.

**Emergency Medical Transport System (EMTS)**

Whilst some higher level facilities in the State have ambulances available, many were non-functional and availability to patients was extremely limited. While ambulances which required minor repairs were seen rusting away for months together, facilities which had functional ambulances were found using them at very sub-optimal levels. In some facilities log books/POL books etc. were not available. Overall, the CRM team noted that usage and maintenance of available ambulances was poor.

Under the new EMTS scheme, 988 new ambulances have been procured by the State and are awaiting fabrication, equipping and deployment as per timeline. Under contract, a private operator will fabricate staff and equip the ambulances to an agreed standard. They will also establish the 24 hour call centre, with government support for the emergency number. A five year flat rate (as opposed to cost per trip or km) contract will support all maintenance and running costs, providing a response within 20 minutes in urban areas and 30 minutes in rural areas to the nearest metalled road. Transport for an estimated 15-20 patients per day will be to nearest CHC, and if required, onward to the next level of referral. Effective referral is a key determinant of maternal mortality reduction and EMTS has significant potential. However, the relatively large and heavy vehicles (5m, high top, and 3000 kg unladen) may limit penetration to underserved populations. Procedures for transport from household/village to metalled road have not been included in planning and this issue requires urgent attention. Standard Operating Procedures which clearly specify that ASHAs may accompany women in labour must be developed as part of the final contract. Additionally, links between the service and ASHAs must be formalised in the EMTS Standard Operating Procedures to prevent undermining the ASHA initiative. Crucially, a solution to provide access for the majority of women who reside on un-made roads to the EMTS medical units requires urgent attention. With unit running cost of Rs 1,17,000 per unit/month (approximately Rs 1,96,56,000 per district with 14 ambulances), cost effectiveness of this model should definitely be evaluated.

Dysfunctional ambulance in Usawa PHC
ASHA PROGRAMME

A total of 1, 31,276 ASHAs are in place against 1, 36,000 required with a yearly attrition rate of 800-2500 on an average. Many ASHA were being selected as ANMs, AWW or school teachers and this was noted as the main reason for attrition. The team noted that the remarkable progress achieved under JSY scheme and in improving institutional delivery in the State can be largely attributed to ASHAs who were doing commendable work. It was noted that payment of ASHA incentives was through electronic transfer who helps in maintaining the transparency in release of funds. 95% of ASHAs have been trained upto 5th module. However, trainings for the 6th and 7th modules have not been initiated in the State. ASHA grievance redressal mechanism is in place in the districts under the Additional CMO-NRHM. Similarly at the State level, an ASHA mentoring group is functional.

The CRM team noted that a significant number of ASHAs have been trained on new initiatives of the GOI such as Home based new born care, menstrual hygiene programme. It was noted that 41,122 ASHAs have been trained under CCSP program and 27,644 ASHAs under Menstrual Hygiene Programme. About 50,000 ASHAs are trained and conducting home visits under HBNC programme. The average amount of incentive earned per month by an ASHA ranges from Rs. 1500-2500 in Badaun and from Rs. 800-1000 in Jalaun. Interaction with ASHAs in the focus group discussions revealed that most of the ASHAs are well aware of their roles and responsibilities. However, there was a greater emphasis on immunization and safe delivery. During the FGD it was also noted that all ASHA have their personal mobile phone.

Interaction with ASHAs in the focus group discussions revealed that most of the ASHAs are well aware of their roles and responsibilities. However, there was a greater emphasis on immunization and safe delivery. During the FGD it was also noted that all ASHA have their personal mobile phone. The team also noted that ASHA maintained due lists and put in commendable efforts in mobilizing mother and children as per the due list for VHND sessions. It was also noted that ASHA were promoting use of contraceptives despite constraints such as irregular supplies etc.
Areas of Concern

1. Role of ASHA in VHSC is very limited. ASHAs can make significant contribution in improvement of health and sanitation of a village if properly associated with VHSC.

2. Role of ASHA were largely restricted to immunizations and institutional delivery. Disease preventive and health promotive functions were not emphasized at all.

3. Lack of night stay arrangement for ASHA in health facilities is a major disincentive for ASHAs to accompany pregnant women to health facilities.

4. Incentives for ASHA as part of DOTS is pending from last 1-1/2 year. Similarly JSY incentives to ASHAs are pending from last 2-3 months.

5. ASHAs have not received drug kits from year 2009 and this was seen to be hampering their work at the village level.
MATERNAL HEALTH

With a high Maternal Mortality Ratio of 359/100,000 live births (SRS 2007-09); Uttar Pradesh is one of the high priority States where immediate steps are required to improve provision and quality of basic antenatal and emergency obstetric care. Annually, 65 lakh pregnancies occur in the State, of which approximately 50% are institutional deliveries as per the HMIS. The State has 4,441 delivery points which include 3510 Sub Centres, 398 Primary Health Centres, 451 Community Health Centres as well as 73 District Hospitals. Though the remarkable success of the Janani Suraksha Yojana (JSY) has improved institutional delivery rate across the State, there is still a long way to go as a large chunk of deliveries still occur in the home setting, in unsafe conditions. Considering the huge number of non-institutional delivery still happening, there is a need to improve utilization of existing delivery points and expand delivery services to inaccessible and hard to reach areas. In the district of Badaun, it was noted with concern that only 22 delivery points including 1 DH, 11 CHCs, 9 PHCs and 2 SCs were catering to the annual estimated delivery load of 110,000. Only 45,000 of these deliveries occurred in institutional settings. In the district of Jalaun, there were 70 delivery points including 1 DH, 5 CHC, 7 Block PHCs and 57 Sub Centres. Out of 53,000 annual estimated deliveries ~23,000 (43%) were reported to be institutional in 2010-11. There is an urgent need to make new PHCs (additional PHCs) functional so that basic obstetric care is available and accessible to more number of pregnant women. Further, provision of free transportation as envisaged in the Janani Shishu Suraksha Karyakram (JSSK), can give a major demand side boost for promoting institutional delivery.

In terms of quality of service, the CRM team observed with concern that basic Antenatal Care was considerably compromised. Thus, basic components such as recording of BP, tests such as Haemoglobin and urine microscopy were not being emphasized. This seriously compromised the ability of medical providers to detect high risk pregnancies. The heavy case load added to this problem as a result of which a pregnant woman was examined for only 2-3 minutes as part of routine antenatal check up. Audio-visual privacy was also found to be lacking, as a result of which abdominal examination was not done properly. The team observed with concern that a large majority of the ANMs/Nurses conducting delivery were not trained as Skilled Birth Attendants. The very few who were trained were not adequately skilled which raised serious questions on the quality of SBA training. Thus staff conducting normal deliveries did not maintain partograph and were not practicing active management of
third stage of labour, infection prevention protocols etc. Further, Basic Emergency Obstetric and Newborn Care (BEMONC) were not being delivered in any of the facilities such as 24X7 PHCs and CHCs. Instead, these facilities were functioning as delivery points handling routine normal delivery. There were neither trained staff nor necessary equipment’s & instruments and drugs to handle complicated deliveries.

Considering the fact that 15% of all deliveries will develop complications which require specialized care, the unmet need for basic emergency obstetric care was extremely high. During the field visits it was noted that doctors in CHCs and 24X7 PHCs were not competent to do forceps/vacuum extraction or handle a case of post-partum haemorrhage or manually extract a retained placenta. Instruments such as Forceps, drugs such as Magnesium Sulphate & Oxytocin and equipments such as Ventouse & MVA were found to be lacking. In some CHCs it was observed that nurses are using retrograde Dai Kits consisting of thread and an ordinary blade to cut the cord. Quality of post natal care was also compromised as newly delivered mothers did not stay in the health facility for more than 4-6 hours. Thus monitoring of the mother and new born in the crucial 48 hours post natal period was virtually non-existent.

