



**UTTAR
PRADESH**
201

REPORT: VITH COMMON REVIEW MISSION 2012



**NATIONAL RURAL HEALTH MISSION
MINISTRY OF HEALTH & FAMILY WELFARE, GOVERNMENT OF INDIA**

EXECUTIVE SUMMARY

State and District Profile

Uttar Pradesh is the most populous state in the country with 19.96 crore inhabitants according to 2011 census. It covers an area of 2,40,928 Square km, equal to 6.88% of the total area of India making it the fifth largest Indian state by area. Hindi is the official and most widely spoken language in its 75 districts, 18 administrative divisions, 312 tehsils, 51914 Gram Panchayat, 822 development blocks and 107480 villages. The State is divided into four economic regions - Western Region, Central Region, Eastern Region and Budelkhand. The State has 44 high focus districts

The CRM team visited the two districts of Hardoi and Jhansi. Hardoi, one of the high focus districts has a population of 40,91,380, making it 51st in the list of most populous districts in India. The district has 5 tehsils consisting of 19 development blocks 1 DH, 1 DWH, 7 CHC, 12 BPHC, 57 APHCs and 432 SCs.

Jhansi borders Madhya Pradesh and is located in the Budelkhand economic region. According to 2011 census 2011, the district has a population of 20,00,755. The district has better health indicators in comparison to State averages and is at par with the National figures. 41.78% of the population lives in urban areas of district, which has 8 blocks. There are District Hospitals (Male & Female), 1 Medical College, 8 Community Health Center, 36 Primary Health Center and 326 Sub Center. Bundelkhand region is affected by poor irrigation facilities, and major economic activity includes mining.

Basic demographic profile of the State and districts as per Census 2011 is given below:

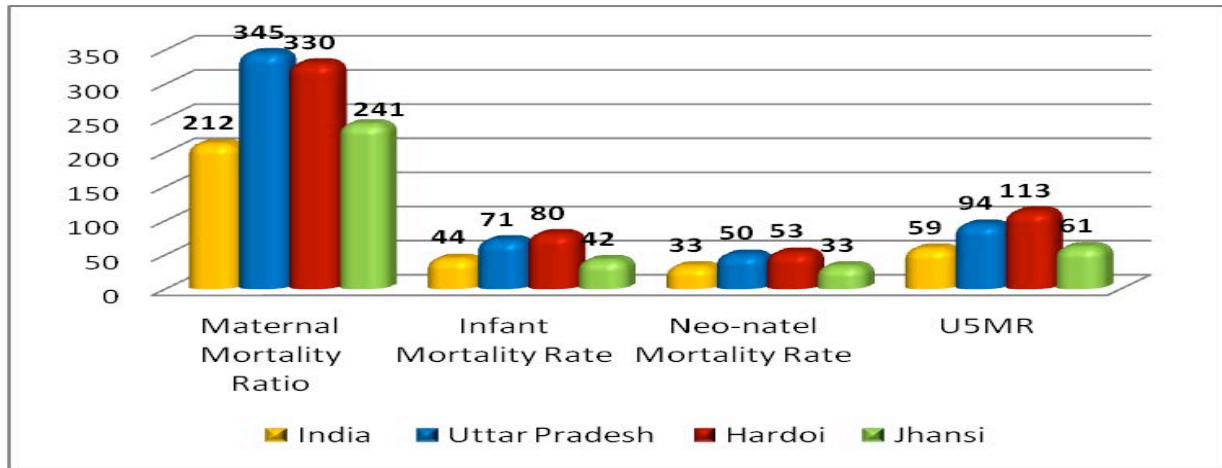
Source: Census 2011

Indicator	Uttar Pradesh	Hardoi	Jhansi
Total Population	199581477	4091380	2000755
Male population	104596415	2204264	1061310
Female Population	94985062	1887116	939445
Density of population	828	683	398

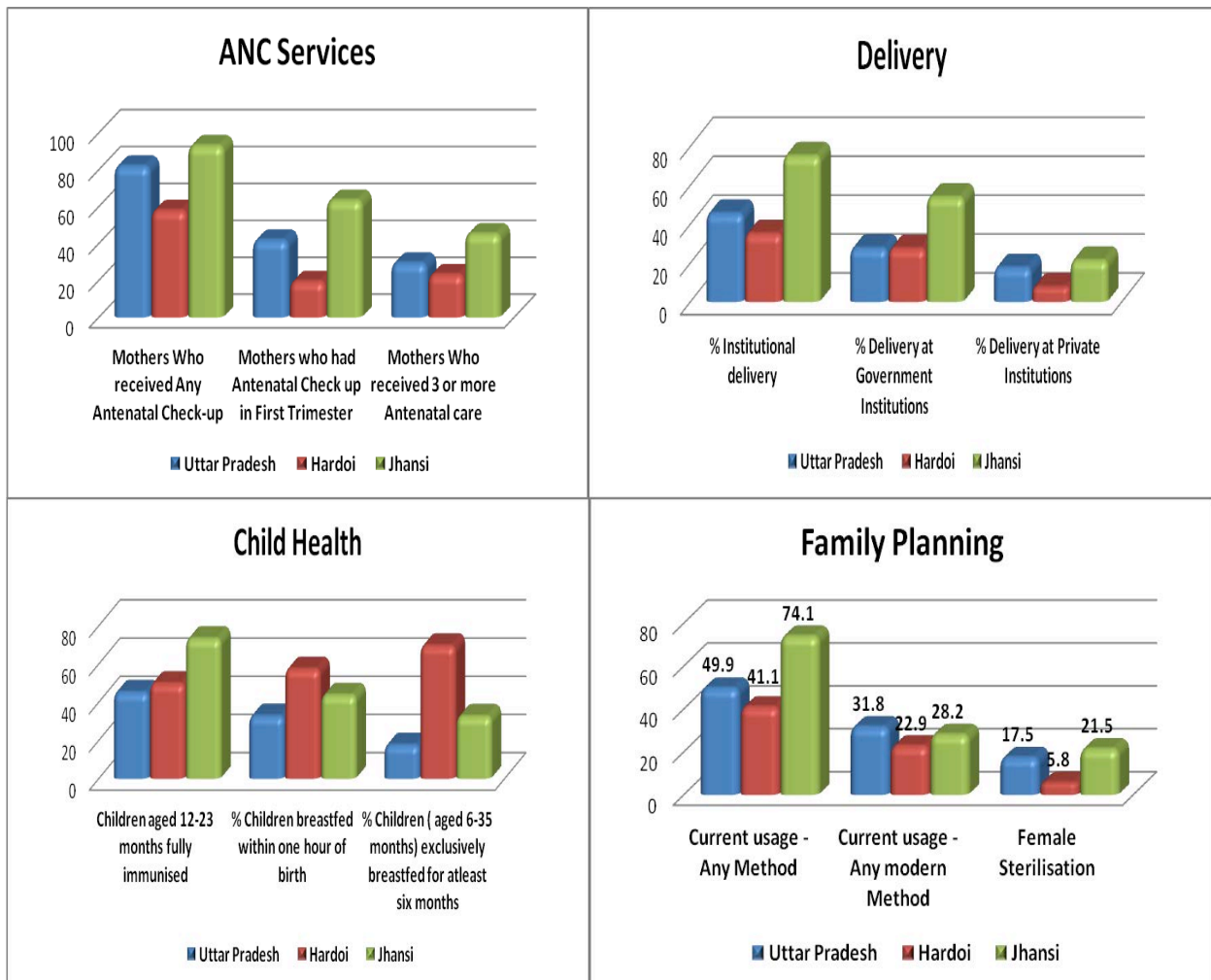
Demographic indicators as per AHS, 2011

Indicators	Uttar Pradesh	Hardoi	Jhansi
Sex Ratio	943	875	873
Sex Ratio at Birth	983	983	847
Literacy Rate	71.2	68.2	78.9
Crude Birth Rate	25.5	27.9	19.6
Total Fertility Rate	3.6	4.4	2.5

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.



Programme Indicators (Source: Annual Health Survey 2010-11)



6th COMMON REVIEW MISSION: OBSERVATIONS FROM THE FIELD

Introduction:

The 6th Common Review Mission was held between 3rd November and 9th November 2012. The team comprised of senior officials and consultants from the Ministry of Health and Family Welfare, representatives from Development Partners, Civil Society as well as Academia. The team of Uttar Pradesh undertook its task under the leadership of Dr. P.K. Prabhakar, Deputy Commissioner, Child Health, Ministry of Health and Family Welfare.

The briefing meeting was held on 3rd November, 2012 at Lucknow and was chaired by Mission Director, NRHM Government of Uttar Pradesh. The Mission visited two districts, Hardoi and Jhansi. Where in Jhansi is a district with better health indicators and Hardoi is one of the High Focus Districts in the state.

Both teams toured their respective districts extensively and the list of facilities visited is given in the table below. Teams had a number of interactions with ANMs, ASHAs, other service providers and beneficiaries & members of the community. Both teams had a meeting with respective District Magistrates at the end of the district visits.

The de-briefing meeting was held on 9th November at Lucknow, which was chaired, by Principal Secretary, Health & Family Welfare, Government of Uttar Pradesh, wherein there was extensive discussion on the field findings and recommendations.

Facilities visited by the Teams

Category of health facilities	Jhansi	Hardoi
District Hospital	District Male Hospital, District Female Hospital	District Male Hospital, District Female Hospital
Community Health Centre	Babina, Bangara, Baragaon, Mauranipur, Moth	Kacchuna, Shahabad, Sandila, Tadiyavan
PHCs	Baruva Sagar, Sakrar	Toderpur, Sursa, Hariyawan, Urban Post
Sub- Center	Ghughuva, Barata, Sakrar, Kotara, Jawan, Moth	Suthena, Saank
Anganwadi Center	Barata	Saank
Villages	Ghughuva, Barata, Sakrar, Kotara, Jawan, Moth	Suthena, Saank
ANM Training Center	Moth	
Medical College	Maharani Laxmibai Medical College & Hospital (NRC & SNCU)	-----
Development Blocks covered	5 out of 8	7 out of 19

Team Members

Jhansi Team	Hardoi Team
Dr. P K Prabhakar	Ms. Limatula Yaden
Dr. Dilip Singh Mairembam	Dr. Balbir Dewan
Dr. Shailesh Jagtap	Dr. Pruthvish
Sh. Naresh Kumar	Dr. Devendra Khandait
Dr. Pushkar Kumar	Dr. Amit Katewa
Sh. Sameer Thapa	Dr. Deepti Agrawal
Sh. Vipin Joseph	Dr. Shahab Ali Siddiqui
State Representatives	
Dr. Uttam Kumar	Dr. Sunil Bharti
Dr. Ram Krit Ram	Dr. Ram Adhar

State Programme officers and respective Chief Medical Officers and their officers in the districts accompanied both teams during the facility visits. CRM team expresses their gratitude to the Mission Director NRHM UP and State & District Officials for their full support in making the mission successful.

POSITIVE FINDINGS

Infrastructure

- All Facilities visited are housed in Government Buildings (except UPHC, Hardoi)
- All facilities visited were functional and satisfactorily maintained
- Most facilities visited were accessible from road
- Most Sub Centers visited were located with within the village
- Essential equipment was available at most facilities.
- Staff quarters found in good condition in the newly constructed facilities
- Clean toilets were found in most facilities with regular water supply
- Power back-up available
- ASHA Ghar/room found in some facilities visited.

Outreach Services

- Out of 20521 HSCs present in the State, 12 % are delivery points, some with high case loads, as found in Jhansi district
- 131 functional Urban Health Post primarily catering to the urban slum population
- Emergency Medical Transport services (108 Service) through GVK EMRI and Patient Transport Services (102 Services) under the *U.P. Ambulance Seva*

RCH

- Delivery points were operationalized
- Overall health facilities are functional; normal delivery care provided through designated delivery points; infrastructure generally good
- DWH functioning optimally in Hardoi; both districts; however FRUs at DWH at Jhansi and CHCs at Sandila utilised sub optimally
- MCP cards in use; scope for improvement
- Drug availability very satisfactory, most drugs available however, few prescriptions found
- 500 basic ambulances have been deployed in the districts till now

Immunization

- Cold chain points well maintained
- Review mechanisms in place for polio programme, RI micro-plans available
- Mechanism for 'Alternate Vaccine Delivery' in Place

Client Satisfaction

- During interaction, all patients, villagers, PRI members reported huge improvement in the public health system in last few years.
 - Facilities were open 24x7
 - Doctors/ ANMs available round the clock
 - Satisfied with drugs availability

Human Resources

- Recently recruited AYUSH doctors found in most facilities visited. They are participating in the national programmes and supporting the existing staff in filling service delivery gaps

JSY

- JSY payments are made by bearer cheque
- No complaints received from mothers regarding payment

JSSK

- Implementation started across both districts visited
- Free drugs available all levels and free diet provided at PHC and above
- Drop back facilities have been initiated (PPP mode)

ASHA Program

- Interactions with ASHAs was the most heartening feature of the visit
- ASHAs were found very knowledgeable, sincere, and enthusiastic for their work

- ASHAs in Jhansi district have been trained in Comprehensive Child Survival Program (CCSP)
- 'ASHA Divas' being celebrated and good performing ASHAs are honored

Disease Control Programs

- IDSP online data reporting is above 85 % from all districts
- Under RNTCP, during 2012, the state has achieved the objectives of 70% NSP case detection and 85% NSP cure rate
- API is <1 and ABER is satisfactory

HMIS

- District and Block level officers are trained on HMIS
- Computers and peripherals were available at the Block level

MCTS

- MCTS has made a remarkable progress and work plan is generated in the district of Jhansi
- Work plans have been generated

Financial Management

- Books of accounts are maintained properly
- Tally accounting software is functional in SHS/DHS
- Governing body meeting of DHS and RKS are being held and minutes of the meetings are being recorded

Tehsil Divas

- Tehsil Divas for intersectoral convergence and participation of community being held regularly in both the districts

AREAS FOR IMPROVEMENT

- Existing public health facilities are based on 1991 census population - large gaps exist according to 2011 census norms
- The sanctioning of new HSCs has not been done which is leading to the increasing shortfall in the number of HSCs over the years. Moreover, the infrastructure development of the HSCs running in Private/ rented buildings is also slow. This is compounded by the hindrances in taking over of the newly completed buildings by the facility in-charges
- Many sub centers, designated as delivery points do not offer all the services expected out of a delivery point. Hence the number of actual delivery points is less than the enlisted figure - ANCs conducted by the SCs is limited to only provision of IFA and TT injection to the pregnant women by the ANMs
- The outreach services ought to be provided by the MMUs has come to standstill owing to the legal hassles in 15 districts, but these services are also not being rendered in rest of the districts

- Substantiation of services at the facilities under which the patients and pregnant women are transported as not being done at the same pace as the rapid phase of expansion of referral transport services in the State (sanctioning and provision of a large fleet of both emergency and non emergency referral vehicles).
- Large Number of vacancies for all categories of healthcare providers - both regular and contractual. There are 4525 MO, 2557 paramedical and 2412 ANM posts lying vacant and only 2566 Male Health Workers are posted against a sanctioned number of 8857
- Irregular recruitment process and lack of candidates has resulted in inability to fill vacancies
- The state does not have a comprehensive strategy to attract and retain healthcare providers in the rural areas - existing financial incentive is too low to make a difference
- Lack of system for performance appraisal and workforce management, particularly for the contractual workforce - including their renewal process, pay parity with regular employees and increments.
- Irregular process of cadre review has resulted in vacancies at almost all levels, most so in the L2 (SMO) level
- Due to inadequate number of faculty members, admissions in the ANM Training Center affected - the process was last carried out since 2009. ANMTC at Moth, Jhansi has produced only 1 batch of ANMs in the past 6 years.
- Training plan and post training deployment plan not in place in the districts visited - Low levels of achievement for critical trainings that include SBA, NSSK, LSAS, F-IMNCI, BeMOC and EmOC.
- Line listing of severe anemic women is not being done at the Sub Centers and PHCs, as HB is not being tested during ANC. BP monitoring at some facilities is not being done due to non-functional BP instruments.
- 21 sub centers are functional delivery points in the 2 districts. However, the sub center delivery points lack appropriate/usable labor tables, newborn corners, power supply, piped water at many of the facilities, compromising on the quality of care being delivered from these centers
- Operationalization of First Referral Units hindered by non-availability of specialists and slow pace of multiskilling of doctors - Comprehensive RCH services are available in the districts at only the FRUs and DH/DWH. However, even these two facilities do not offer the full complement of services - neonatal and adolescent health services are nonexistent at DWH Hardoi. New Born Care Corners at most delivery points have not been set up.
- The still birth rate and IUD (intrauterine death) is quite high in Hardoi district and surprisingly higher than neonatal deaths reported from the district; while there may be reporting issues it is also a reflection of inadequate antenatal care at the peripheral facilities, lack of skills, transport facilities and emergency obstetric care services

- Postpartum stay at most facilities is less than 48 hours; reasons cited for this are twofold-space crunch (inadequate number of beds) and lack of electricity supply
- There have been no initiatives to establish PPP for C-section, abortion services or family planning procedures, except for the recent initiative to hire vehicles for 'drop back' facilities for pregnant women, under JSSK. Branches of professional bodies like IAP or FOGSI do not have a presence in the district. The only visible support is the supply of ORS+Zinc Combipack for childhood diarrhea
- Camp approach is largely being followed for performing the sterilization procedures for women. Minilap and Vasectomy are not performed at any of the health facilities; ECPs are not available within the system. Overall the effort to promote or motivate clients for adoption of contraceptives is weak. Post partum family planning has also not received its due focus.
- While facilities are upgraded on paper (presently called as Designated CHC) and new buildings constructed; sanctioned bed strength and HR not provided - functionality and service delivery not commensurate with the upgraded status.
- IPD trend does not match the significant increase in OPD footfalls - most IPD is on account of delivery cases at all levels of health facilities, more so at level 1 & 2
- Functionality of AYUSH MOs is affected by irregular supply of AYUSH Medicines.
- Limited range of available diagnostic services and laboratories mostly remain non-functional beyond OPD hours.
- Bio Medical Waste management protocols not being followed - waste management services which was outsourced to a private agency has stopped due to lack of funds.
- Most facilities have levied user charge of Re.1 at the time of registration but this has not acted impediment to access to services.
- No trainings under IDSP, other than induction training of epidemiologists. Timely renewal of contracts and no salary increments since 2009 discourage staff. 6 districts are yet to start reporting due to lack of HR
- Irregular release of budget is an issue with DCPs such as IDSP, NLEP, RNTCP
- ASHA trainings on Module 6 & 7 yet to take off in the entire state and refresher trainings are not being planned
- Lack of privacy is an important issue; none of the labor rooms had privacy between the two tables
- Not all the clinics are reporting under the PCPNDT Act and proper scrutiny of submitted forms found wanting
- Out of 75 DPMUs, only 52 have District Programme Managers (DPMs) whereas District Account managers (DAM) are in place in only 43 DPMUs and District Data cum Account Assistants (DDAA) in 47 DPMUs. Overall, there are 100 vacant posts under DPMUs. Most of the vacancies at DPMUs are there since 2008.