Maternity Ward CHC Ujhani – One of few facilities where 48 hours post natal stay was observed

Similarly, it was observed that the unmet need for Comprehensive Emergency Obstetric Care was quite high. The State has a total of 134 FRUs providing services of LSCS. Out of an estimated delivery- of 59 lakh in the State approximately 5% will require intervention in the form of Caesarean Section. However, at present only 1-2% of all deliveries are LSCS. The unmet need for CEMONC is thus very high. In the district of Badaun, the team noted that only the District Hospital was providing LSCS services with an annual load of ~ 600. Three other private hospitals were providing LSCS services in the town of Badaun. In total, the annual number of LSCS was reported to be
less than 1,500 as against the requirement of 5,500. Similarly in Jalaun only ~ 550 LSCS were performed against an annual requirement of 2,600, including private sector providers. Even in functional FRUs such as District Women’s Hospital in Jalaun the non-availability of a specialist e.g. Anaesthetist is a reason of concern. Here, the services of Anaesthetist was loaned from a nearby Civil Hospital which itself was under-staffed. Doctors who were trained in EMONC (16 weeks) and LSAS (18 weeks) were not posted in FRU post training that totally defeats the purpose of this exercise. The non-availability of blood storage facilities at block level compounded this problem. In both Badaun and Jalaon, except for Blood Banks in the District Hospital, there was no Blood Storage Centre in any of the CHCs. The State has to make concerted efforts to establish at least 2-3 FRUs (other than DH) in every district to meet the need for CEMONC.

**Janani Suraksha Yojana (JSY)**

The team noted with great degree of appreciation the efforts made by the State to promote transparency and accountability in the JSY implementation. Every facility visited had displayed entitlements under this scheme in a very prominent manner.

![JSY Website indicating the list of JSY beneficiaries (www.jsyp.org)](image)

Payments under the scheme to all beneficiaries were through the cheques. Further, ASHA were being paid incentives either through electronic transfer or cheques. Payments were being made at the time of discharge or within 2-3 days of delivery in most of the facilities. However, due to lack of funds, payments were delayed across the State for the past 1 month. Documentation was found to be of high quality including registers, JSY cards, Mother and Child Protection cards. The team cross verified these documents and these were found tallying. The State has created a website by digitization of the records of the JSY beneficiaries and ANMs and ASHAs. This website...
will be made accessible to the general public by end – November with plans to launch a
toll-free State-wide grievance redressal number.

The JSY website already has comprehensive details of approximately 7 lakh
cases. The State Programme Management Unit does random check of 350 entries every
week. The State reported that the results of the random verification of beneficiaries
yielded very good results with high level of accuracy. The implementation of Janani
Suraksha Yojana (JSY) in the State is a best practice model which is indeed commendable. State should endeavour to improve the programme further by publicly
displaying list of beneficiaries in all health facilities on a monthly basis and also by
randomly conducting physical verification of at least 10% of the beneficiaries at the
district level either through Health Department or through other Departments such as
Revenue/ State Accounts etc. Further, this endeavour can be expanded to capture
quality of care and services provided at facility from the beneficiaries’ perspective.

RTI/STI Services

Functional RTI/STI clinic was observed in the District Hospital and FRU. The
clinics were following the syndromic management protocol and colour coded kits were
available. STI Clinics were having adequate audio-visual privacy and dedicated
counsellors were provided. However, neglect of these services in the CHCs and PHCs is
a major area of concern. Trained staff and dedicated areas with adequate privacy need
to be identified in CHCs and PHCs for providing quality services to treat STI/RTI.

Janani Shishu Suraksha Karyakram (JSSK)

The JSSK has been recently launched in the State across all 72 districts with a nodal
person being appointed. In the initial phase, the State has decided to operationalize the
JSSK in 165 FRUs. The team did not find any evidence of the scheme being operational in
the Badaun district. At Jalaun, in the District Women’s Hospital free breakfast and post-
delivery home drop off through the facility ambulance had been initiated as part of
JSSK. The JSSK entitlements have also been prominently displayed at the facility.
FAMILY PLANNING

Uttar Pradesh (UP) is the State which has the highest population in the country. The latest, 2011 census figures indicate that the decadal growth rate for Uttar Pradesh is at 20.09% and above the national average. The total fertility rate is significantly high at 3.7. Also, the total unmet need for family planning services (both spacing and limiting options) is substantially higher than the national averages.

Spacing Methods

Oral Contraceptive Pills and Condoms were available in Sub Centres. However, many CHCs and PHCS had an absolute stock out of these. Family Planning Centres in CHCs and PHCs were acting as distribution points for condoms and OC/EC Pills to Sub Centres. The crucial aspect of counselling on spacing methods and provision of condoms/pills to clients was totally neglected. IUD insertions were being done at facilities by trained ANMs at Sub Centres. However, in many CHCs and PHCs, IUDs were found to be out of stock.

It was noted that there was no fixed day approach for provision of these services which was hampering client uptake. There was also a need to focus on IUD removal after product life was over or based on client requirement. As per the recent Government of India (GOI) directive the contraceptive delivery scheme by ASHAs has been taken up by the State. In Jalaun district, the ASHAs were aware of the scheme and the district had received supplies of contraceptives, which were going to be rolled out after the sensitization of the ASHAs. This door-step delivery of contraceptives by ASHAs is expected to have significant impact on uptake of contraceptives and increase the contraceptive prevalence rate. The emergency contraceptive pills were not available at any of the facilities as per the GOI guidelines and neither were the service providers aware of the dosages. This should be immediately looked into.

Limiting Methods

Due to shortage of doctors trained in mini-lap and NSV techniques, the State has promoted family planning sterilization camps across facilities which do not have
qualified trained staff. Male sterilization cases were insignificant in proportion to female sterilization cases. There was a substantial seasonal variation for female sterilization cases in all the facilities with major load during the winter period extending from the months of October- January, due to prevalent myths and misconceptions regarding post-operative recovery and complications. This needs to be addressed by provision of accurate information by front-line health workers. A year-long spread out utilization pattern of female sterilization surgeries will help in reducing the burden on an already HR constrained health system.

**Safe Abortion Services**

It was noted that services for safe abortion were available only in the District Hospital and First Referral Units. A large unmet need for safe abortion is therefore not addressed at all in the State which is one of the important causes for high maternal mortality and morbidity. In the facilities providing services for Medical Termination of Pregnancy it was noted that Dilatation & Curettage still remains the preferred method. The national guideline that prescribes MVA as the method of choice is largely not practiced. This is due to lack of medical providers who are trained in use of MVA as well as lack of MVA kit. This is an area which needs to be addressed immediately by the State. Similarly, medical abortion was not being provided as an option to patients desiring early MTP services.

**ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH (ARSH)**

The team noted that implementation of the Adolescent Sexual and Reproductive Health (ARSH) programme was extremely weak in the State. The State nodal officer has been given the additional responsibility of ARSH along with the heavy portfolio of programme management. At the district level nodal officers have not been appointed. Though the State has trained 1488 MOs and 1711 ANM/Nurses to provide Adolescent Friendly Health Services, their services were not being optimally utilized. Both in Badaun and Jalaun districts, the CRM team did not see even a single ARSH Clinic in any of the health facilities visited. The State has a well functional network of ICTCs and STI clinics under the HIV/AIDS Control Programme whose services could be utilized in providing counselling to adolescents, especially during the afternoon lean hours. Though officers from UP State AIDS Control Society were present during the briefing as well de-briefing sessions of the CRM, it is a matter of concern that mechanisms of convergence are yet to be worked out between the RCH programme and UPSACS. Similarly, it was seen that there was no convergence with flagship programmes of other Departments for adolescents, such as SABLA (ICDS), Teen Clubs (NYKS) and Adolescent Education Programme (Department of School Education) at the field level.
Thus, for all practical purposes, the ARSH programme was non-existent in the State. The only programme for adolescents which was visible in the field was the Saloni Swasth Kishori Yojana in Girls Schools for provision of IFA and de-worming. The team also noted that the State has made substantial progress in training of ASHAs for sale of sanitary napkins to adolescent girls in rural areas under the Menstrual Hygiene Scheme.

**CHILD HEALTH**

The State has a high Neonatal Mortality Rate of 45/1000 live births (compared to the national NMR of 34/1000 live births) which is a major contributory factor for the high Infant Mortality Rate of 63/1000 live births. In order to reduce the NMR drastically, provision of essential newborn care should be made available at all delivery points in the State. It was noted with concern that knowledge of the concept of essential newborn care and availability of equipments for provision of the same were found to be lacking in the facilities. In both the districts visited by the CRM team, not even a single facility was having a Special New Born Care Unit (SNCU) or a new born Stabilization Unit. Even FRUs such as District Hospitals were managing with a New Born Care Corner which was also not being put to optimal use.

The State needs to plan for SNCU at facilities conducting more than 3000 deliveries in a year. Most District hospitals and some Sub-district hospitals would qualify to have SNCU. Similarly NBSU needs to be planned and operationalized at the level of CHCs/FRUs and NBCC at all delivery points.

In the new born care corners, it was noted that radiant warmers were either unavailable or under repair or not being used in most of the facilities. Bag and mask was available in almost all facilities but usage was negligible. Though there was a substantial number of intrauterine death/still birth reported in the Maternity Register, no effort has been made to study the causes of the same. Paediatricians available at District Hospital/FRU informed that excessive and irrational use of oxytocin to the pregnant women, especially in private sector health facilities is leading to this. Concept of infant death audit is yet to trickle down to the health facilities.
Training of health providers in delivery points on essential newborn care was found to be critically lacking. None of the staff such as doctors, nurses, ANMs etc were trained in essential new born care under the Navjaat Shishu Suraksha Karyakram (NSSK). IMNCI training is also yet to be rolled out in the districts visited. However, State informed that components of the same have been incorporated in the Comprehensive Child Survival Programme (CCSP) training which has been imparted for ASHAs, ANMs and LHVs besides Medical Officers. Since these trainings are imparted at Medical College level it was noted that participants from far flung districts were finding it tough to attend. Further, Medical Officers should instead be trained in F-IMNCI of 11/5 days duration (11 days for all MOs and 5 days for those already trained in IMNCI).

The team noted that records pertaining to common and fatal childhood ailments such as pneumonia and ARI, diarrheal diseases etc were not available in the health facilities. Malnutrition is quite high the State with 14.8% of all children being wasted as per NFHS-3. 90% of treatment for malnutrition is required to be given through community based strategy such as Infant Young and Childhood Feeding (IYCF) practices while the remaining 10% should be dealt through intensive strategies such as Nutritional Rehabilitation Centres. The team observed that early initiation of breast feeding was being emphasized to newly delivered mothers. However, counselling for 6 months exclusive breast feeding as well as complimentary feeding was not being given enough focus in the Village Health and Nutrition Days. Currently there are 21 operational NRCs as per reports sent by the State. An NRC has been sanctioned for the District of Badaun, but no initiative has been made to establish this centre.

Home based new born care was another area which needed the focused attention of the State. In order to bolster this, the State has to immediately incentivize ASHAs payment for new born visited under home based newborn care programme at the rate of Rs. 250 per newborn covered (6/7 visits). Training of ASHAs in module 6 & 7 will further help in implementing home based new born care in the State.

**IMMUNIZATION**

As per Coverage Evaluation Survey (CES 2009), percentage of fully immunized children in Uttar Pradesh was 41% in comparison to all India figures of 61%. It was informed that cold chain handlers are largely trained in Routine Immunization. During field visits and interaction, it was found that they had adequate knowledge of RI regarding route, site, dose etc. However, the use of spirit swab was still being practised. The Ice Lined refrigerator (ILR) and Deep Freezer (DF) were found to be functional and breakdown time was informed as less than 15 days. Micro plan was available and was
properly followed. Hub cutter was available and being used. Although AEFI committee has been formed, not a single AEFI case has been reported so far. This was a pointer to the fact that supervision and monitoring was weak. Four key messages on side effects of immunization, disease for which the vaccine has been administered, date of next immunization, and the importance of taking care of RI card were not being given. The team noted that temperature log books were poorly maintained even though thermometers were available. This points out to the need for refresher trainings of cold chain handlers. The State needs to also plan for RI session in hard to reach areas in order to catch up with all India figures as regards full immunization.

SCHOOL HEALTH PROGRAMME

The School Health Programme (SHP) in Uttar Pradesh covers only about one third of primary schools in State. There was no programme in existence for Junior and High Schools. Though there was a nodal officer at the State level it was seen that she was over burdened with other responsibilities. There was no nodal officer for the SHP either at the level of the DG Health Services/FW or at the district level. The team visited schools in both Badaun and Jalaun Districts.

In Jalaun district the team visited a Navodaya Vidyala School funded by the Central Government, which was running a School Health Programme on its own initiative without the support of the State Government. However, in Badaun, the team visited a Government Primary School where it was seen the programme has become dysfunctional since 2009-10. It was noted that there was no nodal teacher nominated for the SHP and nor has any teacher had been trained recently under programme. There has been no distribution of IFA & Albendazole since 2009-10.

There was no screening of students being done for disability, disease, deficiency nor were Health Card maintained or referrals being made. It was noted with concern that except for the Saloni Swasth Kishori Yojana in some Girls Schools which provided IFA and de-worming tablets to adolescent girls, there was no School Health Programme worth its name in the State.
CRM team during its visit to District Hospital and other facilities such as CHCs and PHCs observed that information on number of malnourished women; adolescent girls or children were not available. However, it was evident that malnourishment among women, children and adolescent girls was quite high in the districts. The paediatric ward at the District Hospital did not have basic facilities like weight, height measuring machines. Growth charts were not displayed. The paediatrician informed they have been receiving cases of severely malnourished children. However, no Nutritional Rehabilitation Centre (NRC) has been established in either Badaun or Jalaun. Though it was informed that an NRC has been sanctioned for Badaun, it is yet to be established. The State has also not enlisted the support of NGOs to tackle malnutrition of women, adolescent girls or children. Nevertheless, it was noted by the mothers are educated about importance of breast feeding, homemade food, lentils, milk etc. In the District Hospital at Jalaun, it was noted that inpatients are given one loaf of bread, half a litre of milk and some fruits. Pregnant women are also given 100 IFA tablets at all health facilities.

Under the Saloni Swasth Kishori Yojana, girls are being checked up for height, weight and eye sight. They are also educated about hygiene and nutrition. They are also given IFA tablet once a week and albendazole once in six months. During visit to Sub – Centres and Anganwadi Centres it was observed weight & height measuring machines were there. Charts displaying importance of breast feeding, green vegetables and other home made products were put on the walls.

Provision of Panjeeri at Anganwadi centre in Myori Village

When the CRM team visited the Village Health and Nutrition Day (VHND), panjeeri (nutritious food) was distributed to pregnant and lactating women. However,
ASHA and ANM were not emphasizing the importance of intake of nutritious food and exclusive breast feeding for 6 months to expectant and lactating mothers. In villages visited by the team, complaints were made by villagers regarding irregular and insufficient distribution of nutritious food for children in the age group of 6 months to 3 years and pregnant and lactating mothers from the Anganwadi Centre.

Inter – Department convergence was visible at district level. The District Health Society (DHS) under the chairmanship of District Magistrate had members from other Departments like Education, ICDS, Drinking Water Supply, Rural Development etc. On the other hand the CMO of the district is a member of the similar committees of other Departments like District Sanitation Committee, District Education Committee, Drinking Water Supply, ICD etc. The inter – department convergence down below the district level from block level especially at the Village Health & Sanitation Committee, however, was found to be lacking. Interaction with Gram Panchayat Sarpanch revealed that funds under VHSC have not been received so far. It was also noted that the VHSCs were not giving priority to sanitation in the village and its surroundings. The CRM team observed during village visits that sanitation levels were quite poor and it was found that lanes and roads were lined with human and animal waste. The potential hazard of such waste materials contaminating shallow water tables in and around villages is very high. The District Administration should take urgent measures to sensitize VHSC on these potential hazards so that appropriate steps are taken to improve sanitation in villages.