- At BPMU level 293 BPM and 75 BDAA posts are vacant
- There has been an inordinate delay in setting up of the State Health Resource Center, approval and sanction of funds has already taken place.
- The statutory audit for the period 2010-11 was pending as on October 2012.
- District and Block Account Manager posts are vacant - regular trainings not being conducted for those who are in position
- Annual district budget not available - expenditure based on receipt of funds from SHS

RECOMMENDATIONS

1. Mapping of health facilities should be done with the ASHA and ANMs to identify underserved/un-served areas in the districts.
2. Plan and operationalize new facilities according to 2011 census norms with focus on underserved/un-served areas
3. Easy barrier access for disabled and elderly to be provided at all health facilities
4. Better Signage and Citizen Charter and IEC materials for beneficiaries to be displayed at all the facilities.
5. Privacy in labor rooms should be ensured by provision of attached toilet in all labor rooms.
6. Facility strengthening of delivery point sub centers, with priority to those with high case loads
7. Restore MMU services, in all the districts
8. Revive admissions in all ANMTCs in the state and plan for setting up new ones, ensuring equitable distribution in underserved areas; Preference for candidates from under-served areas in the ANM/Nursing Schools; Faculty development program & quality assurance in nursing schools
9. Pooling of available specialists to ensure a full complement of Obstetrician/ Anesthetist/ LSAS/ EmOC MOs in designated FRUs for operationalization.
10. Clear categorization of health facilities in difficult, most difficult & inaccessible areas and financial incentives for all levels of health care providers, substantial enough to offset the opportunities lost in serving in the rural & remote areas; Implementation of other non-financial incentives including the proposed compulsory 3-years rural posting for their first promotion
11. Innovate Recruitment Processes - Till all regular posts are filled, monthly interviews are held in each division, after advertisements and draw-up waiting lists from each round of interview. Relax recruitment norms- recognize qualifications from other states, for contractual appointments

12. Workforce Management - Develop Protocols for performance assessment and workforce management including renewal of contractual staff
13. Develop a Human Resources Management Information Systems (HRMIS) in collaboration with relevant stakeholders/ partners to ensure "real-time" information on health human resource in the state
14. Creation of adequate number of regular posts, to meet requirement in health facilities - existing & to be created (1991 population norms are still being followed in the state)
15. A comprehensive assessment of the delivery points in both the districts, and especially the CHCs, PHCs, Sub center to identify the gaps in service delivery and priority actions to be taken for filling the gaps
16. The quality of ANC, identification of high-risk pregnancies, HB estimation and line listing & tracking of women with severe anemia require immediate attention.
17. HB testing kits to be available at all health facilities and ANMs trained by Lab technicians in the nearest PHC/CHC for HB testing.
18. Newborn care services including essential newborn care, care of the sick newborn and referral system should be holistically planned at the district level with priority on establishing/strengthening New Born Care Corners (NBCC) at delivery points.
19. The guidelines/ policy for facility transfers (regarding home to facility transfer prior to delivery) under JSSK should be clarified. The provision of referral transport should be closely monitored in the initial phase so as to ensure that a robust system is put in place and the free referral transport provisions under JSSK can be put in place.
20. Call Center facilities for referral transport should be established at the earliest.
21. Referral transport requires high-level review as well as planning. The issue of the vehicle breakdowns (that too in newly purchased vehicles-FORCE) should be taken into cognizance by the state. The use of ambulances in lieu of official vehicles should be discouraged.
22. Priority planning and training of service providers working at the Delivery Points to be done so that they receive SBA, NSSK, IUCD, BeMOC trainings on priority. The adherence to protocols in SBA training sites (use of partographs) should be emphasized and monitored by state level team. Refresher training may be conducted for SBA trainers.
23. Family planning, especially post partum, should receive attention and closely monitored. Action plan should be prepared for creating awareness and motivating clients both at community and facility level about spacing methods as well as vasectomy.
24. Provision of Family Planning Counselor (RMNCH counselor) at heavy case load facilities like district women hospital to be expedited and their services utilized at both OPD and post natal units.

25. Recording of stillbirths, neonatal and maternal deaths should be reviewed more critically and action linked monitoring should be undertaken.
26. The RTI/STI services should be linked to ANC and CAC should be made available at more number of facilities and advertised widely.
27. Infection prevention protocols and Asepsis in labor rooms and newborn care corners and even the postnatal wards requires re-enforcement,
28. Biomedical Waste Management in labor room, laboratories and other sites in the hospital need reinforcement as per IMEP guidelines.
29. Rational deployment of LTs to make laboratory services functional and the labs at DH/DWH and FRUs to be 24x7 is required.
30. Services available at various health facilities should be mapped and HR deployed rationally.
31. Roll out of Module 6 & 7 trainings for ASHA should be taken up as the top most priority, especially in districts not covered under CCSP Trainings
32. Filling up of vacant posts in the program management units at all levels - state, district & block on priority
33. Expedite process of setting up of the State Health Resource Center
34. Expansion of facility wise reporting on HMIS & MCTS, online reporting of JSY payments, and improvement in quality of reporting should be key priorities under monitoring & evaluation. State should expedite the recruitment of the District Data and Account Assistants (DDAA) and Data Entry Operators in the block level.
35. Orientation of District/ block level programme officers on use of HMIS for programme review may be initiated to improve the quality of reporting.
36. Supervisory visits of the State, District officers to the facility were observed to be minimal, especially with regard to Monitoring and Evaluation activities in the State. Supervisory visits to be scheduled to the prioritized districts, block facilities by the concerned officers.
37. Budgetary planning for expenditures should be made at the district and block level
38. The observations made by statutory auditors in year 2010-2011 audits should be followed and any anomalies referred needs to be rectified
39. All the compliance under societies registration act of UP should be done regularly in accordance with relevant provisions
40. Regular training to the staff dealing with accounts needs to be imparted, a training calendar in this regard should be maintained

CONDITIONALITIES AND INCENTIVES: IMPLEMENTATION FRAMEWORK

Conditionality and incentives	Progress by the State	% Incentive/ disincentive	Method of verification	Compliance by the State
1. Rational deployment of HR with the highest priority accorded to high focus districts and delivery points/priority facilities (Non compliance would lead to reduction of up to 7 ½%).				
1.1 Policy criteria				
1.1.1 Rational deployment policy which would inter alia include: Posting of staff on the basis of case load (OPD/IPD/Normal deliveries/C-sections), rational deployment of specialists especially gynecologists, anesthetists, EmOC and LSAS trained doctors in teams, posting of trained HR as per the level of the facility e.g. LSAS and EmOC to be posted in the FRUs, and filling up of vacancies in high focus/remote areas on priority basis	In place by November 2012	Otherwise, deduction of up to 2% of MFP	Policy notification (copy) and Website posting; state report on compliance by November, 2012	Rational deployment policy being prepared at the level of DG-Medical & Health with the decision of posting of staff on the basis of caseload and expertise. Rational deployment of HR was observed as a major concern in districts visited.
1.2 Implementation criteria				
1.2.1 Preparation of baseline data for HR including the current place of posting and their productivity/caseload; system in place for updation.	As a minimum for all delivery points/ priority facilities and SCs in high focus districts; by November 2012	Otherwise, deduction of up to 2% of MFP.	Website posting and state report on compliance by November 2012	District wise staff postings status is available on the website for most of the districts. However, facility wise HR mapping to be done for the entire state. Base line data for H.R. being updated at SPMU and DG's level.
1.2.2 Evidence of corrective action in line with the policy	90% of all delivery points/ priority facilities staffed in line with norms by Dec 2012; 90% of all SCs in HFD should have at least one ANM	Otherwise, deduction of up to 2% and up to 1.5% of MFP respectively	State report; website posting by December 2012.	
2. Facility wise performance audit and corrective action based thereon. (Non compliance would lead to reduction of up to 7 ½% of MFP)				
2.1 Policy criteria				
2.1.1 Range of services (as in MNH guidelines for RCH services,	By September, 2012	Up to 2½% of MFP	State report and	

Conditionality and incentives	Progress by the State	% Incentive/ disincentive	Method of verification	Compliance by the State
OPD, IPD and other services to be determined by the State) specified at least for delivery points			Website posting by September, 2012	
<i>2.2 Implementation criteria</i>				
2.2.1 Facility wise reporting on HMIS portal by all priority facilities/delivery points for October(SC data if needed be uploaded from PHC)	By November, 2012	Up to 2½% of MFP	State report; State HMIS: October data to be uploaded by Nov' 12	
2.2.2 Corrective action (priority to be given to high focus districts) based on facility wise reporting.	By December, 2012	Up to 2½% of MFP	State reports on corrective action by Dec 2012	
3. Gaps in implementation of JSSK (May lead to a reduction in outlay up to 10% of RCH base flexi-pool.)				
<i>3.1 Policy criteria</i>				
3.1.1 Government order for coverage of entire State regarding: <ul style="list-style-type: none"> ▪ Free delivery (including C-section if required) ▪ Free diet ▪ Free treatment to sick new born upto 30 days ▪ Grievance redressal system with specified timelines for redressal 	By September, 2012	Up to 2½% of RCH base flexi-pool	Copy of GO; Website posting	Government order for the implementation of JSSK has been sent to the districts. The order has been posted on the website. However, it was observed that all entitlements under JSSK were not made available to beneficiaries, such as availability of free diet and transport of pregnant women from home to facilities, although drop back facility was ensured, at least at the facilities having dedicated vehicles. Currently, 500 basic ambulances and 200 hired vehicles are operational
<i>3.2 Implementation criteria</i>				

Conditionality and incentives	Progress by the State	% Incentive/ disincentive	Method of verification	Compliance by the State
3.2.1 State wide dissemination of GO/policy ; visible IEC in facilities and community awareness.	By October 2012	Up to 2½% of RCH base flexi-pool	Sample community visits show high awareness.	Government Order for the implementation of the scheme has been circulated across the districts. There was limited awareness about the scheme even in the health functionaries.
3.2.2 No user charges for pregnant women and newborns. Drugs, diagnostics, diet should be available free. Grievance redressal system operational.	By October 2012	Up to 2½% of RCH base flexi-pool	Field visits; exit interviews or community level sample interviews; grievance redressal records, MCTH feedback	There are no user charges for Pregnant women. Drugs diagnostics and diet are available free of cost however availability is not uniform across the facilities.
3.2.3 At least 50% of pregnant women and sick newborns coming in should be using assured and cashless means of transport- and getting a similar drop back home.	By November, 2012, assured referral transport system in place- both local tie-ups and dial 108/102 systems- as per approval in ROP	Up to 2½% of RCH base flexi-pool	-do-	
5. Responsiveness, transparency and accountability (incentive upto 8% of MFP).				
5.1 Demonstrated initiatives including innovations for responsiveness in particular to local health needs e.g. use of epidemiological data, active participation of public representatives in DHS / RKS meetings etc.	Initiative / Innovation implemented and impact demonstrated; State to send brief report in line with format provided in Annex 1 by November, 2012. (3 best practices, preferably one in each of 3 areas)	Up to 8% of MFP	State report (format in Annex 1) by November 2012; state visits for rapid appraisal.	
5.2 Demonstrated initiatives /innovations for transparency e.g. mandatory disclosures and other important information including HR posting to be displayed on State NRHM website, schedule of MMUs and RCH camps etc. to be disseminated among user groups in addition to these being				

Conditionality and incentives	Progress by the State	% Incentive/ disincentive	Method of verification	Compliance by the State
displayed in the State NRHM websites etc.				
5.3 Demonstrated initiatives /innovation for accountability: e.g. call center for integrated grievance handling system, aggrieved party to receive SMS with a grievance registered number; action taken within stipulated time; community monitoring; Jan Sunwai etc.				
6. Quality assurance (incentive up to 3% of MFP).				
6.1 Policy criteria				
6.1.1 States notify quality policy/strategy (align to national policy) as well as standards	In place by November 2012	Up to 3% of MFP	Notification and state report by November 2012.	State Quality Assurance cell and its working group have been formed. State quality Strategy needs to be framed.
6.2 Implementation criteria				
6.2.1 Constitute dedicated teams. Training of state and district quality team and DH quality team completed.	State team trained by November 2012			Constitution of State and district quality teams is under process.
6.2.2 Current levels of quality measured for all “priority facilities” and scored and available on public domain. Deadlines for each facility to achieve quality standards declared.			Quality scores of all priority facilities available in public domain.	Quality scoring of the priority facilities has been done. Standard and benchmarks for the facilities has not been done.
7. Inter-sectoral convergence (incentive up to 3% of MFP).				
7.1 Policy criteria				
7.1.1 Implementation frame work for intersectoral convergence with allied sectors/departments	By November 2012	Up to 1% of MFP	State report (copy of implementation framework)	
7.2 Implementation criteria				
7.2.1 Intersectoral convergence opportunities identified with WCD, PHED, education, etc. and action initiated.	By November 2012	Up to 2% of MFP	Government order, State report	
8. Recording of vital events including strengthening of civil registration of births and deaths (incentive up to 2% of MFP).				
8.1 A strategy paper identifying reasons and the road map for	By October 2012	Up to 1% of MFP	Strategy document	Strategy framing for the proper

Conditionality and incentives	Progress by the State	% Incentive/ disincentive	Method of verification	Compliance by the State
increasing registration			and policy statement.	Birth and death registration under process in the State. Preliminary meetings held.
8.2 Death reports with cause of death (especially any under 5 child or any woman in 15 to 49 age group) shared with district health team on monthly basis.	By November 2012	Up to 1% of MFP	Death reports received at district level- verified in sample of districts.	Infant & maternal death reporting is being carried out with the help of ASHAs however, accuracy & consistency of data is compromised.
9. Creation of a public health cadre (by states which do not have it already) (incentive up to 10% of MFP)				
<i>9.1 Policy criteria</i>				
9.1.1 Stated policy and road map (including career path on creation of a public health cadre)	Policy & road map in place by November 2012	Up to 4% of MFP	State report (copy of policy); website posting by Nov 2012	
<i>9.2 Implementation criteria</i>				
9.2.1 Notification for creation of public health cadre	Government order in place.	Up to 6% of MFP	Web posting/ statereport	
10. Policy and systems to provide free generic medicines to all in public health facilities (incentive up to 5% of MFP)				
<i>10.1 Policy criteria</i>				
10.1.1 Clear policy articulation of free generic medicines to all in public health facilities	By October 2012	Up to 2% of MFP	Web posting / statereport	State is providing free medicines to all OPD patients.
<i>10.2 Implementation criteria</i>				
10.2.1 EDLs finalized and drug formulary published and made available in all public health facilities	By November 2012	Up to 3% of MFP	Notification / Publication / Web posting	The EDL has been finalized. The formulary of drugs has not been made available across the facilities.
10.2.2. Overall procurement and logistics strategy in place. Detailed design and plan for rate contracting, regular stock up date, indent management, warehousing, promotion of rational drug use, contingency funds with devolution of financial powers etc. in place.	By November 2012		State report/ strategy document	Procurement and logistics strategy is being prepared at the level of DG-M & H.