**PC- PNDT ACT**

The child sex ratio in Uttar Pradesh declined from 916 in 2001 to 899 in 2011 which is pointer to the fact the foetal sex determination is rampant. Though PC-PNDT Committees (Appropriate authority, supervisory, advisory) have been formed at the state and district level and nodal persons identified, the team noted with concern that regular and periodic meetings are not being held and timely follow-up action is not being initiated. In Jalaun district, there were 11 registered sonography centres wherein the Badaun district there were 26 registered centres. However, there were no sonographies being done at any of the public health facilities in any of the district, due to absence of a radiologist. Although, Form F is filled in by facilities, a large proportion of forms are partially filled, with ineligible entries, making it difficult for tracking cases. The periodicity of inspections is irregular and they are conducted in an ad-hoc manner. Multi-stakeholder involvement is currently limited. The voluntary NGOs participation,
professional bodies’ sensitization needs to be promoted across the State in a well-structured manner. Facility raids, sting operations are non-existent in spite of the skewed sex ratios being reported. Action should be initiated on suspected facilities with fool-proof investigations and documentation. It was noted that Mobile USG clinics pose a serious hazard to the declining sex ratio and should be tackled by co-ordination between different district and department authorities. There is limited awareness amongst service providers and community members of the provisions of the PC-PNDT Act. This needs to be addressed with sensitization and prominent display of Act regulations at facilities and IEC material at the community level.
REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

Uttar Pradesh has highest burden of Tuberculosis (21%) and leprosy (25%) in the country. Thus while the State carries great burden of mortality and morbidity due to MCH related causes, the infectious disease burden continues to be alarmingly high. About 2.8 Lakh TB cases were notified under the RNTCP in 2010 alone, out of which more than 1.7 lakh cases had infectious TB, who continue to fuel the epidemic. An additional burden of more than 15,000 cases of Drug resistant TB occurs in the State annually. At present only 2% of State’s population have access to diagnostic and treatment services under the RNTCP programme for management of drug resistant TB (PMDT). Rapid scale-up of these services are necessary to prevent mortality and morbidity among these cases.

New smear positive case detection rate, 3rd Quarter 2011

RNTCP performance indicators for UP remain sub-optimal. Total TB notification rate is about 140 per 100,000 populations against the expected levels of more than 160 per 100,000. More than 60% districts (45 out of 72) have low case detection rates. Also among the detected cases the bulk is smear positive TB, smear negative cases being less than 30%. This is due to greater emphasis by programme officers at all level and also due to limited number of functional X-ray facilities at sub-district level. More over X-ray facility is not provided free of cost at sub-district level (Rs.44 charged for X-ray). Case detection among children is less than 7% as against an expected proportion of 10 to 15%.
of all TB cases. Measures to improve detection in these categories of patients should be undertaken by the State to achieve the RNTCP objective of detection and successful treatment of more than 90% TB cases in the community.

The performance in case holding activities in the State is also sub-optimal, 34/72 districts have initial default rate of more than 5% (TB cases detected but not initiated on treatment), which accounts for loss of more than 5500 cases annually. Among newly detected cases about 6% defaults during DOTS treatment. The default among re-treatment cases is still higher. This is despite the fact that close to 70% of all TB cases are being treated through community volunteers like ASHA at a place close to patient’s residence. Moreover TB treatment in institutions like CHC, Block PHC and APHC too is provided through a community volunteer, which is not acceptable. Overall the treatment provision is not monitored by the Medical officer and ANM in the field. The State should ensure that paramedical staff provides better quality treatment and care, at least at the level of institutions and the ANM monitors provision of DOT by ASHA and other community volunteers.

Infrastructure and Human resources under RNTCP

Overall at the State level there is deficiency of about 300 microscopy centres (DMC) considering RNTCP norm. The programme provides for up-gradation of laboratory, binocular microscopes and contractual LT for upto 20% DMC’s. The new post of district TB-HIV /DOTS plus supervisor one per district should be filled as a priority along with vacancies of key contractual staff at the State TB cell and STDC’s. The contract renewal of State level staff at STDC Agra which is pending since Sept-2011 is also necessary to keep up with requirement of State level supervision and monitoring. Further, vacancy of key contractual RNTCP staff of 22 STS and 45 STLS should also be filled at the earliest.

Finance under RNTCP

TB programme activities are adversely affected in the State due to erratic release of funds both at district and State level. The last fund release by State NRHM was less than 40% of that received from central TB division (CTD), but surprisingly it was
distributed uniformly (36% each) in some budgetary head without considering the distribution suggested by programme division. The pending payment liabilities in critical budget heads like laboratory consumables, training, NGO-PP was not considered in the release. Funds were not released under IEC and NGO/PP head, resulting in lack of activities in this year. It is observed that payment of honorarium to ASHA for DOT provision (Rs.250 per successfully treated patient) is pending for more than 18 months in all districts. A sum of Rs.5 Crores was specially allocated by CTD to clear pending dues in September 2011, but release of the same to districts is still pending at State level. Similarly funds approved by State NRHM for up-gradation of drug resistant TB culture facility at Agra (Rs.20 Lac) are also pending. Rationale and timely release of funds should be ensured as a priority activity to ensure implementation of key activities under the programme.

At District level, the salary of contractual staff is pending for 3 to 8 months in all the districts while the travel allowances are pending for 12 to 18 months in majority districts. These pending dues should be cleared urgently. Moreover delays are noted at district level due to lengthy approval process even for committed expenditures like salary, NGO-PP, honorarium to ASHA etc. These can be avoided by approval of the activity in DHS once a year and further delegation of the power to DTO based on performance. A directive regarding the same may be issued to districts.

Implementation of TB/HIV intensified package activities not yet implemented uniformly in the State, inspite of completion of State and district level training in majority districts. This may be ensured.

NATIONAL LEPROSY ERADICATION PROGRAMME

Leprosy burden in the State continues to be large with 204 out of 820 (25%) blocks having Prevalence rates of more than 1%. Annually more than 25000 cases new case are still getting detected, which is marginally lower than those detected at elimination level in 2007. About 2.3 % cases are detected with disability and 7% cases occur among children. These indicate ongoing transmission in the community and delay in detection of cases.

No programme activity was implemented in the State in 2011, as budget was not released to districts reason being the 2011-12 PIP is not approved. Moreover instructions for expenditure of unspent balance with districts are also not given. The payment of Incentive for ASHA and compensation for reconstructive surgery to patients is also pending. While the supply of MDT was maintained, supportive medicines, self- care kits, MCR shoes etc. are not available.
A renewed focus on NLEP is necessary to prevent reversal of leprosy epidemic in the State. This may be achieved by ensuring compulsory healthy contact examination of all new cases by ANM, Involvement of ASHA in contact screening and facilitating MDT collections by patients to ensure compliance. Timely payment of honorarium to ASHA is critical to strengthen this activity. Further an active case search for cases in high endemic blocks should be undertaken for detection of hidden cases in community. All these activities can only be strengthened if adequate time is allotted for review of officials and staff at State and district level. The State NRHM may ensure the same.

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDCP)

Uttar Pradesh is endemic for Malaria, Filariasis, JE/AES, Dengue Fever/DHF and Kala-azar.

**Malaria**

During 2010, a total of 64606 malaria positive cases were reported from the State, out of which 1382 were P.f. and during 2011 (till Oct), 50683 positive cases of malaria were reported with 1578 P.f. cases. No death due to malaria was reported from the State. ABER (Annual Blood Examination Rate) reported from the State is between 2-3% which is much below the national target of 10%. Less collection of blood slides may be due to the reason that number of post of MPWs/BMWs, Malaria inspectors (MI), AMO and regular DMO post are lying vacant. To improve blood supply collection, State may involve ANMs and ASHAs. Most of the DH/CH/PHC visited was without malaria drug policy 2011 charts. Even MO-in-charge was not aware of the recent malaria drug policy. DDT spray is not carried out in the district as the API in the State is below 2%.