ACTION TAKEN ON 5TH CRM REPORT AND OBSERVATIONS OF 6TH CRM TEAM

Major Recommendations of 5 th CRM	State Action Taken Report	CRM-VI Observations on Actions Taken
State should expedite the process of making new PHCs fully functional so as to reduce the load on DH & CHCs and increase access to hard to reach and vulnerable populations	Efforts to fill all the posts of MOs at new PHCs. Recently recruitment of about 1700 new UP PSC Public Service Commission Further 1410 AYUSH male MOs have been posted at New PHCs	Delivery points have been identified by the State and priority in resource allocation to these facilities is being followed. Most facilities visited had adequate number of MOs. Recently appointed AYUSH doctors were present. However , no AYUSH medicines supplied, they were prescribing Allopathic medicines
Recruitment process for MO, Nurse, ANM to be expedited	The delivery points (L-1, L-2 & L-3) have been identified for strengthening. Contractual Staff: 176 Specialists @ L-3 facilities, 566 MBBS MOs @ L-2, L-3 delivery points and NRCs. 1887 SN @ L-2 and L-3 delivery points, SNCUs and NRCs. 4197 ANMs @ vacant sub centers and 2007 @ JSY accredited sub centers conducting >10 deliveries/month.	There are about 4546 vacancies in the PMHS cadre of the doctors in the State across various levels. In the contractual workforce there are large number of vacancies across the following categories: 141 Specialist,1307 MBBS Doctors, 786 AYUSH Doctors, 18 Dental Doctors, 2057 Staff Nurse, 3775 ANM, 1648 Paramedical indicating the lethargy of the State for the recruitments. SpecialistsGynaecologist, , Paediatricians s, and Anesthetics were not present in full complement at most PHCs/CHCs visited. 24x7APHCs visited not having staff nurses in Jhansi, but present in Hardoi.
Innovations such as compulsory rural posting after MBBS and 3 Year Rural Medicine Course to be considered as gap between requirement and availability of doctors is too large to be bridged	As per State GO, all newly recruited doctors have to undergo compulsory 3-years rural posting for their first promotion. The state is also considering various options to bridge the gap of availability of doctors against population, as per norms	Irregular recruitment process and lack of candidates has resulted in inability to fill vacancies There are no waiting lists for regular appointments; hence there is no system to fill up posts of those who did not join the services. Weak financial & non-financial incentive mechanism for healthcare providers working in rural & remote areas.
ANMTCs to be strengthened with more HR in every district	Strengthening of ANMTCs had been proposed in the PIP for 2011-12 and had also been approved by GOI but activity could not be taken up due to unavailability of funds. The same has been again approved in the PIP for the year 2012-13 and will be taken up soon	Due to inadequate faculty, admissions in the ANM TCs have been highly irregular. ANMTCs are in bad shape across the State. It was observed that ANMTCs in both the districts visited were non-functional since a number of years.

<p>Display of protocols in critical areas of hospitals</p>	<p>SBA protocols and EMOC protocols could not be printed this year by Directorate of Family Welfare. The same has been included to be printed and displayed at all delivery points in the year 2012-13.</p>	<p>Displays not found</p>
<p>BMW: Low awareness of Hospital staff on BMW SHARPS not collected in Puncture Proof containers & pits not available Disposal of Plastic Waste without mutilation Non-availability of Hypochlorite solution Placenta being given to patients relative for disposal. Non-monitoring of 'out-sourced' waste management services (by CWTF operator)</p>	<p>Strengthening of BMW done through UPHSSP project in the year 2012-13. SIHFW has completed 5 days TOT of Doctors who in turn, train SNs and support staff regarding segregation of Hospital Waste, collection and proper disposal. The monitoring of out-sourced waste management services is being planned at division level for the year 2012-13</p>	<p>The are colour coded bins are available in some of the facilities however the usage as per the protocol was not being done. Awareness of BMW protocols is very low among staff. The collection of the bio medical waste by the outsourced agency is not being done regularly. The dumping pits were open at most of the facilities.</p>
<p>PROCUREMENT SYSTEM:</p> <ul style="list-style-type: none"> ▪ Storage area needs improvement - Lighting, Bin card system, Pellets, etc. ▪ All equipment are not covered under the CMC/ AMC, thereby increasing downtime of equipment ▪ Forecasting the demand and starting procurement action well before time to avoid stock-outs ▪ All new procurement of equipment should have extended warranty ▪ CMC of Equipment 	<ul style="list-style-type: none"> ▪ The same is being ensured ▪ The districts have been instructed to include amount of AMC/CMC for each equipment, they propose to procure. ▪ The districts have been instructed to analyze the demand well in time and do the needful. ▪ The same is being ensured 	<p>No IT based inventory management system.</p> <p>The procurement has been decentralised at district level.</p> <p>The availability of drugs and supplies at the facility level has been found to be satisfactory.</p> <p>AMC/ CMC of most of the equipments not in place.</p>

TOR-I: Facility based Health Care Services: Access, Affordability, Quality and Equity

Infrastructure

1. The Health Infrastructure in the state is not adequate as per population norms as is evident from the following data:

Health Facilities	Number of functional facilities	*Population covered per facility
Sub Health Center	20521	7558
PHC	3692	58290
CHC	773	250321
District hospital	157 (104 DH +53 DWH)	14,88,805

* As per 1991 census

These sanctioned public health facilities, is based on the 1991 census population norms, which when revised according to the current census will require creation of a lot of additional facilities

While almost all the health facilities visited were located within 18 km from the habitations, access to health facilities was impacted by lack of good public transport. Consequently, patients had to travel in rudimentary transport or pay substantial amount to reach the facilities. The Team was also told of a village that did not have a delivery point within 35 km though there was a Sub Health Center within 3 km and a Primary Health Center within 10 Km. However, inside the facilities, there were no problems of access to public health care services. Though user charges of Re.1 was being charged, it was found that this was not an impediment to access in any way. The general sense was that presently there was improvement, not only in the range of services but also in the quality of services as compared to seven years ago. However this is not to say that there were no gaps in service delivery. There were gaps and areas of concern such as, lack of adequate HR, irrational deployment of limited/scarce resources, high out of pocket expenses on diagnostic tests and drugs which were not available in the facility, lack of number of beds to handle the case load in the some of the high load facilities etc. During FGDs, the team also met some villagers who preferred to go to private facilities because of long queues at the public facilities.

Most of the delivery point facilities visited had good delivery caseload. However, the neonatal and newborn care services clearly need immediate attention and scaling up. More importantly the health care givers need to be sensitized about the importance of newborn care services. There were no separate trauma care services, but the district hospital had a dedicated 10-bedded burns ward.

2. As compared to 2005, there is an improvement on the infrastructure front. However the development of infrastructure is marred by delays. The quality of recent constructions, which have been taken over is good. However, few facility in-charges have shown reluctance to take over new buildings due to poor quality and construction defects. In some cases the scaling up of buildings has not been followed up by deployment of HR and equipment.

At few high caseload sub center delivery points in Jhansi, better infrastructure and accommodation for the sub center ANMs needs to be taken up on priority basis

The status of infrastructure development in the state is as follows:

Total Numbers of facilities

Sl.	Particular	2005			2012 (Oct. 2012)		
		Established	Govt. Building	Rented	Established	Govt. Building	Rented
1	District Hospital	134	134	-	142	142	-
2	CHCs	426	426	-	806	806	-
3	PHCs	3640	2422	1218	3735	3575	160
4	Sub Center	20521	6468	14053	20521	16379	4202

Sl.	Particular	Sanctioned	Completed	Under construction
1	District Hospital	129	2	127
2	CHCs	328	247	81
3	PHCs	779	733	46
4	Sub Centre	10604	7923	2681

Even though the OPD load has gone up substantially, the IPD figures are low, and consisted mainly of delivery cases. In all the facilities, residential accommodation was available. However, the condition of the buildings especially in the older facilities is very poor. There were no amenities for patient's attendants or for ASHAs to stay in most of the facilities. However due to low occupancy, the ASHAs and attendants were found using the vacant beds. Poor supply of power is a major issue with some facilities getting only about 4 hours of power in a day. However, all the facilities had generator sets and some facilities also had inverters in addition. Some facilities did not have running water.



3. In Hardoi, no surgeries were being conducted in the facilities except at DH & CHC Sandila. The reasons cited were lack of trained HR and equipment in most cases. In Jhansi, DH /DWH was the only other health facility other than the Medical College where surgeries are conducted, except the family planning and cataract camps. Since all these facilities were delivery points, delivery cases formed a huge part of the caseload. The CHCs and one PHC had caseload of about 200 OPD per day. In all these facilities, there were separate male and female wards.

4. Limited range of available diagnostic services at the public facilities is one of weakest link in the chain of health care service deliver resulting into increase in out-of-pocket expenditure. There was no outsourcing or contracting of diagnostic services. Availability of drugs is not a major issue and in all the facilities information of the availability of drugs was found displayed. However, the out of pocket expenditure on drugs was evident during interaction with patients. As mentioned earlier, the expenditure on travel to facility also contributed to out of pocket expenditure. In most facilities, lack of HR and equipment is a major issue. Consequently, C-sections, surgeries (major /minor) were not being conducted in most of the facilities. Cold Chain equipment was found to be available and functional in all the facilities but erratic and inadequate supply of electricity was a cause of concern. The DH had a functional and well-maintained blood storage unit. However, information on the management of the near expiry blood units was not satisfactorily furnished by the facility in-charge. Round the clock diagnostic facilities are unavailable even at the District Hospital in Jhansi. Emergency tests are also not available at the Government health facilities in the district. In Jhansi, Blood Component Separation Units are located in the lone Government Medical College and District Hospital at Jhansi. Blood Storage Units are absent at the 2 other designated FRUs.

5. In all the facilities above PHC level in both Hardoi and Jhansi, food was being given to women under JSSK which was either cooked in the facility or catered from outside, though it was not provided strictly as per the prescribed menu. The facilities had seating and drinking water amenities and patient information was adequately displayed, but toilets were not adequate. In Hardoi, the CHC at Kacchuna had an open space with stagnant water. There was apparently a legal dispute over the ownership of the land and hence were not being cleaned or maintained. There was no washerman posted/engaged in some of the facilities and laundry was being given to the local dhobi. Jhansi DH and DWH had facilities for solar heater, drinking water and *rain basera* for overnight stay of the relatives and good waiting area.

6. Bio waste management needs to be focused upon in both Hardoi and Jhansi. In Hardoi, though it was found that the health care givers were conversant with disposal of hospital waste, the BMW management protocols were not being followed. Open pits were found dug in all the facilities visited and the facilities had boundary walls. We were informed that waste management was being outsourced to a private agency but due to lack of funds, the service had stopped. However we were informed that the tender process has been completed and the services would be restored shortly. In Jhansi, infection control system is not in place and bio medical waste management in the facilities is highly compromised. Color coded bins were unavailable at all the health facilities visited and waste segregation was largely not being done at the health facilities, nor were the staff oriented on the same

7. In all the facilities in Hardoi Re.1 was being charged as registration fee. Apart from this, in Kachauna CHC, Rs. 16 was being charged as admission charge in admission cases. In the District Hospital and Sursa PHC, it was found that patients were being exempted from user charges and their number constituted about 15% to 20% of all patients per month. In Jhansi, user charges are exempted for patients under the National Programs and JSSK. While user charges were not levied for the sick neonates and pregnant women coming for delivery and ANC, pregnant women coming for the diagnosis of pregnancy and ANC for the 1st time were being charged due to lack of awareness among the personnel collecting charges.

8. In Hardoi, out-of-pocket expenditure is mainly on travel to facility, diagnostic tests and drugs that are unavailable with the facility. In Jhansi, in absence of referral transport from home to health facility, cost is incurred for travelling to the facility for delivery. Patients other than pregnant women and sick neonates, incur expenditure on prescription medicines.

9. No services were contracted to development partners in Hardoi. In Jhansi, drop back for pregnant women, after delivery, has been started in the month of October and diet contracted out at places.

10. All the facilities had separate female wards. In Hardoi, the labor rooms were found to be well located and were said to be safe. However attached toilets was not found to be the norm. Though wards were largely separate for the males and females in Jhansi, privacy was issue at the DWH.

RECOMMENDATIONS:

1. Immediate attention is required in strengthening infrastructure of Sub Center especially, which are delivery points and have high cased loads. The facilities need to be provided with adequate equipment for the essential service deliveries.
2. Easy barrier access for disabled and elderly to be provided at all health facilities
3. Better Signage, Citizen Charter and IEC materials for beneficiaries to be displayed at all the facility
4. State has to ensure that the upgraded facilities are provided with all the infrastructure, equipment and manpower commensurate with their upgraded status and also provides the mandated services.
5. Major clinical services including Disease Control Programme to be provided at the public health facilities in addition to RCH services.
6. Laboratory services have to be expanded and strengthened to provide major and common pathological and Biochemical test at the CHCs and 24x7 PHC level as most of the laboratory technicians are under utilized

TOR-II: Outreach & Patient Transport Services: Sub-Centers, Mobile Medical Units, EMRI/ALS/BLS

State details:

There are 20521 HSCs in the State out of which 15570 are in government buildings (RHS 2011). There is a shortfall of 5810 HSCs considering the norm of 1 HSC per 5000 population (rural) on the basis of 2001 population. Now, there is an eminent need to fill the short fall of sub centers on the basis of 2011 population.

There are 23578 sanctioned posts of ANM in the State out of which 21166 ANMs are in position and a vacancy of 2412 ANMs. There are only 2566 Male Health Workers posted against a sanctioned number of 8857 resulting in a vacancy of 6291. The outreach activities to be carried out at sub center levels are being affected because of these vacancies.

The services offered by HSCs in the State are Antenatal Care, Normal Delivery, Immunization and a small range of family planning services. Out of 20521 HSCs present in the State, only 12 % i.e. 2610 HSCs are delivery points.

There are 131 functional Urban Health Post in the state. These UHCs are primarily catering to the urban slum population in the districts.

There are 133 MMUs in the State, which were sanctioned in 2011-12 however these are not operational, owing to some legal obligations. In the year 2012-13, 150 new MMUs are sanctioned. These MMUs are supposed to provide services such as General OPD, ANC, Post Natal Check-ups, Routine immunization, provide Family Planning supplies, routine diagnostic tests etc. in the remote and hard to reach areas.

There are two types of Ambulance services in the State.

- Emergency Medical Transport services (108 Service): This service is being operated through GVK EMRI. 133 ambulances are operating in 13 selected districts since Sept. 2012. 300 new ambulances are slated for launch on 11th November 2012 (as informed by the State Officials). These ambulances are running under the name of *Samajwadi Swasthya Sewa*. Since these have been launched recently, it's too early to make a comment on the operational status of these ambulances. The State has planned to operationalize 988 ambulances by December 2012. The total number of beneficiaries catered up to October 2012 is 12919. The awareness among the public regarding the service is currently nominal.
- Patient Transport Services (102 Services): The State has planned for a fleet of 972 ambulances under the 102 services, which will take care of the referral needs of patient other than those who require emergency referral. This service is operating under the name of *U.P. Ambulance Seva* since August 2012. The target is to provide one ambulance at each block and two ambulances at each district head quarter. 500 basic ambulances have been deployed in the districts till now, however a centralized call center number (102) is yet to be established. The ambulances under this service are being utilized primarily for the drop back of pregnant women. There are problems in recruitment of driver for these ambulances in some of the districts. The awareness in the public

regarding the services is minimal owing to its recent launch.

- There are 131 functional Urban Health Post in the state. These UHCs are primarily catering to the urban slum population in the districts.

Issues

- The sanctioning of new HSCs has not been done which is leading to the increasing shortfall in the number of HSCs over the years. Moreover, the infrastructure development of the HSCs running in Private/ rented buildings is also slow. This is compounded by the hindrances in taking over of the newly completed buildings by the facility in-charges.
- Many sub centers, which are designated as delivery points do not offer all the services expected out of a delivery point. Hence the number of actual delivery points is less than the enlisted figure.
- The ANC's conducted by the SCs is limited to only provision of IFA and TT injection to the pregnant women by the ANMs.
- The outreach services ought to be provided by the MMUs has come to standstill owing to the legal hassles. However, this is limited to 15 districts only. The MMUs services in rest of the districts are also not being rendered.
- The referral transport services in the State are in rapid phase of expansion with the sanctioning and provision of a large fleet of both emergency and non-emergency referral vehicles. However, substantiation of services at the facilities to which the patients and pregnant women are transported in not being done at the same pace.

District Details

In Jhansi district there are 326 Sub Centers, 311 of which (95%) are located in government buildings. On an average each sub center covers a population of 6137 (District population: 20,00,755). Similarly in Hardoi district there are 432 sub centers present out of which only 254 (58 %) are present in government building and 178 Sub centers are in private rented buildings. 153 SCs buildings are under construction.

The lack of adequate number of ANMs hampers service delivery across all the sub centers in the district Jhansi. There is a total of 276 ANMs in the district (R: 234, C: 42) and most of the contractual ANMs have been appointed in the month of October only. Almost 100 sub centers are without ANMs. This has resulted in an ANM having to manage more than one sub center and also those with high ID load. The availability of MPW (M) is also poor and only 33 are presently posted in the district. Likewise in the district Hardoi, there are only 16 Male Health Workers in the entire district. The number of MPWs is too small to contribute significantly in the outreach services.

Institutional Deliveries are conducted in 44 sub centers including night deliveries. Two of the sub centers (Ghugua and Barata) visited by the CRM team had high numbers of deliveries taking place. ANMs in these delivery points were residing in the sub center building and were conducting night deliveries as well.

In district Hardoi, 11 out of the 432 sub centers are conducting normal deliveries. 4 out of these 11 sub centers are conducting more than 3 deliveries per month. Sub centers are also rendering outreach services such as ANCs, immunization in the VHNDs, distribution of a small range of Family Planning supplies. The quality of ANCs is poor as revealed during the interaction with the beneficiaries. It is limited only to TT injection and IFA tablets distribution. Components such as BP monitoring, HB estimation, physical examination of the pregnant women are rarely done as evident from the statement of pregnant women as well ASHAs.

The ANMs conduct field visits on Mondays & Fridays, and immunization sessions on Wednesday & Saturdays. These immunization sessions are held in anganwadi centers and are synonymous with Village Health & Nutrition Day (VHND). On Thursdays, she runs OPD/ANCs at the sub centers and on Tuesdays she has to attend the weekly meeting at the Block PHCs. During field visits, she mobilizes the community for immunization, family planning and registration for ANCs. In district Hardoi, 2nd ANM is present at 4 sub centers however in spite of having 2nd ANM only 2 sub centers are conducting deliveries. ANMs at around 21 HSCs are staying at the HSCs however even at these facilities deliveries are not being conducted. In district Hardoi, it was observed that in one of the HSCs family planning supplies and IFA syrup were out of stock. The Social Marketing of Contraceptives Scheme was not well received by the ASHAs since charging an amount of Re.1 from the beneficiaries for the contraceptives which were otherwise available free of cost was difficult.

The record maintenance at the sub center level presents a mixed picture in the districts visited. MCH registers were not available in the facilities across the district Hardoi. The HSC funds Utilization record could not be produced by the ANM on the day of the visit to the Suthena HSC in block Shahabad in district Hardoi.

The ASHAs compliment the community outreach activities of the ANM and also in the communicable disease programs: slide collection for malaria and DOT provision etc. However, irregular payments are deterring ASHAs to expand beyond the RCH activities. An ASHA in "Futura Gaon" said that she is yet to receive payments for 2 DOT patients, since 2008 and for 15 slides she had collected for detection of Malaria in September this year.



Reaching the Unreached: ANM & ASHA of Ghugua Sub Center conducting house-to-house mopping-up exercise for Polio Immunization

There is no functional Mobile Medical Unit (MMU) in both the districts visited.

In Hardoi, There are 3923 Aanganwadi centers in the district. The sessions organised upto September are 20885 against 42912 planned.

The vaccines are being brought from the block by a vaccine carrier (loader) who is paid Rs. 50 per session. There is no arrangement for picking up the vaccines. Although the due list is being prepared by the ANM and the ASHA, they are not recorded in registers. MCH registers were also not available supposedly on account of non-supply.

The Hardoi District is providing biannual Vitamin A supplementation for under 5 children. The first round was held in June, 2012 and the second round is scheduled for December 2012. The IFA paediatric syrup was not in stock in most of the facilities visited. The frontline workers were aware of the dosage to be administered.

RECOMMENDATION:

- 1) State need to plan for filling up the gap in terms of infrastructure of HSCs as per the 2011 population in a phased wise manner. The priority should to be given to the HSCs running in private/ rented building in the plan. The infrastructure development plan should also be complemented by a synchronous HR provision plan.
- 2) Priority should be given in resource allocation to the HSCs which are designated as delivery points. A training plan for the ANMs posted at these Delivery point HSCs to be prepared and executed.
- 3) The quality of ANCs conducted through HSCs need to be improved through trainings and hand holding support to ANMs. Required tools and equipments to be provided to all the delivery points HSCs in the first phased.
- 4) The provision of stationery required by ANMs at sub centers need to be provided to the ANMs in timely manner so as to streamline the documentation of vital information.
- 5) Interim measures to be taken at the district levels to fill the service gap in absence of the MMUs services

TOR-III: Human Resources for Health: Adequacy in Numbers, Skill and Performance

PUBLIC HEALTH WORKFORCE SITUATION: Against the regular sanctioned posts, there are substantial vacancies in all categories of healthcare workforce in the state.

Regular Workforce				
Sl. No	Cadre	Sanctioned posts	In position	Vacancies
1	Doctors	14785	10260	4525
2	Nurses	5795	5148	647
3	Paramedical	10646	8089	2557
4	ANM	23578	21166	2412
5	BHW (M)	8857	2566	6291
6	Pharmacist	5409	3933	1826
7	Lab. Technicians	2286	1836	450
8	X-Ray Technicians	818	531	287

Although, NRHM has provisions for engaging health care providers on contractual basis; which would help reduce the gap, the state has been unable to fill all the posts.

Contractual Workforce				
Sl. No	Cadre	Sanctioned posts	In position	Vacancies
1	Specialist	176	35	141
2	MBBS Doctors	1487	180	1307
3	AYUSH Doctors	2284	1498	786
4	AYUSH Pharmacist	569	549	20
5	Dental Doctors	70	52	18
6	Staff Nurse	3213	1156	2057
7	ANM	6204	2429	3775
8	Paramedical	1915	267	1648

These sanctioned posts are for the public health facilities, which is based on the earlier census population norms, which when revised will require revision according to the additional facilities that need to be created

Current Status of Public Health Facilities in the State		
Health Facilities	Number Functional	Average Population Covered
Sub Centers	20521	7558
PHC	3692	58290
CHC	773	250321
District Hospital	157	1488805

The 20521 Sub Centers in the State were sanctioned on the basis of 1991 census. GOI has been requested to sanction an additional 12000 SCs as per census 2001. The approval is awaited. According to 2011 Census, the State would need about 20000 additional SCs

ISSUES:

- Large Number of vacancies for all categories of health care providers; both regular and contractual
 - Sub Centers without ANMs (almost 100 in Jhansi)
 - In Jhansi, the 44 Sub Centers, which function as delivery points (some with High Delivery load) being managed by single ANM
- Availability of specialists is a major hindrance in operationalizing First Referral Units in the State e.g. In Jhansi District, there is 1 contractual anesthetist and all the 6 sanctioned regular posts are vacant. Only 1 FRU each is functional in Jhansi & Hardoi District.
- AYUSH MOs have been recruited in place but their functioning has been affected by irregular supply of AYUSH Medicines and they end up practicing allopathic care
- Shortage of Ward Boys / Ayas and cleaning staff, although some have been hired on payment basis under RKS & user charges schemes

HUMAN RESOURCE GENERATION: Government Sector Medical Colleges in the state:

Sl. No.	Name of the Institute	Total Seats
State Government Medical Colleges (9)		
1	C.S.M. Medical University, Lucknow	250
2	G.S.V.M. Medical College, Kanpur	190
3	S.N. Medical College, Agra	150
4	M.L.N. Medical College, Allahabad	100
5	L.L.R.M. Medical College, Meerut	100
6	M.L.B. Medical College, Jhansi	100
7	B.R.D. Medical College Gorakhpur	50
8	U.P. Rural Institute of Medical Sciences & Research, Saifai, Etawah	100
9	Mahamaya Rajkiya Ellopathic Medical College, Ambedkar Nagar	100
	Total	1140
Centrally Aided Medical Colleges (2)		
1	Institute of Banaras Hindu Medical Sciences, Varansi	59
2	Jawaharlal Nehru Medical College, Aligarh	150
	Total	209
Dental College (1)		
1	Dental Wing, C.S.M. Medical University, Lucknow	70

In addition, there are 14 Medical Colleges with a total annual intake of 1550 and 26 Dental Colleges with a total annual intake of 2500 in the Private Sector

The details of ANM & Nursing Schools are as follows:

Institutes	Government		Private	
	Number	Intake	Number	Intake
ANM Schools	40	2400	84	3870

LHV Schools	4	120	-	-
GNM Schools	-	-	148	6570
MPHW Schools	11	660	-	-
Post-Basic BSc Nursing College	1	25	11	360
BSc Nursing College	1	60	36	1660
MSc Nursing College	-	-	4	85

ISSUES:

- Due to inadequate faculty, admissions in the ANM TCs have been highly irregular.
 - The candidates are selected during a state level selection process and allocated to ANMTCs in different districts, but the process was last carried out in 2009.
 - ANMTC at Moth, Jhansi District has produced only 1 batch of ANMs in the past 6 years.

RECRUITMENT, TRANSFER & POSTING: Recruitment for Regular Doctors is done by the UP Public Service Commission and posting & transfer is done at the Secretariat level, which is primarily vacancy-based. Around 1700 Doctors were recruited in the recent round of recruitment carried out in September/October 2012, who are in the process of joining the service. The Office of the Director General, Medical & Health Services does the recruitment for Nurses & Paramedics.

Contractual recruitment is done at the district level by a committee headed by the District Magistrate and the Chief Medical Officer as one of the members. District wise sanctioned posts are communicated by the state and recruitments are done through interviews

ISSUES:

- Irregular recruitment process and lack of candidates has resulted in inability to fill vacancies
- There are no waiting lists for regular appointments; hence there is no system to fill up posts of those who did not join the services.
- The state only recognizes UP registration for recruitment
 - In a district like Jhansi, which is surrounded by Madhya Pradesh on 3 sides, only 39 contractual ANMs could be appointed (September 2012), out of a total vacancy of 162

TRAINING AND CAPACITY BUILDING: At the State Level, there is a State Institute of Health & Family Welfare (SIHFW) situated in Lucknow. Apart from this there are 11 Regional Health & Family Welfare Training Center (RHFWTC), which are the nodal centers for multi-skilling and skill-upgradation of service providers.

There is a training calendar and trainees selected after training needs assessment

Training Status under NRHM (2005-12)				
Training	ANM	Staff Nurse	LHV	Medical Officer
IUCD	452	54	32	32
NSSK	764	627	15	940
SBA	2340		-	-
FBNC/F-IMNCI	-	486	-	625
BEmOC	-	-	-	643
EmOC	-	-	-	77
LSAS	-	-	-	134
MTP/MVA	-	37	-	147
NSV	-	-	-	314
Minilap	-	68	-	99
CCSP	5586	-	721	484
In addition, 41122 ASHAs have been trained under CCSP program				

Comprehensive Child Survival Program (CCSP) is a skill intensive training program, which integrates Home Based Newborn Care (HBNC) and Integrated Management of Newborn and Childhood Illnesses. This training has been done in 18 districts in collaboration with UNICEF and NRHM. Jhansi being one such district, the ANMs and ASHAs were found conversant with newborn care measures. The IMR in this district has decreased in the last few years and is currently on par with the national average

ISSUES:

- Training plan and post training deployment plan not in place in the districts
- Progress of training is poor resulting in low levels of achievements of SBA, NSSK, LSAS and other trainings
 - So far in Jhansi, only 1 round of SBA Training has been conducted for ANMs and LHVs (in 2008), where 16 of them were trained. This, in a district where high delivery loads were noted in some of the sub centers visited by the CRM team (Ghugua and Barata) is a matter of concern.

RETENTION STRATEGIES: Weak financial & non-financial incentive mechanism for healthcare providers working in rural & remote areas.

There is an incentive of Rs. 100/- per month, only for doctors working in the rural areas. The State intends to enforce the 3-year mandatory rural posting for the 1700 doctors recruited recently.

ISSUES:

- The state does not have a comprehensive strategy to attract and retain healthcare providers in the rural areas
- The financial incentive in place is too low to make a difference - incentive should be substantial enough to attract and offset opportunities lost
- Other categories of healthcare providers are not in the ambit of the incentive scheme

WORKFORCE MANAGEMENT: Salaries of the regular healthcare workforce has been fixed according to the 6th Pay Commission. The doctors are entitled to time-bound scale revision after a period of 5 years and 16 years.

There are 7 levels of Uttar Pradesh Provincial Medical Health Services (PMHS) Doctors, and the Departmental Promotion Committee decides on the promotion. Annual Confidential Reports (ACR) also forms one of the criteria for these promotions.

The state had experimented with separate cadres for public health and clinical streams in the early 2000 but had to revert back to a single cadre due to career progression issues

Sanctioned and Working Strength of PMHS Doctors			
Levels	Total Sanctioned	In Place	Vacancies
L1: Medical Officer	5530	4859	671
L2: Senior Medical Officer	3422	695	2727
L3: Deputy CMO	3136	2271	865
L4: CMO/ Joint Director/ Consultant	2571	2329	242
L5: Additional Director	104	67	37
L6: Director	20	16	4
L7: Director General (Health / Family Welfare)	2	2	0
TOTAL	14785	10239	4546

ISSUES:

- Irregular process of cadre review has resulted in vacancies at almost all levels, most so in the L2 (SMO) level
- Issues related to promotions payment and HR management is multiple
 - There is no system of performance appraisal and workforce management, particularly for the contractual workforce - including their renewal process, pay parity with regular employees and increments

AREAS FOR IMPROVEMENT

Training Institutes:

- Revive admissions in all ANMTCs in the state and plan for setting up new ones, ensuring equitable distribution in underserved areas
- Preference for candidates from under-served areas in the ANM/Nursing Schools
- Faculty development program & quality assurance in nursing schools

Innovate Recruitment Processes:

- Till all regular posts are filled, monthly interviews are held in each division, after advertisements.
- Draw up waiting lists from each round of interview
- Relax recruitment norms- recognize qualifications from other states, for contractual

appointments

Training & Capacity Building:

- Training calendar based on needs assessment and strict adherence to training plan

Ensure Rationalization:

- Pooling of available specialists to ensure a full compliment of Obstetrician/ Anesthetist/ LSAS/ EmOC MOs in designated FRUs for operationalization
- Ensure all MOs with PG qualifications are posted in CHCs, block PHCs/ higher centers
- Priority posting of 2nd ANMs in Sub Centers with high delivery load

Retention Measures:

- Clear categorization of health facilities in difficult, most difficult & inaccessible areas and financial incentives for all levels of health care providers, substantial enough to offset the opportunities lost in serving in the rural & remote areas
- Implementation of other non-financial incentives including the proposed compulsory 3-years rural posting for their first promotion

Workforce Management:

- Protocols for performance assessment and workforce management including renewal of contractual staff
- Develop a Human Resources Management Information Systems (HRMIS) in collaboration with relevant stakeholders/ partners to ensure "real-time" information on health human resource in the state

Policy Matters:

- Decrease salary gap between contractual and regular staff
- Creation of adequate number of regular posts, to meet requirement in health facilities - existing & to be created (1991 population norms are still being followed in the state)
- Rework policies and work towards recreation of Public Health & Specialist Cadre

TOR-IV: Reproductive and Child Health Program

Antenatal Services

ANC checkups are being carried out at the sub centers and PHCs, CHCs. MCP cards are being filled up by the ANMs/SNs but the same is not followed up at the time of delivery and post-natal check up. The ANMs and other service providers need to be oriented on proper filling of the MCP cards during the monthly meetings at the block level. Tetanus immunization and IFA distribution are being done which was verified during field visits to the community. Line listing of severe anemic women, are not being done at the Sub centers and PHCs. BP measurements at some facilities are not done due to out of order BP machines. In absence of regular HB testing, and regular BP measurement, identification, management and referral of high-risk pregnant women are not being done in the 2 districts. Counseling by the ANM during ANC visits is lacking except at some of the sub centers like MCH Moth and SC Barata. FP counselors are posted at few high caseload delivery points but are only doing FP counseling rather than comprehensive RMNCH counseling.

Intra-natal services

	Jhansi	Hardoi		Jhansi	Hardoi		Jhansi	Hardoi
Total Health Facilities	374	508	Delivery points in the State	39	21	Nos. Conducting C-section	2	2
SCs	326	432	SCs > 3 deliveries/month	20	1			
24x7 PHCs	38	12	24x7 PHCs>10 del./month	9	10			
PHCs /non FRU CHCs	6	57+4	PHCs /non FRU CHCs>10 del./month	6	7			
FRUs	2	2	FRUs>20 del./month	2	2	Nos. Conducting C-section	0	1
DHs/DWHs	1	1	DHs >50 del. month	1	1		1	1
Medical Colleges	1	0	MCs >50 del./month	1	NA		1	NA
Accredited PHFs	-		Accredited PHFs>10 del./month	-	-	-	-	-

Delivery Points in the 2 districts:

- 21 sub centers are functional delivery points in the 2 districts
- Out of the 4 designated FRUs, only 1 is conducting C section
- 46% of the 24x7 PHCs are conducting 10 deliveries per month.
- Out of the 60 functional Delivery Points in the 2 districts of Jhansi and Hardoi, the sub center delivery points do not have proper functional labor tables, newborn corners, proper electricity, running water at many of the facilities and need to be strengthened with proper infrastructure, equipment on priority.