**Lymphatic Filariasis**

In UP, about 50 districts are reported to be endemic for LF. These districts are being covered under the strategy of annual single dose mass drug administration (MDA) with the DEC tablets. But, the MDA is still to be carried out in the State till date. During 2010, 152776 blood slides were collected and 412 were found positive for Microfilaria (Mf). Emphasis should also be given on morbidity management and Hydrocele operation.

**Japanese Encephalitis (JE)/ AES**

JE/AES is endemic in some of the districts of the State and the worst affected districts are Gorakhpur, Khushinagar, Maharajganj, Basti, Deoria, Siddharth Nagar etc. During 2011, JE/AES was reported from 15 districts and a total of 3021 AES cases and 462 deaths and 190 JE cases with 27 deaths were reported. Positivity of JE in the State is
about 6%. In Jalaun district, 1 case was reported in 2011. The area has a potential for JE transmission in terms of vector breeding places with floating vegetation, presence of migratory birds and piggeries in the area. The district has to be vigilant and further spread should be prevented.

**Dengue/DHF and Chikungunya**

During 2010, a total of 960 cases of Dengue cases were reported from the State in which 8 deaths were reported and during 2011 till Oct, 125 cases of dengue fever were reported with 4 deaths. In 2011, few cases of Chikungunya were also reported from the State. In the district of Jalaun, 2 cases of dengue were reported and the district health authority has to be vigilant and further should be prevented.

**Kala-azar**

Kala-azar is a serious though sporadic problem in district of Eastern UP which Khushinagar, Deoria, Varanasi, Balia, Basti and Gonda districts. During 2010, 14 cases were reported with deaths and 2011 till Oct, 11 cases were reported with 1 death. For the control of Kala-azar, DDT spray is being used for 2 rounds of spray, but the quality and coverage is very poor. In Jalaun district, no case has been reported.

**Entomological setup in the State**

The post of State entomologist, zonal entomologists, insect collectors and lab technicians are lying vacant. As a result, surveillance of vector borne disease is not adequate to predict any outbreak like situation in the State. These posts should be filled up on priority basis in order to strengthen the vector borne surveillance in the State and control of vector borne diseases.

**INTEGRATED DISEASE SURVEILLANCE PROJECT (IDSP)**

IDSP in the State is working with State surveillance officers are State level with the district surveillance units. The unit collects information from all the districts on P and L formats which are compiled regularly and sent weekly to NCDC, New Delhi. Monthly compiled reports of the communicable and non-communicable disease from all the districts are also sent regularly to NCDC. Online data is being obtained from all the districts. In Jalaun district, District Surveillance Unit (DSU) is established and well coordinated at various levels under the overall supervision of district nodal officer. Post of epidemiologist, data manager and data entry operator is filled. The information is collected on regular basis from 48 units on various proforma and sent to the State and online to IDSP National Portal. During 2011, the DSU Jalaun reported 2 positive cases of Dengue fever and 1 case of JE. Reporting is 100%.
NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAM (NIDDCP)

Not much progress was noticed at district level. No IDD kits were seen during the visit to district Jalaun. Only few posters were displayed on Iodine deficiency and use of Iodized salt in some of the PHCs/SCs.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

Main activities carried out under this program include cataract surgery, school eye screening, eye banking etc. During 2010-11 around 7, 14,000 cataract operations were targeted by the State and around 7, 67,838 were achieved (107%). During 2011 till Oct, around 7, 70,000 operations were targeted and 2, 03,577 were achieved (26%). In the district of Jalaun, 2 eye surgeons were working for carrying out daily OPDs/eye operations. Regular eye camps are held in the periphery areas and the patients are being operated in the fields. School eye scanning program is conducted to detect the refractive errors for 8-14 years old children and appropriate glasses are provided. Target set for cataract surgery is satisfactorily achieved.
PROGRAMME MANAGEMENT

Management Capacity

The State has committed managers at District level, both in the Health Department and PMUs. Despite this commitment the full potential of these officers is not being realised. It was clear to the CRM teams that the AD, JD, CMO, ACMO, DCMO, Medical Superintendents and IC-MOs all require further training in Management Skills and Public Health. Under the PMUs, the SPM, DPMs and BPMs similarly require support and training in these areas. There are competent institutions in the State that could support this work. Capacity building will result in significant improvements in programme management and ultimately service delivery.

The CRM teams found that DPMs are very actively focused on their routine functional tasks; however, they are not providing a longer term strategic focus and direction to District activities. In addition to routine management, DPMs should have a strategic and supervisory role; they urgently need additional support and skills in this area. Again, there are competent training institutions within the State which could provide the required management and public health training. We recommend that the State support them in moving from a basic administrative and managerial role, to providing a more strategic function; applying public health knowledge and management skills to drive development in the sector.

At present, the District Accounts Manager under the DPMU is not utilised effectively. Each national programme has a concerned accounts person with whom the PMU accounts manager is required to coordinate. This is inefficient and time consuming; options should be explored to streamline these activities.

Supervision

The CRM teams found that supervisory and monitoring functions from District level, especially by ADs, CMOs, ACMOs and DCMOs were rather weak. Whilst some monitoring was taking place, mobility allowances had not been received, visits were not routine and also recording was inadequate. Supervision and monitoring was also weak at the level of Superintendent of the Block CHCs as well as the IC-MO of the PHCs. DPMs were also not sufficiently involved in monitoring and supervision. Where supervision had taken place, facilities were not left with a written action plan which would focus attention and hold staff accountable. The weakness of the RKSs, lack of BPMs, and lack of untied funds further limited the ability of facilities to respond to suggestions, and be held accountable to local communities.
In some Districts, CMOs are holding monthly meetings which provide a forum for sharing best practice and addressing problems. These should be made more routine, formalised and extended to Block level. Minutes of these meetings should be forwarded to the next senior authority and progress on action points actively monitored. Furthermore, cross District sharing meetings should be instigated to further share good practice and improve coordination between neighbouring Districts.

**Planning**

DPMs have a central role in District level planning and have demonstrated considerable skill. However bottom up planning is not taking place with Village Health Action Plans often absent and VHSCs not performing. Additionally BPMs are not in place, further hindering evidence based planning. The CRM tram recommend that the State expedite the recruitment of BPMS and provide further support to bottom up needs based planning in the Districts. Also greater coordination viz. intra-district, inter-district and neighbouring States is required to help achieve health related outcomes e.g. coordination with appropriate authorities of district, State and with neighbouring States for strict implementation of PC PNDT act.

**DRUG PROCUREMENT SYSTEM**

The State of Uttar Pradesh has two independent technical directorates (a) Directorate General Medical & Health, and (b) Directorate General Family Welfare. Drug and supplies are procured by Central Medical Stores Division (CMSD), which functions at the office of DG Medical & Health. In 2009, a central purchase committee has been constituted at the office of DGFW, which had been entrusted with the job of procurement of drugs & supplies under the National Health Programmes. Subsequently, the State has constituted District procurement Committees at district level, which has been entrusted with job of procurement of drugs and supplies for all health facilities except for district hospitals.

CMSD enters into the annual rate contract with drug suppliers. Till last financial year, district hospitals were given budgetary allocations and were entrusted with the task of placing demand indents directly with the contracted suppliers, but within the given financial envelope. During the current financial year, the hospitals place their requirement of drugs and supplies on six monthly basis with the CMSD, which in turn places the supply order to the contracted firms. The hospital receives their drug supplies directly from the contracted firms. The hospitals have an effective system of monitoring of drug expiry in medical stores.
The following areas of improvement were noted by the CRM team:

a) Extended warranty and Comprehensive Maintenance Contract of Hospital Equipments

b) Protocol for quality testing of drugs and supplies by hospitals

c) VED analysis of drugs and working out the drug requirement, based on the analysis

d) Strengthening FIFO system

e) Storage conditions of drugs – maintaining low temperature during summer months.