Contrasts among the maternal delivery services provided at the CHCs/PHCs and the Sub Centers

Under NRHM there is now emphasis on strengthening the delivery points in terms of the infrastructure, equipment and human resource. In Jhansi, there are total 39 delivery points, which include 1 District hospital, 1 Medical College, 8 CHCs/BPHCs, 9 PHCs and 20 Sub centers. Only 9 (25%) PHCs/APHCs out of 36 and 20 (6%) sub centers out of 326 are delivery points in the district.

It is observed that sub centers are conducting more deliveries than its CHCs, eg. Sub center Barata with only one ANM has an average delivery load of 40 per month while the adjacent CHC Baragaon, within 5 km distance from the sub center, with 4 medical officers including one gynecologist and 2 AYUSH doctors has a delivery load of 10 to 15 per month. MCH center Moth, which is also a sub center conducts 40 to 60 deliveries per month and CHC moth conducts 20 to 30 deliveries per month and has 7 MOs including one pediatrician.

It is recommended to have 2 ANM at sub centers with high delivery load. But the HR crisis in Jhansi is very critical. There are total 326 sub centers in the district and total 276 ANMs including the 42 ANMs on contract. Under NRHM it is also envisioned that all the deliveries will be done by an SBA trained health worker or a Medical doctor. In Jhansi only 16 ANM/SN were trained in SBA in 4 batches of which a few of them have already retired and few of them have been transferred to other district. For the past 1 to 2 years not a single ANM has been trained on SBA and non-SBA trained care providers conduct most of the deliveries e.g. CHC Babina where more than 80 deliveries occur, none of the staff are SBA trained

In Hardoi, the condition of labor room was found to be satisfactory across the facilities visited except at CHC Shahbad, which is still functioning as a PHC. The facility was built about 4 years ago but the condition of the labor room is deplorable - badly lit un-tiled, no attached toilet and inadequate arrangements for hand washing. Lack of privacy is an issue across all labor rooms, including the DH. There are no curtains or separation between labor tables and no strict protocols about who can enter the labor rooms. The labor tables are directly visible from outside. The waste management is weak and color-coded bins for waste segregation were not found in any of the locations. Staff Nurses and ANMs mainly conduct deliveries and involvement of doctors is perfunctory, barring the DH and another facility.

The still birth rate and IUD (intrauterine death) is quite high in the district and is a reflection of poor antenatal care at the periphery, lack of transport facilities and emergency obstetric care.

Postpartum stay at most facilities is less than 48 hours and this holds true even for the DH. The reasons cited for this are twofold: space crunch (inadequate number of beds) and lack of electricity supply through the day. Most facilities function by the use of the generator and find it difficult to maintain the same level of functionality 24x7 by this means.

The team at Hardoi was informed that breastfeeding is initiated within one hour of birth. No pre-lactals or feeding bottles were found with the mothers and breastfeeding is being promoted in the health facilities. The presence of ASHAs at the bedside of the pregnant and newly delivered mothers eased the burden on the hospital staffs.

Comprehensiveness of RCH Services

Cesarean Sections are conducted in only the Medical College and District Hospital at Jhansi

Similarly in Hardoi district, comprehensive emergency obstetric care is available only at two health facilities - the DH and CHC Sandila. However, even these two facilities do not offer the full complement of services. DH Hardoi provides a range of services that includes basic & emergency obstetric care, spacing methods and sterilization, comprehensive abortion care, RTI/STI treatment and PPTCT services. However, the neonatal and adolescent health services are nonexistent even at DH. Essential newborn care is provided in the labor room and OT to some extent, but beyond that there are no services for sick newborns or even for normal low birth weight or preterm babies. The facilities are not oriented towards emergency care for sick children (Facility based IMNCI) even where pediatric specialists are positioned. \ These two FRUs cater to a population of 40 lakhs and emergency obstetric care to an estimated 120,000 deliveries per year. The FRU at CHC Sandila lacks blood storage facilities and as there is no pathologist. DH has a functional blood bank; a closer look at the number of units made available by the blood bank shows that 33 units have been used in last two months for pregnant women.

The tracking of women with severe anemia is totally missing. The poor quality of ANC at the peripheral level results in non-identification of cases of severe anemia. The hemoglobin testing apparatus is not available at sub centers and only 'clinical assessment' is carried out by ANMs. No list of severely anemic women was available at any level of the health system; not even at the DH where Hb estimation is done in the laboratory.

Partographs are available at both the FRUs in Hardoi, but they are not really being used to track the progress of women in labor. The DH is a site for SBA training but even the SBA trainers lacked the will (and skills) to use partograph.

Ultrasonography machine is available at DWH but lying unused due to unavailability of the radiographer/trained service provider. The USG services are currently available only at DH Hardoi, while 23 centers in private sector are registered as centers performing Sonography (under the PC-PNDT Act)

Utilization of health facilities

Hardoi: Overall the health facilities and service providers in the district are underutilized. The three CHC visited by the team: CHC Shahabad, CHC Hariyawan and CHC Tadiyawan are a case in the study. The first two are designated CHCs (since 2008) but still to receive the approved number of staff and beds although both are housed in a new building. 5 doctors each are available at these facilities that apparently still have only 4 functional beds officially. The third CHC (Tadiyawan) has the full bed strength (30) and 6-7 doctors, but indoor services are sub-optimally utilised. At the time of the visit, only two women in the postnatal ward were found as indoor patients. This may presently be linked to non availability of power (electricity) as explained by the staff but the facility definitely has the potential to be more optimally utilised. In total, at just these three facilities, there are about 15-20 doctors who could be more optimally utilised to provide a range of services and make atleast 90 indoor beds functional in the district.

It is also obvious from the data that the major inpatient load is on account of delivery care under JSY scheme. DWH Hardoi has lower OPD footfalls compared to the DH Hardoi, but larger IPD load. Similarly, CHC Tadiyawan, with full bed strength and team of doctors (7) has much lower IPD than other 4 bedded designated CHCs (which also have much lower staff strength). This requires that reasons for low rate of admissions, posting of Specialist/s and total number of doctors at each of these facilities be reviewed against the patient load and type of services delivered.

Quality of the delivery service provided:

Out of the observed delivery points in Jhansi, none of the staff was trained in SBA or Medical Officer trained in EmOC or CEmOC. ANM and staff nurses were not confident enough to treat patient of eclampsia with Inj. Magnesium Sulphate as recommended under SBA guidelines. There were no misoprostol tablets available at any of the delivery points visited used for prevention of PPH as recommended as per SBA guidelines. Normal delivery kits were available at most of the points.

The infrastructure for deliveries were good at PHCs/CHCs and district hospitals where delivery load were less per available staff as compared to the sub centers where there was inadequate delivery space. The area for deliveries conducted at the sub centers were cramped and in unhygienic conduction with inability to maintain privacy. More dedication and motivation was seen among the sub center ANM as compared to the staff at the CHC, district hospital, in spite of having limited knowledge and resources.

Infection control system is not in place and bio medical waste management in the facilities is highly compromised. While color coded bins were unavailable at all the health facilities visited, waste segregation was largely not being done at the health facilities, nor were the staff oriented on the same.



Delivery in progress at sub center Barata, Block Baragaon, District Jhansi



Newborn delivered safely



Low utilised clean delivery rooms at the CHC Moth, Block Moth, District Jhansi



New Born Care Corner at the CHC Moth, Block Moth, District Jhansi

Skills for providing RCH services

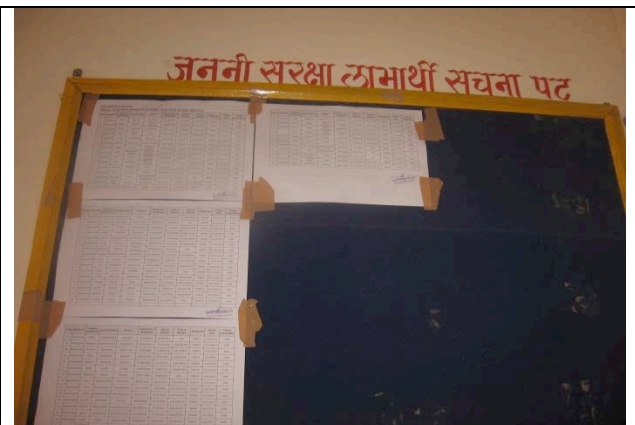
Skills gap is very significant in Hardoi. Considering that normal delivery care and services are made available through a number of delivery points, only very few personnel were found adequately trained for the job. Both SBA training and NSSK training was lacking across the health facilities (with just one or two trained staffs at each facility) and therefore not much can be said about the quality of care and adherence to protocols. No doctor was BeMONC trained.

Janani Suraksha Yojna

In Jhansi, JSY payments are made within one week to 10 days of discharge from the block PHCs/CHCs rather than at all delivery points. Payments are made through bearer checks. Sample verification was done by visiting a couple of beneficiaries at home. It has led to improvement in institutional delivery in the State, which can be largely attributed to ASHAs who are doing commendable work. Requirement of photos and other identity proof like Ration card/Voter card, etc are required at the block PHCs/CHCs. ASHAs are paid monthly through account transfer.



Verification of the receipt of JSY benefit by CRM team in Village Katra, Block Mauranipur, Jhansi



Display of JSY beneficiary list at CHC Baragaon



JSY Register

In Hardoi, the JSY is being implemented in the district and has led to delivery cases being the top reasons for high delivery load at most health facilities. It is interesting to note that DH Hardoi, which has much larger number of footfalls in OPD, has fewer inpatients despite more beds (164?) as compared to DWH which has more inpatients compared to the OPD load. In most CHCs the inpatient load is on account of delivery care. The payments are made by bearer-cheques. Delay in handing over cheques was noted at some facilities; requiring that women come back and collect the cheques after discharge. This would entail not only travel time and effort but also an additional cost burden.

Comprehensive Abortion Care

CAC is currently available at only one facility each in both the districts i.e. the DH/DWH. The data in Hardoi shows that 987 MTPs were conducted in the period April-October 2012. Considering that DH is the only facility in the public health system that is providing this service, it is possible that these services are being sought after in the private sector; it should come as no surprise that there are at least 23 nursing homes provide ultrasonography services and several others, obstetric and gynecological services (5 Nursing Homes) in the district headquarter itself.

Essential New Born Care Services

To achieve the targets of reducing IMR, provision of essential newborn care services plays a crucial role. As per various report most of the infant deaths occur during the first week and first day of Life. Under NRHM it is recommended to operationalize New Born Care Corners (NBCCs) at all the levels, new born stabilization units (NBSU) at CHCs and FRUs and Sick New born Care Units (SNCU) at District Hospitals and Medical colleges.

Guidelines have been received regarding the operationalization of these units but most of these units are yet to be established. SNCU at District Hospital and NBSU at CHCs are not operational. Radiant warmers have been procured but are not installed in most of the facilities - as seen in Jhansi. Early initiation of breastfeeding being done and mothers are encouraged for exclusive breast-feeding.

Government of India has initiated a *Navjat Shishu Suraksha Karyakram* (NSSK) training programme to build the capacities of Medical officers and Health workers for management of newborns. In Jhansi district only 6 MOs had received the training on NSSK. NSSK training for Staff Nurse and ANM have not yet been initiated in the district. A Facility Based New born Care (FBNC) training has been initiated in the district.

Neonatal and Child Care

As per the Annual Health Survey, the Under 5 mortality rate in Hardoi is 113, Infant mortality rate is 80 and neonatal mortality rate is 53. This should have brought a sense of urgency in addressing various causes of child deaths but concerted actions for child survival are generally missing in the public health system.

Neonatal care facilities and focus on malnourished children is totally absent. No newborn care facility is available in the district; Home based newborn care is yet to be rolled out.

Except for one physician trained in IMNCI (7 days package), the team did not come across any other personnel trained in IMNCI. Despite the availability of Pediatricians, there is no 'value addition' to neonatal or child health services at any of the health facilities where they are posted. Cases of diarrhea or pneumonia or fever in children are not being reported in the HMIS. ORS and Zinc combi-pack promoted by Micronutrient Initiative is available across facilities. However IFA syrup is not available in the system.

Phototherapy machines and radiant warmers are found at odd locations in the DH, DWH and some of the CHCs. Presence of PT machines and RW in between the beds in open wards is irrational and cannot be used for newborn care unless placed in an environment that is conducive to providing newborn care and is under supervision of trained staff. Display of protocols (for e.g. neonatal resuscitation in labor room) is uniformly missing.

Immunization

Cold chain facilities in the district are well maintained except for stray (but very risky) instances of finding insulin injection in the vaccine refrigerators. Most facilities have a single generator connected to the facility and the cold chain. No stock-outs for vaccines was found in the district though the Immunization Officer shared the problems faced in accessing vaccines from the state (and which may be linked to the central supply of vaccines). Immunization micro-plans are being prepared and shared with WCD.

Jannai Shishu Suraksha KaryaKram (JSSK)

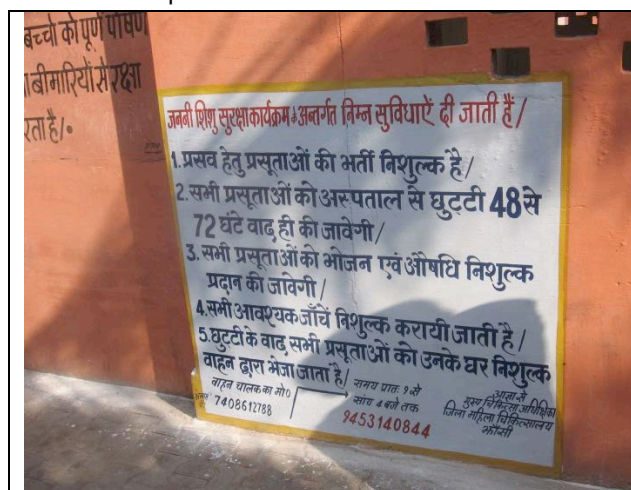
JSSK is being implemented at the Delivery Points in Jhansi. IEC on JSSK were visible at the health facilities, but limited to the provision of free entitlements. Drugs and consumables largely provided free to PW, which were verified by interview with the beneficiaries. At places prescription were being done in absence of certain drugs. For diagnostics, only Basic lab test like Hb testing, Urine for Sugar are provided at CHCs and above. 24X7 laboratory facilities are unavailable at DH/DWH. Blood Bank is available only at the Medical College and the District Hospital in Jhansi. No Blood storage unit is planned at the other designated FRUs. Free diet has started since October 2012 above PHC level. Referral Transport has been initiated but is limited to drop back from health facility to institution and limited to 20 to 30

percent of deliveries. User charges are exempted for the pregnant women coming for delivery and sick neonates but PW coming for 1st ANC and detection of pregnancy were being charged due to lack of awareness among the personnel collecting the charges. Home to facility transport is not yet initiated, but planned for implementation by providing the new ambulances and after setting of the call center. Rate contract as per the EDL is being finalized in the current month. Effective grievance redressal mechanisms were not functional in absence of the implementation of all the free entitlements and lack of awareness among beneficiaries and service beneficiaries.

In Hardoi, the JSSK provisions have been partly implemented in the health facilities. While most delivery points provide drugs free of cost and free diet in most cases, the diagnostics and transport are still in the initial phases of roll out. The District is in the process of receiving ambulances and a comprehensive plan is yet to be put in place including the call center. This arrangement for diet varies in the different facilities, with DWH only providing bread and milk, while some others (eg; CHC Sandila) provide full-fledged meals through the kitchen on the hospital premises.

Referral transport

Emergency Response Ambulances available in the district does not seem to be optimally utilized; those located at the CHC only perform inter-facility transfers but these ambulances are not providing emergency response transport. Maintenance of records is poor and it is not possible to track the distances travelled and the indication for inter facility transfers. Along with the referral transport for pregnant women under JSSK, revamping of the Emergency Response Mechanism is required to ensure that the vehicles serve the purpose for which they have been provided to the district.



Display of JSSK benefits at the CHC



Beneficiary availing the benefit of referral transport (drop-back) under JSSK

Routine Immunization (or VHND):

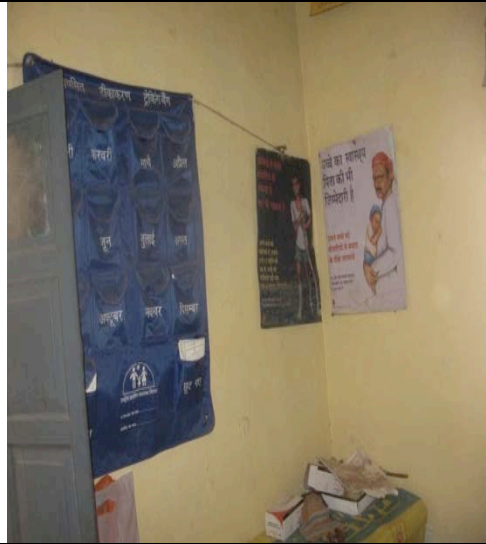
District Jhansi has a good well-maintained cold chain store with adequate number of Ice Lined Refrigerators (ILR) and Deep Freezers (DF). All the cold chain points had adequate functional ILR and DF. But Cold chain mechanic who was on contract was waiting for his renewal from

the state. This delay can lead to failure of cold chain system during emergencies. At block cold chain points, there are no dedicated cold chain handlers; responsibilities given to LHVs, Pharmacists etc.

All the health workers have been trained in 2 days RI training in 2007 and Medical officers are being trained since last year; but the whole district is yet to be saturated.

Routine Immunization micro-plan is available in the district and at the block cold chain points. Monthly HMIs report of the district shows change in the number of planned sessions every month, which is contrary to the fixed sessions planned for the year in the micro-plan.

Unavailability of ANMs in all the sub centers is the striking feature seen in the district. LHVs are doubling as vaccinators in many of the sub centers. In the Jhansi district RI sessions were cancelled during the Pulse Polio rounds.

	Immunization Coverage (AHS -2010-11)	Total (%)	Rural (%)	Urban (%)
	Children aged 12-23 months having Immunization Card (%)	88.5	82.3	96.2
	Children aged 12-23 months who have received 3 doses of Polio vaccine (%)	83.7	79.8	88.5
	Children aged 12-23 months who have received Measles vaccine (%)	77.1	70.8	85
Immunization Beneficiary tracking bag at sub center	Children aged 12-23 months Fully Immunized (%)	73.4	67.7	80.6

There was no RI session monitoring plan in the district. DIO expressed inability to monitor sufficient number of sessions due to inadequate mobility support and inadequate supervisory human resource. Whatever limited RI sessions are monitored using the RI formats, are not analyzed and there is no feedback system streamlined in the districts.

Village Health and Nutrition Day

As per NRHM the RI days are to be conducted as VHNDs providing bundle of health services to the beneficiaries ranging from ANC services to management of sick children and provision of FP services and counseling on nutrition, sanitation and hygiene etc. It is observed that these VHNDs are not operationalized and are still being implemented as Routine Immunization days in most of the villages.

Family Planning Methods

The family planning services include the IUCD, OCP and condoms for spacing and sterilization procedures in both districts. IUCD services are available on demand. Camp approach is largely being followed for performing the sterilization procedures for women.

Minilap and Vasectomy are not performed at any of the health facilities within the districts. In Hardoi, the skills to perform vasectomy are available with the doctor at the FRU (CHC Sandila) who incidentally also provides services to other health facilities in the district. According to the service providers, vasectomy is not accepted in the local communities but the effort to motivate men or create awareness regarding its relative benefits (vis-a-vis tubectomy) is not visible. ECPs are not available within the system, nor are there any efforts to promote the same. Overall the effort to promote or motivate clients for adoption of contraceptives is weak. Post partum family planning has also not received its due focus.

The 'business as usual' approach to family planning is hurting the achievement of targets. Almost all women delivering at the health facilities were multiparous (4th, 5th or even 8th gravida); this is a huge 'loss of opportunity' if women go back without spacing methods.

Service	Cumulative for April-October 2012 at DWH Hardoi (FRU)	Cumulative for April-October 2012 at CHC Sandila (FRU)
Total OPD attendance	49,994	48,297
Total Indoor admissions (labor room)	18,034 (includes both mothers & newborns)	822 institutional deliveries (out of a total of 2,466 deliveries reported in the same period from Sandila block)
Caesarean sections	626 (7 % C section rate; total 8,543 deliveries)	Data not provided
Lap ligation	86	7 (against a target of 876)
Copper T	509	863 (against a target 2649)
Maternal deaths	11	Data not provided

- *Vasectomies not being performed in the district, hence no data reported*

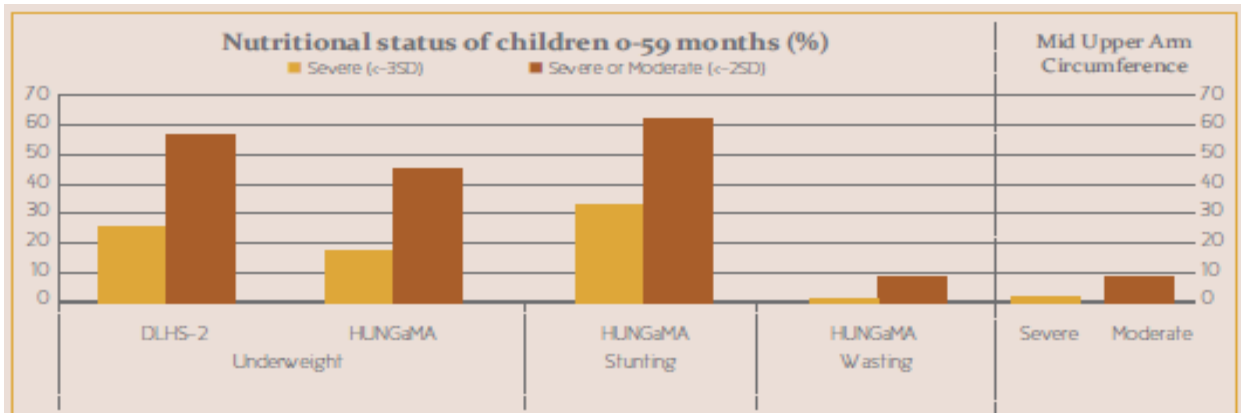
The data shows that the footfalls in OPD and the labor room admissions are quite significant at the two FRUs. Most women in the reproductive age group presenting to these facilities can be considered as potential candidates for spacing or a terminal method. But even at these level 2 facilities, the total number of family planning procedures performed is very low; with most women leaving the facility without a contraceptive method and representing a 'missed opportunity'. The fact that men are not being reached out at all for terminal methods is another issue that calls for attention.

Mother Child Tracking System:

All the mother and children are tracked through the MCTS programme. The work plans, which are actually the due-list of beneficiaries, are being generated; but there is a delay in the entry of these work plans and ANMs receive their work plan after 20 to 25 days. Some of the beneficiaries may have received the next due services. The work plans are not serving the purpose of functioning as duelist. Generating village-wise list and making available the work

plan immediately with in 3 to 4 days of submitting the work plan can tackle this issue. Dedicated data entry operator for the MCTS needs to be made available at blocks.

Management of Malnourished Children: The Hungama Survey Report - 2011

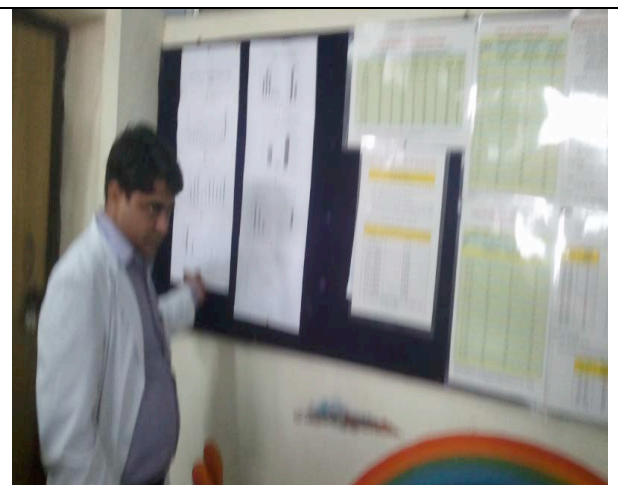


As per the Hungama report 2011, Jhansi District has severe to moderately underweight children (≤ 2 SD) of around 40% and severe to moderate stunting of more than 60% among 0-59 months children.

In the district of Jhansi, apart from the provision of supplementary nutrition by ICDS department no initiatives have been taken for management of malnutrition among children. In the Maharani Laxmibai Jhansi Medical College, a Malnutrition Treatment Center (MTC) has been established with the initiative from UNICEF and Pediatric department. Now this MTC is supported through NRHM. It is a 6-bedded ward providing treatment for SAM children as per the WHO SAM management protocol. It is a clean and well-maintained ward with SAM management protocol well displayed. Round the clock residents are available to manage these children with support from two staff nurse, one caretaker and one counselor. Average admission rate is of 14 to 20 per month; all SAM children referred are from pediatric OPD and no referral from community by ASHA or ANM. Four follow up visits are done every 15 days; but follow up at the community need to be linked up under NRHM.



SAM child being treated at the MTC, Maharani Laxmibai Medical College, Jhansi



SAM protocols displayed at the MTC

Maternal Death Review:

Maternal Death Review started in Jhansi and Hardoi. Facility Based Maternal Death Review is conducted at Medical College and District Women Hospital in Jhansi and at the DWH in Hardoi. While facility based MDR has been started at the DWH and MC and reviews are being conducted, the review is limited to the medical causes only rather than the programmatic causes. Community based MDR is not taking place, nor are ASHAs aware of this incentive. Training /Orientation of the field functionaries is needed on the same. The record of proceedings show that the analysis is quite superficial and does not really identify the root causes, which in most cases is delayed arrival at the health facility. But they are brief and fail to make an in-depth analysis of the causes of death - both medical and social.

A more detailed analysis of the complication management at the health facility would help to identify if the certain management protocols need to be changed or adhered to as the skills of the providers at the facility in dealing with medical complications may vary. The objective is not served if the cause of death is assigned to level 1 or level 2 delay. At the level of the review Committee the causes of level 1 and level 2 delays should be analyzed at length so that systemic changes can be brought about. The ANM and ASHAs of that particular village/SC should also be involved in the process to delineate the cause of delay.

The overall reporting of the number of deaths should also be reviewed closely. While most facilities do not report deaths (maternal, neonatal and infant deaths), those like DWH, which do, present quite an unexpected data. As per the HMIS, Still Births against reported 1000 live Births is 268% of the expected numbers. Unexceptionally high rate of IUDs but extremely low rate of neonatal deaths in absence of neonatal care services requires in-depth analysis and validation of deaths reported.

Deaths (Apr-Oct 2012)	DWH Hardoi
Total deliveries	8,543
Maternal deaths	11
IUD	350
Still Births	2
Neonatal deaths	6

Adolescent Health

ARSH Clinics are not available in both the districts.

RTI/STI treatment

The RTI/STI management is limited to the DWH and DH at Jhansi and Hardoi and these have effective cross referrals with ICTC. The staffs at RTI/STI clinic and ICTC at DH and the LT at CHC Sandila (there is no counsellor presently at the ICTC, Sandila CHC) are well trained and well versed with the systems, processes and the tasks assigned to them. Color-coded drug kits for syndromic management of RTI/STI are available only at the level of DH/DWH in both the districts and unavailable at most other health facilities. In Hardoi, the orientation on RTI/STI management has not been provided to the doctors; the RTI/STI Counselor posted at DH through UP SACS was the only one formally trained on this issue.

HIV testing & PPTCT

In Hardoi, HIV Testing of most pregnant women presenting to the FRUs (DH Hardoi and CHC Sandila) is being undertaken. So far 2 antenatal cases have tested positive out of a total of 5296 women tested between April-October 2012 at DWH Hardoi. The positivity rate is very low and the cases are being tracked; so are the babies after birth to HIV positive mothers. At the DWH Nevirapine prophylaxis is provided to HIV positive women and the baby. The records are well maintained at both these sites and regular reports are sent to UP SACS.

The DWH Hardoi has the availability of protective kit for conducting delivery of HIV positive women.

Whole finger prick test (for women presenting late and directly in labor) kits are out of stock for last two months in the DWH.

PPP:

There have been no initiatives to establish PPP for C-section, abortion services or family planning procedures, except for the recent initiative to hire vehicles for 'drop back' facilities for pregnant women, under JSSK.

Branches of professional bodies like IAP or FOGSI do not have a presence in the district. The only visible support is the supply of ORS+Zinc Combipack for childhood diarrhoea.

In such a scenario, the supportive supervision from the state becomes imperative; and with Hardoi district being close to the State HQ, it should be comparatively easier to do so.

Laboratory Services:

Laboratory services are available at PHCs and above but vary in the range of investigations that are available. Overall only very basic set of investigations is performed. None of the delivery points provide 24x7 laboratory facilities even where more LTs are deployed. Appropriate Biomedical Waste Management was mostly found lacking and must be strictly implemented at the laboratories.

RECOMMENDATIONS:

1. A comprehensive assessment of the delivery points in both the districts, and especially the CHCs , PHCs, Sub center should be made to identify the gaps in service delivery. Priority actions to be taken for filling the gaps at delivery points and those having major financial implications may be reflected in the PIP.
2. HSCs with heavy case load need to be strengthened with proper infrastructure, equipment on priority.
3. The quality of ANC, identification of high risk pregnancies, HB estimation and tracking of women with severe anaemia require immediate attention for implementation as the maternal deaths are unlikely to come down just with facility based emergency obstetric care.

4. Hb testing kits be provided at all health facilities and ANMs trained for HB testing at PHCs. Repair of faulty BP instruments taken up.
5. Line listing of severely anemic women to be made available with the ANM of sub center & MO in charge of the PHC, which should be reviewed by the CMO and by MOIC at the block level meetings.
6. The ANMs and other service providers need to be oriented on proper filling of the MCP cards during the monthly meetings at the block level.
7. The establishment of newborn care services should be holistically planned at the district level. This includes essential newborn care, care of the sick newborn and referral system. The priority should be to strengthen the Newborn care corners at the delivery points.
8. Facility based services need to be planned in order to receive the referral (sick newborns) from the community in both districts.
9. In Hardoi, An audit of all newborn care equipment available in the district should be undertaken and these units mobilized and placed in a single unit at the CHC or the DWH. The unit should be separated from the ward and new born care protocols followed. RWs that are currently unutilized can be placed at newborn care corners where these are presently missing.
10. In Jhansi, the NICU (New Born Intensive Care Unit) at Medical College has been identified for up gradation to SNCU and funds sanctioned for the same. The process may be expedited as the Unit is undergoing renovation.
11. Roll out of Home Based newborn care by ASHA should be taken up as the top most priority.
12. Referral transport requires high-level review as well as planning. The issue of the vehicle breakdowns (that too in newly purchased vehicles-FORCE) should be taken into cognizance by the state.
13. The use of ambulances in lieu of official vehicles should be discouraged at Hardoi.
14. Call center facilities for referral transport should be established at the earliest.
15. The guidelines/ policy for facility transfers (regarding home to facility transfer prior to delivery) under JSSK should be clarified. The provision of referral transport should be closely monitored in the initial phase so as to ensure that a robust system is put in place and the free referral transport provisions under JSSK can be put in place.
16. Priority planning and training of service providers working at the Delivery Points to be done so that they receive SBA, NSSK, IUCD, BeMOC etc. trainings on priority. The adherence to protocols in SBA training sites (e.g. use of partographs) should be emphasized and monitored by state level team. Refresher training may be conducted for SBA trainers.

17. Family planning, especially post partum, should receive attention and closely monitored.
18. Action plan should be prepared for creating awareness and motivating clients both at community and facility level about spacing methods as well as vasectomy.
19. Provision of family planning Counselor (RMNCH counselor) at heavy case load facilities like district women hospital to be expedited and their services utilized at both OPD and post natal units.
20. Recording of stillbirths, neonatal and maternal deaths should be reviewed more critically and action linked monitoring should be undertaken. In Hardoi, the high incidence of stillbirths, almost no reporting of neonatal and maternal deaths (other than the DH) is a matter of concern and must be investigated.
21. Maternal Death Review is taking place but limited to the medical causes and the inference/conclusion drawn regarding the causes of death is almost being repeated 'ad verbatim'. It is important that the root causes are analyzed for taking necessary action.
22. The RTI/STI services should be linked to ANC and CAC should be made available at more number of facilities and advertised widely.
23. Infection prevention protocols and Asepsis in labor rooms and newborn care corners and even the postnatal wards requires re-enforcement,
24. Biomedical Waste Management in labor room, laboratories and other sites in the hospital need reinforcement as per IMEP guidelines.
25. Rational deployment of LTs to make laboratory services functional and the labs at DH/DWH and FRUs to be 24x7 is required.
26. Services available at various health facilities should be mapped and HR deployed rationally.

TOR-V: Disease Control Programs: Communicable and Non Communicable

State of Uttar Pradesh has not been released funds from Gol under the National Disease control programmes during the last and this financial year due to non-compliance of financial norms like submission Utilization Certificates which has resulted in severely curtailing of the programme activities and hampered the implementation of the programme.

1. INTEGRATED DISEASE SURVEILLANCE PROGRAM (IDSP)

IDSP collects information from all the districts on P and L formats which is then compiled at Lucknow division in Uttar Pradesh situated in HQ H&FW, Lucknow and sent weekly to National communicable Disease Center, New Delhi. Online data reporting is above 85 % from all districts.

Surveillance units have been operationalized except in 6 districts. Epidemiologists posted at district level are actively working whenever there is any outbreak or warning signal of any epidemic.

Data Managers appointed in the districts are doing collection, collation, compilation & dissemination of data to State Head Qtr & from state to Central Head Qtr. Monthly compiled report of communicable and non-communicable diseases from state HQ. and from the districts is regularly sent online to Central Bureau of Health Intelligence, New Delhi. Microbiologist is working in the regional lab established in Health Directorate, Swasthya Bhawan, Lucknow.

Hardoi District

District Surveillance Unit of Hardoi was established in 2009. One room was allotted for DSU in District Hospital, Hardoi. The equipments are installed at the Unit. Epidemiologist was appointed in April 2009 who resigned in August 2009. After that another Epidemiologist joined in November 2011 (Transferred from Farrukhabad). Rapid Response Teams formed at the district and block levels. The IDSP portal is meant for both communicable and non-communicable diseases reporting weekly and monthly regularly. Analysis of routine data for inference of trends and patterns of diseases is being done thereafter along with annual planning for epidemic, flood & drought control (if any).