EFFECTIVE USE OF INFORMATION TECHNOLOGY

Data Collection

Management Information system is the most crucial factor for programme implementation in any programme. The CRM team noted that the State has provided computer with printer and broadband connection up to the block level. The State also has also made provision for a data entry operator at the block and district level. The post of data entry operator was however found to be vacant in some of the facilities visited by the team. The team observed that data uploading on JSY and HMIS portal was satisfactory. Nevertheless, the State needs to institutionalize systems for validating the data and minimizing the time lag of more than a month for uploading of HMIS data.

Many fields of reports were lying vacant or filled as ‘NA’ and therefore quality of data needs to be improved. In some instances it was noted that denominator was missing; for e.g. the denominator of eligible children for immunization was left vacant. It was also noted that there was no mechanism for validation and quality check of the data. These deficiencies can be bridged by increasing the frequency of supportive supervisory visits in the field at the village and block levels. It was also noted that analysis and use of data was very limited. Capacity of staff
at all levels needs to be built for reporting of data as well and planning based on data analysis at block, district and State levels.

**Data Management**

The State is putting up the data on the web portal and the flow of information is regular for JSY and HMIS. However it was noted with concern that RIMS is not operational. Though data entry operators and data managers are in place, they urgently need to be trained. As already mentioned, the State has computers up-to block level but quality of data is not up to the mark. Validation and triangulation mechanisms are not there and mechanisms need to be put in place for institutionalizing this. It was also noted that in many facilities there was no uniformity in registers which were provided for OPD, IPD and referral. It was also noted that old formats are in use in some facilities. These contribute to poor data quality. State may like to have a uniform format for registers and get the same printed and distributed to all facilities.

The most important gap observed was regarding usage of data. The team observed that use of data for planning or for facility assessment was minimal. There is no feedback happening at any level, and most programme managers were unaware of what the data is trying to convey. A culture of feedback needs to be institutionalized at every level to ensure the regular and timely use of correct data.

**Mother and Child Tracking System (MCTS)**

The team observed that Maternal and Child Tracking System is in its very early stage of implementation. State needs to organize the orientation and training sessions at all levels and provide support for effective implementation of the MCTS. State may like to have a provision of usage fee for ASHA in order to motivate her to implement the SMS alert system.

**FINANCIAL MANAGEMENT**

Key observations regarding financial management at the State level were as follows:

**Budget Vs Expenditure**

The total approved budget of the State for financial year 2011-12 Under NRHM is Rs.2462.62 crores against which the expenditure has incurred by the State up to Sep 2011 is Rs.850.38 crores equivalent to 35% of approved PIP. The State has only 20.57% expenditure under RCH flexible pool against the approved SPIP of Rs.1073.75 crores and only 18% expenditure reported under Mission Flexible pool against the approved
SPIP of Rs. 645.45 crores. The reasons of low utilization of funds are pending payment of JSY beneficiaries, ASHA incentives and advances outstanding at various agencies.

**Pending Utilization Certificate**

(Rs. in Crore)

<table>
<thead>
<tr>
<th>Programme</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCH</td>
<td>-</td>
<td>56.23</td>
<td>605.90</td>
<td>662.13</td>
</tr>
<tr>
<td>Mission Flexi Pool</td>
<td>58.79</td>
<td>542.30</td>
<td>671.97</td>
<td>1273.05</td>
</tr>
</tbody>
</table>

**15 % State Contributions**

State has not contributed State share for the year 2011-12. State has using State contribution in NRHM activities. Overall outstanding State share is as under:

(Rs. in Crore)

<table>
<thead>
<tr>
<th>Year</th>
<th>Amounts to be contributed</th>
<th>Amounts Credited</th>
<th>Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>222.14</td>
<td>-</td>
<td>222.14</td>
</tr>
<tr>
<td>2008-09</td>
<td>260.28</td>
<td>225.00</td>
<td>35.28</td>
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<tr>
<td>2009-10</td>
<td>346.91</td>
<td>255.52</td>
<td>91.39</td>
</tr>
<tr>
<td>2010-11</td>
<td>386.71</td>
<td>317.49</td>
<td>69.22</td>
</tr>
<tr>
<td>2011-12(BE)</td>
<td>392.32</td>
<td>-</td>
<td>392.32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1608.35</strong></td>
<td><strong>798.01</strong></td>
<td><strong>810.34</strong></td>
</tr>
</tbody>
</table>

**Human Resource (Finance)**

There is huge manpower shortage in the State. Out of 71 districts 22 positions of District Accounts Manager are vacant and vacant position of Block accountant in 823 blocks are needs to identify and fill the vacant post. One post of Sr. Finance Manager, 2 post of Manager Finance, 2 post of accountants and 2 posts of internal auditor are vacant at State level.

**Concurrent Audit**

State has implemented the concurrent audit system in 2009-10 and 2010-11. Concurrent audit has not been conducted for the 2011-12. Appointment of Concurrent audit is under process from State level. State is going to appoint 9 auditors from State level for all 72 District Health Society.

**Statutory Audit**

State has submitted the statutory audit report for the year 2009-10. State has not yet submitted the statutory audit report for the year 2010-11 which is under process. The expected of submission of audit report by December 2011.
Funds Flow Mechanism

Electronic funds transfer system is being used in the State up to CHC/PHC level. Activities wise funds transferred under NRHM to District Health Society. Timely funds are not transferred from the State Health society to District Health society for implementation of RCH and NRHM activities. JSY and ASHA incentive is pending for payment at District Hospital and CHC/PHC level. District Accounts Managers are not properly monitor the release of funds and outstanding advances.

Accounts Training

Training to accounts personnel is not provided at District level and State level. CHC/PHC accountants are not provided Accounts training for maintained the books of accounts on double entry system.

Tally ERP9 Software

Tally software ERP9 procured and training has been conducted up to district level. Tally software is working properly at State and District level. Print out of tally ERP9 accounts are not seen at District level. Approved SPIP has not uploaded in software at District Health Society level.

Delegation of Financial Power

The State has issued delegation of financial powers up to Sub centre level.

Advances outstanding position as on 30-09-2011:

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Programme</th>
<th>Outstanding Advances 30/09/2011 (Rs. in Crore)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RCH</td>
<td>233.21</td>
</tr>
<tr>
<td>2</td>
<td>Mission Flexi pool</td>
<td>530.09</td>
</tr>
<tr>
<td>3</td>
<td>RI</td>
<td>21.66</td>
</tr>
<tr>
<td>4</td>
<td>Pulse Polio</td>
<td>-5.72</td>
</tr>
<tr>
<td>5</td>
<td>NDCPs</td>
<td>64.72</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>843.96</td>
</tr>
</tbody>
</table>

Bank Balance as on 30-09-2011

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Programme</th>
<th>Outstanding Advances 30/09/2011 (Rs. in crore)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RCH</td>
<td>161.98</td>
</tr>
<tr>
<td>2</td>
<td>Mission Flexi pool</td>
<td>242.74</td>
</tr>
<tr>
<td>3</td>
<td>RI</td>
<td>38.76</td>
</tr>
<tr>
<td>4</td>
<td>Pulse Polio</td>
<td>0.82</td>
</tr>
<tr>
<td>5</td>
<td>NDCPs</td>
<td>23.91</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>468.21</td>
</tr>
</tbody>
</table>
Funds are available in Bank accounts of State Health Society. State has not monitored the pendency of JSY, Family Planning and ASHA incentive for funds transfer to District level.

Integration of Financial Management process with NDCPs

It was observed that the integration of finance staff at State /District Health Society level is done for reporting of expenditure purpose.

Diversion of Funds

State has diverted the funds of Rs. 40.80 crores from RCH flexi poll funds to Pulse Polio Programme.

Implementation of Model Accounting Hand Books

State has not properly implemented the Model Accounting Hand books, however the State has sent the books to District Health Society and District Health Society has sent the books to CHC/PHC level in month of April 2010 for implementation the Model Accounting Hand book.