Jhansi District

District Surveillance Unit of Jhansi was also established in 2009. Two rooms were allotted for DSU in district hospital Jhansi and one unit was established at SPM Department in MLB Medical College. The equipments provided by the center are installed at both the units. EDUSAT has been installed in Medical College unit. An Epidemiologist was appointed in 2008 and the Rapid Response Teams formed at the district and block levels. The IDSP portal is meant for both communicable and non-communicable diseases reporting weekly and monthly regularly. Analysis of routine data for inference of trends and patterns of diseases is being done thereafter along with annual planning for epidemic, flood & drought control (if any).

IDSP HR Status of UP State

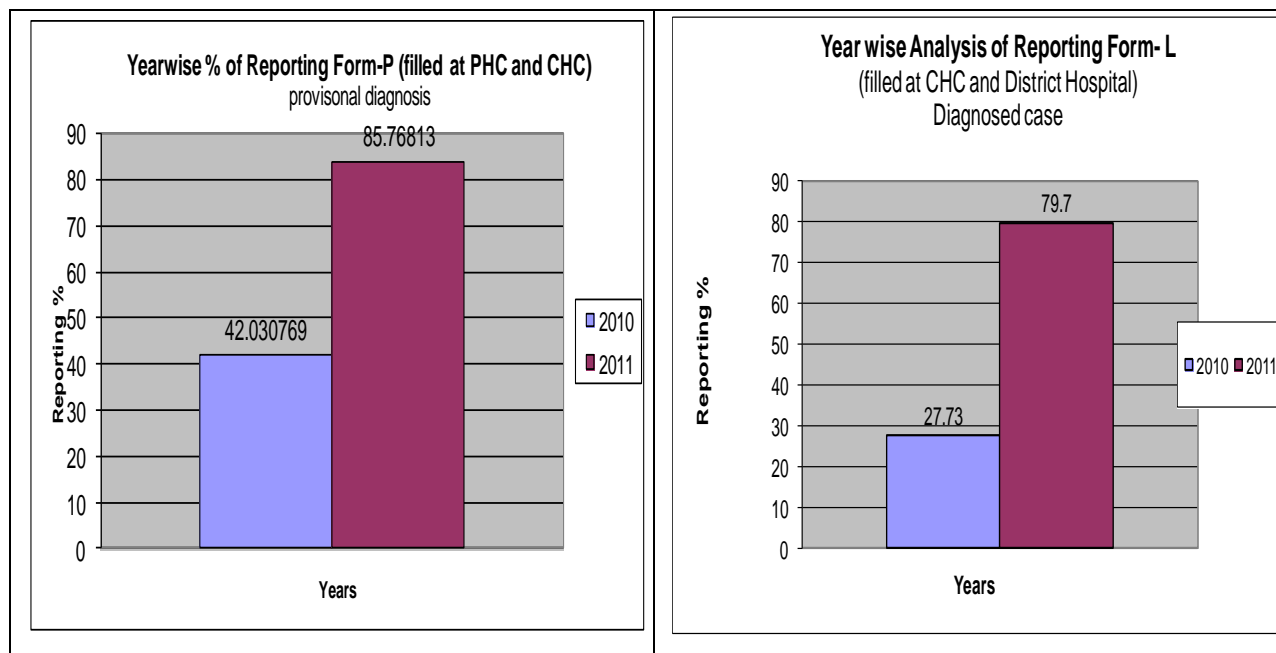
Status of human resource

Sl. No.	Designation	Sanctioned Posts	In position	Vacant
1	Microbiologist	2	0	2
2	Epidemiologist	75	37	38
3	Data Manager	75	54	31
4	DEO	75	41	34
5	DEOs at 10 Medical Colleges	10	6	4

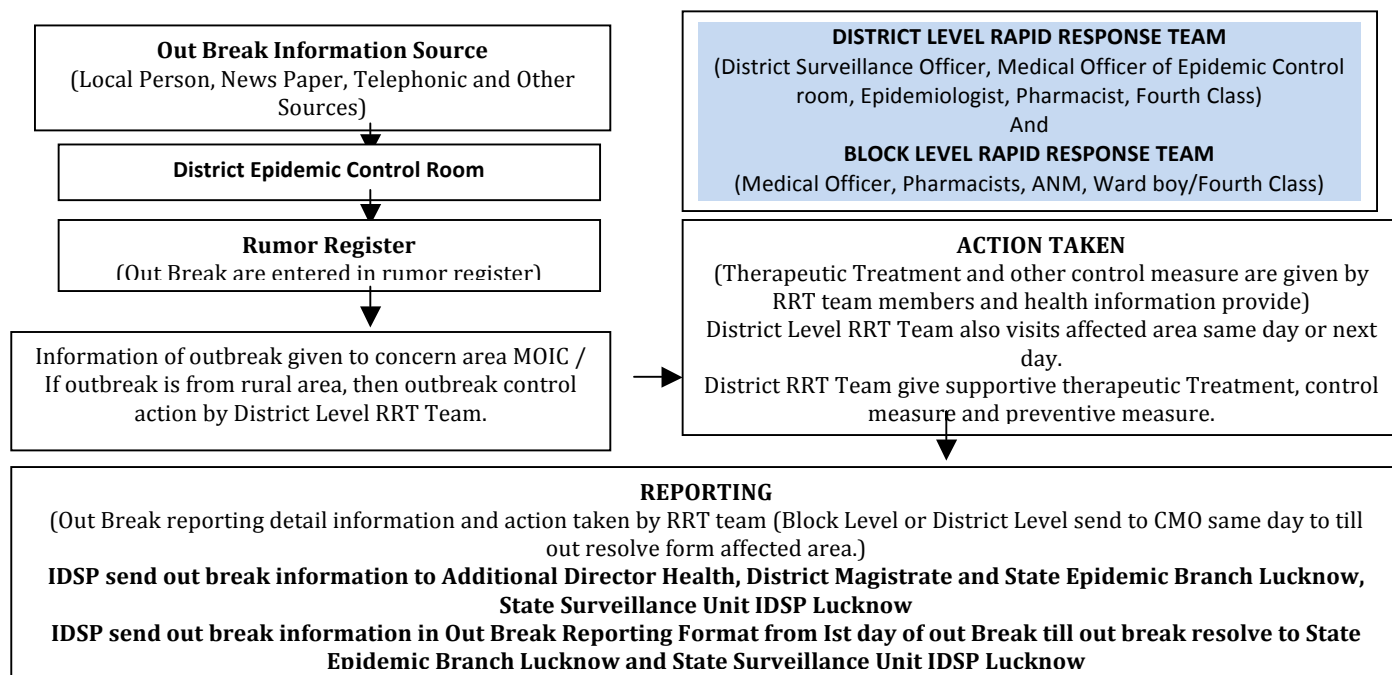
Training status of human resources under IDSP

SI	Designation	HR	Trained	Untrained
1	District Surveillance Officer (TOT)	72	71	1
2	District Surveillance Officer	72	21	51 (scheduled in Nov and Dec at PGI Chandigarh)
3	Microbiologist	3	1	2 (Post Vacant)
4	Epidemiologist - (Induction Training)	72	40	30 (Post vacant)
5	State Data Manager	1	1	0
6	District Data Manager/ DEOs / Medical Colleges/State HQ	154	0	0
7	RRT Members	200	200	0

Reporting Status:



The response to outbreaks in the districts follows the following algorithm:



Reporting:

- 6 Districts of Uttar Pradesh are not reporting due to lack of HR under IDSP (Ambedkar Nagar, Baghpat, Jaunpur, Chhatrapati Sahuji Maharaj Nagar, Rampur & Gautam Buddha Nagar)

Training:

- No training other than Induction training of Epidemiologist was conducted by State for Epidemiologist, Data manager, Data Entry Operator.
- No training was given to paramedical/Medical staff responsible for reporting from PHC/CHC/Medical College etc. due to lack of fund.

Renewal of IDSP Staff:

- Timely renewal was not done of IDSP staff from State.
- In 2012 Extension was given by Central government for Five years to IDSP project but state gave only one-year extension of IDSP staff.

Budget:

- No PIP was demanded by state from district level.
- Budget of IDSP not released timely and no budget released for AMC of instrument from 2011 and 2012
- In 2011-12, budget of 7 month was released in month of March, which comprised of only the salary component. For 2012-13 only 1st quarter budget was released in September

- No budget allocated for training, infrastructure development, laboratory strengthening, review meetings and limited budget for printing, which is not even sufficient for printing of S-form (sub center reporting form)

Salary Increment of IDSP Staff:

- No salary increment has been given to IDSP staff since 2009.

2. NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDCP)

State Level

- Surveillance related activities for Vector Borne Diseases are being undertaken. National Drug policy on Malaria 2010 is being followed.
- PHC medical officers are actively involved in National Vector Borne Disease Control Programme. ASHA is involved in NVBD's.
- 22 sentinel surveillance labs and 1 apex lab is functioning for dengue. NIV kits are available and reporting is being done.
- For JE GOI has approved funds for 10 bedded Intensive Care Unit for Children in 9 highly JE /AES affective districts. Construction of 100 Bedded JE ward at BRD Medical College is in progress.
- Diagnostic center at affected districts are functional.
- JE vaccination is a part of routine immunization coverage.
- In malaria Control: Fund has been released to district in IRS. IRS is observed twice per year. A proposal for LLN purchase was sent to Director NVBDCP New Delhi and instructions are awaited. Drug availability is adequate.
- Mass drug administration for Filaria was done in only 14 districts for year 2011 due to inadequacy of budget. For MDA budget is required for year 2012.

Performance of State for last 6 years in NVBDCP

Sl. No.	Year	Malaria			Filaria		Kala-azar		Dengue	
		Positive	P.f.	Death	Disease	M.f.	Cases	Death	Cases	Death
1	2006	91566	1875	0	5609	817	83	0	-	-
2	2007	81580	1989	0	5791	637	69	1	130	2
3	2008	93383	2310	0	5956	491	26	0	51	2
4	2009	54488	660	0	3077	466	17	1	161	2
5	2010	64606	1382	0	2289	412	14	0	960	8
6	2011	56829	1857	0	848	137	4	1	155	5
7	Up to Oct 12	42240	581	0	1626	262	5	0	158	1

Cases and Deaths of AES / JE 2009-2012																	
S.N.	2009				2010				2011				2012 (08-11-2012)				
	AES		JE		AES		JE		AES		JE		AES		JE		
	C	D	C	D	C	D	C	D	C	D	C	D	C	D	C	D	
	3061	556	302	17	3548	498	344	59	3490	579	224	27	3276	488	134	23	

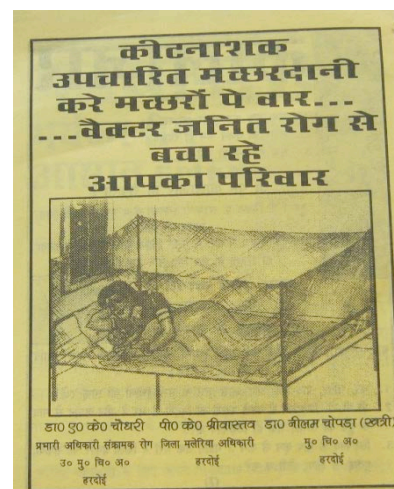
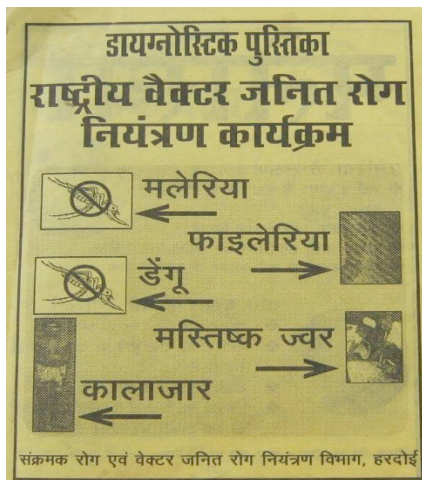
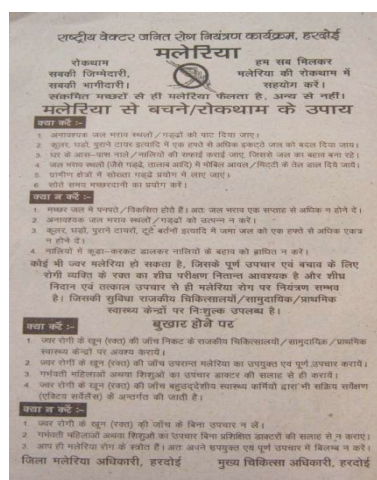
Note- The treatment for the patients of Acute Encephalitis Syndrome/Japanese Encephalitis is available in all treatment centers (PHC's/CHC's/District Hospitals/Opec Hospital Kaili Basti & Medical Colleges) of all endemic districts.

Hardoi: Malaria and Dengue are the major vector borne diseases in the district. The National Drug Policy 2010 for malaria is not being followed. No sentinel laboratory for Dengue/Chikungunya/JE has been set up in the district. Dengue cases were reported in 2010 (4), 2011 (2) and one case in 2012. JE vaccination was started in April 2010 and part of routine immunization. The district has reported no JE case.

Year	Malaria			
	Cases	Deaths	ABER	API
2005	86	0	1.8	0.03
2006	107	0	1.33	0.032
2007	32	0	0.82	0.009
2008	64	0	1.284	0.019
2009	55	0	1.43	0.016
2010	156	0	1.38	0.040
2011	94	0	1.39	0.025
2012 upto Oct.	35	0	Data not available	

Salient observations in Hardoi District: No VBD is found to be in the facilities visited Kachhona, Shabad CHCs and Todarpur, Tandiana PHCs but there are malaria and dengue cases at district level from other facilities. The support facilities are adequate but training is yet to be started for the Health personals working for VBDs. Still the prophylactic treatment of malaria was in vogue as the Malaria Drug Policy 2010 is yet to take off in the district. No poster display was seen in the labs visited. Even the posters were displaying free treatment for the positive case for dengue at all the health centers.

IEC material for VBDs



Jhansi

Malaria and Dengue are the major vector borne diseases in the district. The National Drug Policy 2010 for malaria is being followed. The sentinel laboratory for Dengue has been set up in the Medical College and NIV Kits are supplied.

Year	Malaria			
	Cases	Deaths	ABER	API
2005-06	1348	0	4.8	0.84
2006-07	1087	0	4.9	0.67
2007-08	935	0	3.9	0.58
2008-09	1434	0	4.4	0.82
2009-10	1298	0	3.6	0.7
2010-11	974	0	3.1	0.52

3. REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

State

- Recruitment under process for Vacancies of communication facilitator 13, APO-1, TBHIV coordinator- 1, Urban TB coordinator-4, DPS Sr.MO-14, MO STC-3, DPS SA-13, At District level STS-44, At District level STLS-34, Senior DOTS Plus TB-HIV Coordinator-75. at State level
- Lab technicians and lab consumables are available for conducting quality diagnostic sputum smear microscopy at designated microscopy centers.
- No funds received from Central TB Division for FY 2012-2013, funds were released to SHS by taking loan from mission flexi pool.
- Financial Management guidelines of NRHM shared with programme officers.
- RNTCP officers are called for review meetings.

Performance of State for last 6 years in RNTCP

During 2012, The state has achieved the objectives of 70% NSP case detection and 85% NSP cure rate

Year	Population in lakhs	Annualized TB Suspect examination Rate.	Annualized Total TB Case Notification Rate. (per lakh per year)	Annualized New Smear Positive Case Notification Rate. (per lakh per year)	Annualized New Smear Positive Case Detection Rate (In percentage; Expected at least 70%)	Treatment Success rate among New Smear Positive TB cases	Default rate among New Smear Positive TB cases	Treatment Success rate among Smear Positive Re-treatment cases
2006	1839	126	122	50	52	86	8	74
2007	1874	129	131	53	56	87	7	75
2008	1909	149	146	63	66	89	6	77
2009	1944	154	146	64	67	88	6	76
2010	1973	148	141	62	65	88	6	76
2011	2008	151	143	63	72	82	6	68
1q12	2029	156	132	66	68	-	-	-

Programmatic Management of Drug Resistant TB (PMDT):

Currently 8 districts implementing PMDT and 25 districts have been appraised and ready to roll out. 42 more districts are to be fast tracked for PMDT roll out. At present, 91 MDR-TB patients are receiving treatment in the state.

Districts

Hardoi: There are 8 TB Units (including the District TB Unit) and 40 Designated Microscopy Units (DMC); 40 of them in govt. facilities.

Currently there are 11 sputum microscopists on contractual basis and another post has been sanctioned, recruitment for which needs to be expedited.

RNTCP programme is being implemented as per the norms. MDR-TB programme yet to be implemented in the facilities visited.

Jhansi: There are 4 TB Units (including the District TB Unit) and 19 Designated Microscopy Units (DMC); 14 of them in govt. facilities, 2 in NGO set-ups and 1 each in the Medical College and Railways Hospital.