Procurement Manuals

No procurement manual found at State and District level. Budaun district procured the emergency medicine on the basis of local tender.

TDS provisions

State and District level are following the rules of TDS deduction.
DECENTRALIZED LOCAL HEALTH ACTION

District health plans were available for each district, however these did not seem to be developed using inclusive or participatory processes, involving non State actors, as envisaged in the spirit of community action. Sample village health plans were made available to the team but the process underlying this planning was unclear and poorly managed. VHSC at village level are relatively weak and their capacity to develop and implement village plans and need to be strengthened. VHSCs must be supported in both communities monitoring and planning.

At the State level instead of forming an action group on community monitoring it will be worthwhile broadening the focus to the full scope of community action, including integrated approaches to Village, Block and District level planning. Decentralized planning must involve capacity building of local NGOs, PRIs, other non-State bodies and government officers at each level so that realistic plans can be prepared, and implementation monitored by both government and external community stakeholders.

Since Panchayat elections had taken place only two months prior to the CRM, Village Health and Sanitation Committees were not particularly active in the State. However, the team found that the previous VHSC had also been very weak - the community at large was unaware of the existence of the VHSC, regular meetings did not seem to be held and how decisions on fund utilization were made was unclear. The membership of the VHSC was also not broad based to include community and civil society representatives and those of marginalized groups. With imminent reconstitution of new VHSCs, there seems to be a window of opportunity to sensitize and activate this space of community action. Clear guidelines on broad basing membership needs to be made along with a wide dissemination and training on the roles and responsibilities of the VHSC. Meetings with Pradhans at Pradhan Sammelans may be used for this. Also, VHSCs need to be cross sectorally linked at district level with Panchayati Raj and Rural Development activities.

MAINSTREAMING OF AYUSH

It was noted that Medical Officers under AYUSH stream of medicine have been provided in several CHCs and PHCs. However, the AYUSH doctors were not practicing AYUSH stream of medicine. Instead they were found to be running OPD under modern medicine, providing antenatal care and conducting deliveries, assisting the Medical Superintendent/ IC Medical Officer in administrative matters and even running IEC
campaigns. Thus, the very purpose of mainstreaming AYUSH under NRHM is defeated.

The State should endeavor to provide opportunities for AYUSH doctors to practice AYUSH stream of medicine by providing them separate space in the health facility with requisite equipment and furniture. Further, AYUSH medicines should be made available in all health facilities having AYUSH doctor. Further, AYUSH pharmacist should be provided in large health facilities. Provision of funds for procurement of AYUSH medicine needs to be taken up with the Directorate of AYUSH in the State. Availability of AYUSH doctors in health facilities should be announced to the public by providing signboards with names of the doctors and the system of medicine they are practicing.

AYUSH doctors who are providing antenatal, intra-natal and post-natal services should be recognized and their services may be made more professional by giving them training as skill birth attendants, IMNCI etc. The system of recruitment of AYUSH doctors under NRHM should be based on merit.
Chapter 5
RECOMMENDATIONS

Infrastructure Development

- New PHCs which have been constructed in the past 3-4 years need to be maintained well and provided with appropriate manpower so that they are made functional.
- Upgradation work in various health facilities should be expeditiously completed after undertaking 3rd party evaluation as required.
- Prioritization of works for upgradation of infrastructure should be based on the requirements at the local/district level and not based on top down approach which currently exists.
- Construction of residential quarters as well as ASHA waiting room should be taken up on top priority.
- In order to ensure better maintenance and timely repair of life saving equipments in health facilities annual maintenance contracts may be signed.
- Sub-centres relocation: SCs that are not conducting deliveries and not located near the villages may be re-located to the centre of the village based on the delivery load.

Human Resources

- State needs to plan and implement reforms in Human Resource Policy in the State to solve the chronic shortage of staff in the State.
- Recruitment process for MO, Nurse, and BHW/MPW needs to be expedited.
- In order to ensure rational deployment of existing manpower a transparent posting and transfer policy is to be implemented, through legislation if required, so as to circumvent political compulsions.
- State needs to develop strategies to attract skilled professionals to serve in rural and remote area sand to keep them motivated.
- Innovative HR initiatives are required to retain and motivate contractual employees who are posted in various health facilities.

Training

- State to give priority to complete all training programmes planned for 2011-12 expeditiously.
• Innovations such as Skill labs – based on skill assessment and competency based certification – (e.g. AMTSL/New Born Resuscitation etc.) which has been successful in Bihar & Tamil Nadu may be initiated by the State.

• There is a need to enlist more institutions especially private sector training institutions to impart training for staff as the training load is very high and cannot be managed by existing government training institutions alone.

• Post training supportive supervision and mentorship by mobile trainers. For e.g PH Nurse can follow up SBA trained ANM on a regular basis.

• Quality of training needs to be given more emphasis. Officers from district and State level to visit and assess quality of training being imparted. Also pre and post assessment of trainees to be made mandatory.

Health Care Service Delivery:

• Citizens Charter to be displayed prominently in every health facility. A system of eliciting patient feedback to be established for all health facilities.

• Enabling orders/circulars to be issued to improve access of services by marginalized populations.

• For ensuring proper management of healthcare waste, it is proposed that the State needs to undertake following actions:
  a. Periodical training of the staff of hospitals, CHCs, PHCs and Sub centres on hospital waste management practices. The recommended topics for the training could be segregation as per colour coding, usage of needle cutters, mutilation of needles & syringes, and usage of chlorine solutions
  b. Provision of puncture proof containers for collection of SHARP Waste
  c. Mutilation & disinfection of plastic waste – to ensure its disinfection and to prevent its repackaging and circulation
  d. Dissemination of information from State to districts and facilities, regarding out-sourced waste management (if any) and terms & conditions of the contract. The State may also evolve a monitoring system for services to be rendered by CWTF operator
  e. The peripheral health facilities should identify an area within their premises for digging two pits – one for burial of SHARP waste and second pit for the burial of human tissue.
  f. Issue of Personal Protective Equipment (PPE) & Personal Protective Clothing (PPC) to all waste handlers and full immunization of all of them.

• Sanitation and hygiene in health facilities to be strengthened by emphasizing on:
  1. Hand washing and availability of liquid soap and dispensers at users points;
  2. Connecting hand-wash basins and sinks with over-head tanks to ensure availability of 24-hours running water at the users point;
3. Training on correct hand-washing practices (six steps over 2 minutes) and display of protocols for hand wash;
4. Installation of elbow operated taps in Operation Theatre;
5. Usage of colour change strip to monitor autoclave procedure;
6. Standard Operating Procedures (SOP) for weekly cleaning of floors and wall with disinfectant and water;
7. Supervision of the construction work for ensuring better quality of construction (seamless joining of tiles and avoidance of dead spaces);
8. Monitoring of disinfection in the operation theatre by periodical swab testing;

Outreach Services

- Strengthen outreach activities from Sub-Centre level and increase the scope of activities beyond immunization, with support from additional contractual staff.
- Provide additional mentoring support to improve ANM and ASHA ability to conduct VHNDs which provide counselling and other preventative and protective services beyond immunization (ANC, family welfare, home based new-born care, ARI, Diarrhoea, nutrition and disease prevention). A coordinated District level BCC strategy should be developed to support these efforts.
- The location of VHNDs must optimize accessibility for women with many competing household responsibilities.
- Village Health and Sanitation Committees have an important role to play in increasing local ownership and oversight of health services, they must be provided with more support to better integrate them into the health system.
- A significant investment has been made into MMUs and it now falls to the State to provide the necessary evidence based guidance to optimize their public health impact; this should include an analysis of their role in reaching underserved populations and strategies identified to serve those unable to access fixed or mobile services.
- For EMTS, links between the service and ASHAs must be formalized in the EMTS Standard Operating Procedures to prevent undermining the ASHA initiative.
- A solution to provide access for the majority of women who reside on un-made roads to the EMTS medical units requires urgent attention.
- A comprehensive review and cost effectiveness analysis should be planned for year two of EMTS operation to ensure public health gains and cost effectiveness is maximized.
Reproductive and Child Health

Maternal Health

- In order to improve access to institutional delivery for all pregnant women, more delivery points need to be identified by making APHCs functional.
- Quality of antenatal care has to be improved at all levels of health facilities.
- SBA trained staff should provide delivery services in Sub Centres and PHCs.
- Labour rooms needs to be improved by providing adequate illumination, essential equipments and instruments. Essential drugs such as Injectable Antibiotics, Oxytocin & Magnesium Sulphate should be available in all labour rooms. Partographs to be maintained for every case.
- Basic Emergency Obstetric Care should be provided in facilities such as 24X7 PHCs and CHCs.
- More FRUs to be established to meet the requirement of CEMONC for complicated pregnancies.
- Minimum postnatal stay of 48 hours to be ensured.
- JSSK programme has just started in the State and needs to bolstered urgently in order to give the demand side push for institutional delivery.
- Delivery of STI/RTI services to be improved in CHCs and PHCs by training MOs and Nurses and earmarking a separate space with audio-visual privacy for STI clinic.

Family Planning

- Availability of spacing methods such as condoms, OC/EC pills for family planning along with proper counselling on the same to be strengthened at all facilities from Sub Centre to District Hospital.
- Limiting methods such as minilap and NSV to be given adequate focus;
- There is a large unmet need for safe abortion services and State has to make provision for MTP services at all CHCs by training doctors on MVA and by providing equipments for the same.

Child Health

- State should ensure provision of essential newborn care at all delivery points and expedite training in NSSK for the same.
- Operationalising SNCUs and NBSUs (FBNC operational guideline of MOHFW, 2011) and training staff in SNCU training (4 days + 12 days observer-ship) and F-IMNCl respectively.
• Implement Home Based Newborn Care programme, train ASHAs in Module 6 and 7 and incentivize ASHAs @ Rs 250 for every newborn visits completed (HBNC operational guideline of MOHFW, 2011).
• Immediate steps may be taken to identify severely malnourished women, adolescent girl or children.
• Nutrition Rehabilitation Centres which is sanctioned for Badaun needs to be established immediately on priority. An NRC needs to be sanctioned for Jalaun district also.
• ASHAs should emphasize importance of early initiation of early breast feeding and exclusive Breast feeding for six months.
• There should be better coordination with other concerned Departments e.g. Drinking Water Supply and Sanitation.
• Every Health Facility should have weight height & BP instruments.
• Proper monitoring of food supplements provided under various programmes needs to be done.
• Efforts should be made to marginalized sections either through Mobile units or outreach camps for nutrition and other health related activities.

School Health Programme

• Nodal officers to be appointed in Directorate General of Health Services/Family Welfare and in every district for SHP;
• Coverage of the programme needs to be improved by leaps and bounds. All junior schools to be covered. Further the programme should extended to include junior and high schools;
• Nodal teachers to be identified and trained on the SHP in every school and health cards to be maintained for every student;
• Screening for disease, disability and deficiency to be prioritized without appropriate referral services and linkages with the health system;
• Health education, healthy life style and good hygienic practices to be prioritized under the programme.

Adolescent Reproductive and Sexual Health (ARSH)

• Nodal officers for ARSH and menstrual hygiene to be nominated in every district.
• State to enlist counsellors working in ICTCs and STI clinics run by UPSACS to provide counselling for adolescents during the afternoon lean hours. Counsellors of ICTCs/STI clinics to undergo 5 day training for this as per training module available for Nurse/ANM;
• State should endeavour to establish facility integrated ARSH clinics in sub-district level facilities such as CHCs and Block PHCs using existing MOs and ANM/Nurses who have been trained to provide adolescent friendly health services.
• State to strengthen convergence with SABLA, NYKS and adolescent Education Programmes so more and more adolescents who are covered under these programmes have proper knowledge on health issues concerning adolescents and have access to adolescent friendly health services.

**Preventive and Promotive Health Services**

• ASHAs and ANMs should emphasize initiation of early breast feeding and exclusive Breast feeding for six months in their interactions with pregnant and lactating mothers.
• Every Health Facility should have weight, height & BP instruments.
• Interdepartmental convergence at the grassroots level should be improved.
• District administration should undertake proper monitoring of food supplements provided under various programmes such as ICDS.
• District administration may give an impetus to improve sanitation level in villages through the mechanism of VHSCs which are underutilized.

**Revised National Tuberculosis Control Programme**

• Ensure timely release of funds - clearance of pending dues
• Streamline fund flow from DHS – committed expenses may be delegated to DTO after one time approval
• Ensure appointment of new and existing contractual staff
• Increase number of designated microscopy centres (DMC)
• State should enhance Contribution from district hospitals, Detection of smear negative, paediatric TB cases and EP-TB
• Detection of Strengthen referral and feedback to minimize initial defaulters - best practice in Badaun
• Ensure timely payments of pending honoraria to ASHA - treatment compliance
• Fast track coverage of programmatic management of drug resistant TB (PMDT)
• Fast track coverage of TB/HIV activities

**National Vector Borne Disease Control Programme**

• Posts of Entomologist should be filled up on priority basis in order to strengthen the vector borne surveillance in the State and control of vector borne diseases.
• Similarly vacant post of MPWs/BMWs, Malaria inspectors (MI), AMO and regular DMO to be filled up.
• Strict measures for JE need to be taken with convergence between health, drinking water and sanitation, rehabilitation of disabled children and nutrition.
• State to strengthen and expand JE vaccination; improve case management capability at district hospitals and medical colleges including medical rehabilitation.
• To improve blood supply collection, State may involve ANMs and ASHAs.
• Emphasis should also be given on morbidity management and Hydrocele operation.
• State should regularly monitor and supervise regular DDT spray in vulnerable areas.

Programme Management

• AD, JD, CMO, ACMO, DCMO, Medical Superintendents and IC-MOs all require further training in Management Skills and Public Health
• Under the PMUs, the SPM, DPMs and BPMs similarly require support and training in these areas
• DPMs should have a strategic and supervisory role and urgently need additional support and skills in this area.
• DPMs should also be supported to move from a basic administrative and managerial role, to a more strategic function; applying public health knowledge and management skills to drive development in the sector.
• Supervisory and monitoring functions at all levels need strengthening. All officers and facilities being monitored require a specific action plan to which they are held accountable, or change will not take place.
• The State may expedite the recruitment of BPMS and provide further support to bottom up needs based planning at Village, Block and vitally: District level.

Financial Management

• State Health Society should ensured timely appointment of Statutory Auditor and Concurrent for timely submission of auditor report to Ministry of Health.
• Books of Accounts should be maintained properly. Double entry system should be followed for maintained the books of accounts like Cash Book, Ledger, and Journal Register.
• Trial Balance should be prepared on monthly basis at CHC/PHC level.
• Bank Reconciliation should be prepared on monthly basis CHC/PHC level.
• Statement of Expenditure should be sent on the basis of Trail balance.
• Advance register should be maintained.
• Payment to suppliers, Contractors and other agencies should be made after proper approval. “Pass for payment” “Paid and Cancel ceal” should be affix on the Invoice before making any payment to concern. Stock register entry number should mention on the Invoice before release payment to concern.
• Cheques should be issued after the approval. Cheque issue registers to be maintained. Cheque books should be kept in lock and key with authorized person.
• Model accounting Hand book for Block accountants /CHC/PHC/SHC/VHSC and RKS should be follow these hand book to improve the quality of accounting records, monitoring and reporting of funds utilization.
• State contribution should be deposited in State Health Society bank accounts for the year 2011-12.
• Vacant positions of accounts personnel should be filled up on priority basis.
• State should properly monitor the fund flow system and ensure the timely payment of JSY, ASHA and Family Planning cases.
• Supervision and Monitoring visit should be planed from State and District level for monitor the financial activities.