Currently there are 10 sputum microscopists on contractual basis and another 6 posts have been sanctioned, recruitment for which needs to be expedited.

The district has been achieving the target cure rate of NSP cases (85%) but the NSP case detection rate remains low.

4. NATIONAL PROGRAM FOR CONTROL OF BLINDNESS (NPCB)

State

- Demand for 30 contractual eye surgeons were made in 2010 but were not materialized. Fresh demand of contractual eye Surgeons will be made in PIP 2013-14.
- 47 (10 bedded and 20 bedded wards) eye OT's were sanctioned before 2001 by GOI.
- New OT's were merged / constructed with District Hospitals after 2001

Performance on cataract operation

Cataract	2010-11	2011-12	2012-13 (Oct 2012)
Govt. sector	194000	158752	42677
NGO sector	261605	223045	55102
Private sector	312233	285207	87070
Total	767838	667004	184849

School Eye Screening Programme

Achievements against annual targets of Free Spectacles provided to poor Children			
2011-12	70,000	35509	50.73%
2012 up to Oct (Reports of 10 dist. Awaited)	1,00,000	4,120	*4.12%

IOL Status

- Tender Process at CMSD is almost complete.

Bottlenecks

- Delay in RC of IOL/Spectacles has been a bottleneck for conducting cataract surgeries and School Eye Screening programme.

Cataract Operation Performance of last 6 years till Oct 2012

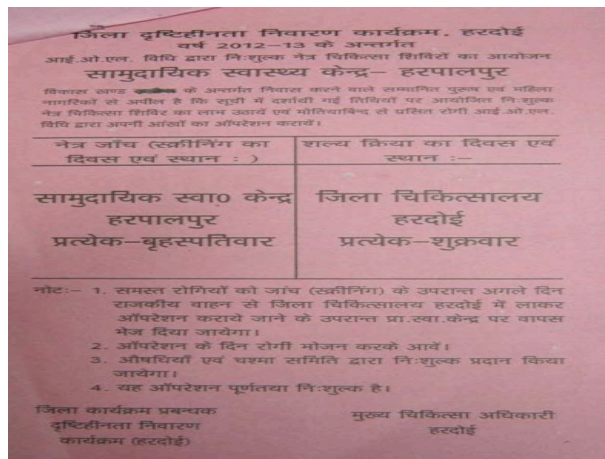
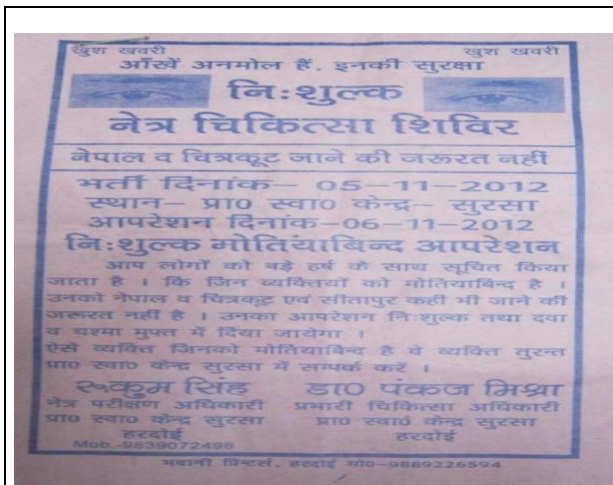
Year	Annual Targets	IOLs Operation among total Cataract operation	% Ach. of IOLs	Annual Achievement	% Ach. Against Annual Target
2007-2008	5,50,000	5,59,672	93.66%	5,97,541	108.64%
2008-2009	7,14,000	6,58,696	96.59%	6,81,910	95.51%
2009-2010	7,14,000	7,20,028	98.39%	7,31,827	102.50%
2010-2011	7,14,000	7,57,124	98.60%	7,67,838	107.54%
2011-2012	7,14,000	6,59,385	98.86%	6,67,004	86.62%
2012 up to Oct	10,26,000	1,82,727	98.85%	1,84,849	18.01%

HARDOI

The details of target and achievements of cataract in Hardoi district are as under:

Year	Target year wise	Performance of cataract operations in Government Section		Performance of cataract operations by NGOs		Performance of cataract operations by private practitioners and others		Total cataract operations
		Target	Achievement	Target	Achievement	Target	Achievement	
2007-08	13884	-	1179	-	7546	-	273	8898
2008-09	13753	-	1923	-	2677	-	1167	5767
2009-10	13753	4126	1993	2750	4829	6877	2742	9564
2010-11	13753	4126	1987	2750	4563	6877	3691	10241
2011-12	13753	4126	2561	2750	1057	6877	4670	8288
2012-13	21033	6310	777	4206	298	10517	1025	2100

NPCB is implemented in all the facilities visited. Although, eye surgeons in rural areas not available but they are available at Sandila (FRU) and district hospital. No shortage of IOL reported. In schools, children are examined twice a year for Refractive errors as well as referral for cataract surgery. No record was found for the children examined but record was available with the Optometrist for the children given spectacles for refractive errors and cataract surgery.



JHANSI

IOL surgeries are conducted at the District Hospital and Medical College. Apart from an OT, there is a dedicated 22-bedded ward and a team of 4 Ophthalmic Surgeons in the District Hospital. The Eye Hospital at the Medical College has 3 surgeons and logistic support provided by the District Health Society (Blindness Control). Screening takes place in 8 PHCs/CHCs where Ophthalmic Assistants have been posted.

Year	Target year wise	Performance of cataract operations in Government Section		Performance of cataract operations by NGOs		Performance of cataract operations by private practitioners and others		Total cataract operations
		Number	%	Number	%	Number	%	
2005-06	10888	3130	28.75	1905	17.50	2867	26.33	7902
2006-07	8888	2690	30.27	1591	17.90	2841	31.96	7122
2007-08	8888	2565	28.86	1565	17.61	3105	34.93	7235
2008-09	8071	3897	48.28	1391	17.23	3193	39.56	8481
2009-10	8071	4619	57.23	1862	23.07	2946	36.50	9427
2010-11	8071	6261	77.57	1973	24.45	2710	33.58	10944

Note: Percentage against target per year

As part of School Health, vision testing is carried out in 10 schools and during 2012-13, 196 spectacles have been provided for refractive errors.

5. NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAMME (NIDDCP)

State level

- Iodised salt is in universal use. Test kits are not in use as they are not available for last two years. As per information by the state, State Laboratory is functional.

District level

IDDCP implementation was reported in districts.

6. NATIONAL LEPROSY ELIMINATION PROGRAM (NLEP)

State level

- A. No budget has been received from the GoI against approved budget for year 2012-13. 40 % of approved annual budget released to districts from unspent balance of FY 2011-12 at SHS. MDT drug stocks are adequate and available at all health facilities
- B. Staff is adequate at state and district level
- C. 5 Reconstructive Surgery Centers providing free of cost surgery to disabled leprosy affected persons at JALMA Institute, Agra, Medical College, Lucknow, TLM Hospital Naini, TLM Hospital Faizabad, BCM Hospital, Sitapur, Procurement of MCR footwear under process. Loss of wages compensation is paid to BPL patients

New Case Detection trends for last 5 years.

Sl.no.	Year	New cases	ANCDR per Lac Population
1	2007-2008	31,028	15.9
2	2008-2009	27,577	13.8
3	2009-2010	27,473	13.5
4	2010-2011	25,509	12.5
5	2011-2012	24,624	12.1

Treatment Completion rate

Rural		Urban		Total
PB	MB	PB	MB	
94.8	91.3	94.2	89.7	93.2

- a. 21 Districts have not achieved prevalence less than 1 per 10000 population: Gazipur, Kannuj, Fatehpur, Deoria, Maharajganj, Chandauli, Kaushambi, Barabanki, Lakhimpur Kheri, Amethi, Shrawasti, Hardoi, Badaun, Barielly, Sitapur, Shahjahanpur, Moradabad, JP Nagar, Pilibhit, Baharaich
- b. Status of grade I and II disability of new cases detected:
 - 2.43% grade I disability.
 - 2.52% grade II disability.

Hardoi

The disease prevalence rate in the district is 1.3. Certain posts are lying vacant since long time. ASHA is not active in NLEP programme in the district.

NLEP programme was being carried out in all the facilities visited above. All PB & MB cases were registered and given treatment as per norms. Rehabilitation measures are not reported anywhere.

Jhansi

The disease prevalence rate in the district is 0.63/10,000. The district NLEP Unit comprises of 1 Deputy DLO, 1 NMA and 2 PTTs. The post of DLO and 1 NMA needs to be filled.

The DHS (Leprosy Control) provides support (Facilitator & Logistics) to the Trust-Run Bundelkhand Kusht Ashram. The Netherland Leprosy Relief Foundation is also involved in the leprosy program in the district.

Due to lack of fund, ASHA payments have been delayed and the vehicle is not in a functional state, thereby affecting mobility of the team.

7. NON-COMMUNICABLE DISEASE CONTROL PROGRAM

- Data on the prevalence of NCD including Mental Health Programme is supposedly available at the state level but no data was provided.

8. INVOLVEMENT OF AYUSH DOCTORS

- AYUSH doctors are involved in National health programme activities and total 1061 male and 753 female AYUSH doctors have been appointed under mainstreaming of AYUSH in 2012-13.
- No involvement of AYUSH doctors in national health program for NCDs was noted in districts. Preventive and promotive services are in the primitive planning in the district.

9. GENETIC DISORDERS

Genetic Disorders screening facilities are available at SGPGI Lucknow. No such programme is started as on date at the district level.

10. SCHOOL EYE SCREENING PROGRAMME

School Eye Screening Programme is being undertaken for screening and free spectacles are provided to poor children for correction of vision.

School Eye Screening Programme is being undertaken in Hardoi district as reported in the facilities Sandila FRU, Shahbad CHC on six monthly basis. The data for providing spectacles is recorded in the registers available with the Optometrists as well as cases diagnosed and referred for cataract for the needy.

RECOMMENDATIONS

1. Vacant Posts of Microbiologists, epidemiologist, Data Mangers and Data entry operators to be filled on priority.
2. HR to be strengthened in districts which are not reporting (Ambedkar Nagar, Baghpat, Jaunpur, Chhatrapati Sahuji Maharaj Nagar, Rampur & Gautam Buddha Nagar) due to human resource shortage
3. Trainings to paramedical/Medical staff responsible for reporting from PHC/CHC/Medical College etc. to be conducted.
4. Payment of incentives to ASHAs for national disease control programme, which has not been released, may be expedited.

TOR-VI: Community Processes: Including ASHA, PRI, VHSC, CBM and NGO

There are PRI representatives in the VHSNCs, RKS and District Health societies. However they have not been found to be actively involved in the functioning of these bodies. The Pradhan, who is an elected PRI member, is the president of the VHSNC and joint account holder with the concerned ANM. The elected members of the Gram Sabha are members of the VHSNC. Both the Governing body and Executive body of the RKS have PRI representatives. The Chairman of the Zila Parishad is the Chairperson of the District Health Mission and the District Health Society also has local PRI members. While the PRI representatives generally attend VHSNC meetings, their participation in RKS is poor.

A total of 51914 VHSNCs have been constituted in the state against 52002 Gram Panchayats. However, not all VHSNCs have bank account and the coverage is 99%. The VHSNCs funds are generally used for cleaning drains, sprinkling lime, purchase of Dari for conducting community awareness, purchase of mosquito spray, bleaching powder and chlorine tablets. Two days awareness training of about 30% of the VHSNC members was conducted in 2008-09 and 2009-10. However thereafter no trainings has been conducted. Till 2011, Tehsil level Pradhan Sammelans were also held which forum was utilized to spread awareness of function of VHSNCs and utilisation of funds. In the current year, the State intends to hold a one day training of 6 members each from each VHSNC along with the Pradhan at the Naya Panchayat level to build capacities for preparing of need based village Health Plan. This would be organized by SIFSA.

About 136094 ASHAs have been selected against the target of 136174 of which 122525 are active ASHAs. About 129150 ASHAs (95%) have been trained upto Module-4 and about 121580 (89%) ASHAs have been trained upto Module 5. As on date 3000 new ASHAs have been selected against 6000 ASHAs that had dropped out and are to be trained. Districts and State level observers prepare the ASHA training plan/ calendar and monitors are engaged to monitor the training quality. However, training of personnel is one weak area for the state and needs to be scaled up

The payment to ASHA is electronically transferred in their account and the payment is made based on the voucher filled by the ASHA and verified by the concerned ANM and the Block Program manager. There is no separate ASHA grievance redressal mechanism and the concerned ANM is responsible at the cluster level for addressing the grievance of the ASHA. The Health Education Officer and the Medical Officer in charge of the concerned block at the Block level, ACOMO-RCH at the district level and Family Welfare Directorate beyond the district level addresses the complaints/grievances. No specific rest rooms ASHA rest rooms have been constructed though attendant's rest houses have been constructed at few places and these are open for use by ASHAs. ASHA database has been prepared for 62 of the 75 districts and uploaded on the state NRHM website. Regular updation of the database has been started. There is no ASHA Resource Center. However a team of three professional consultants from NHSRC is providing support to the State. An ASHA Mentoring Group has been constituted at the State level and district levels. The state level AMG meets quarterly and discusses feedback received from District AMG meetings. 62 of 75 districts have District Community mobilizers. However there are no ASHA facilitators. The State has planned to select ASHA

facilitators in a phased manner and is in the process of selecting ASHA facilitators in 17 selected districts in the first phase. Community monitoring programmes have not been implemented.

1101 VHSNCs and 437 VHSNCs have been constituted in Hardoi and Jhansi respectively with joint bank accounts and ASHAs as conveners/member Secretary of the Committee. In Jhansi, during 2010-11, PRI members of the VHSNC were trained but since then Pradhans have changed, there is a necessity for continued training programs. In Hardoi, in Suthena village and Saank villages, the PRI members of the VHSNCs claimed not to have received any training. In addition, the VHSNCs had not received any funds last year and hence, no activities were being undertaken. In Suthena village, activities such as bleaching of well, cleanliness drives, payment of fare for poor patients for transport from home to facility were undertaken with the balance amount lying in account. The community members of Saank Village, which incidentally had been awarded Presidential award for Nirmal Gram in 2011-12, were unaware of the existence of VHSNCs though they were aware of the Shiksha Committee. It was ascertained from the Anganwadi worker that this may be because the village community members were not associated or consulted in health matters. The change in nomenclature (addition of Nutrition) has resulted in difficulty in withdrawal of funds and management of bank accounts. VHSNC meetings were being held and minutes of meeting are being maintained.

After directives from the state, the RKS are functional only at the block PHC/CHC level. Funds for all the PHCs are managed at 10 block levels (8 blocks + 1 D.H. + 1 Maternal Hospital). The concept of decentralized funding remains defeated and large amounts of unspent balance accumulate. The peripheral PHCs send their requirements to the respective blocks, which are then supplied to them. In all the facilities visited in Hardoi, the process of renewal of registration of RKS was under process. In Hardoi, the PRI representatives generally attend the VHSNC and RKS meetings though their involvement in RKS is not wholehearted.

ASHAs were the most visible face of NRHM. ASHA is the Convener/Member Secretary of the VHSNCs. She proposes dates for meetings, organizes the meetings, and maintains the meeting minutes register. The activities of ASHAs primarily focused on maternal and childcare, sanitation & hygiene and immunization. The main tasks performed by ASHA include those under JSY, Polio Campaigns, and RI. ASHA database is available in both the districts.

JHANSI: Out of a total of 1230 ASHAs, 1204 are in place, including 86 newly selected ASHAs. 1165 have been trained up to Module 4 and 1074 in Module 5. 1072 have been trained in Comprehensive Child Survival Program (CCSP).

Blocks	Target	In Position 2008	Training			In Position 2012	Untrained		
			1,2,3,4 Module	CCSP Training	5th Module		Dropout/left	New Selected	In Process
Badagaon	162	151	151	150	146	149	2	11	2
Chirgaon	140	136	136	119	119	121	15	19	0
Moth	169	161	161	155	150	150	11	15	4

Gursarai	159	150	150	146	146	150	0	0	9
Bamaur	143	142	142	131	131	136	6	7	0
Mauranipur	154	138	138	134	137	138	0	13	3
Bangra	152	144	144	137	132	139	5	5	8
Babina	151	143	143	100	115	135	8	16	0
Urban	0	0	0	0	0	0	0	0	0
Total	1230	1165	1165	1072	1076	1118	47	86	26

HARDOI: 2865 ASHAs were selected of which 2608 are in position (-257). 2747 ASHAs have been trained upto 4th Module and 2608 ASHAs have been trained upto 5th Module.

Block	Target	In Position 2008	Training			In Position 2012	Untrained		
			1,2,3,4 Module	CCSP Training	5th Module		Dropout/left	New Selected	In Process
Bawan	180	180	169	0	138	138	42	0	42
Ahirori	175	175	170	0	170	170	5	0	5
Tadiyawan	120	120	117	0	112	112	8	3	5
Hariyawan	171	171	162	0	143	143	28	11	17
Sursa	200	200	197	0	196	193	7	7	0
Bilgram	150	150	143	0	135	135	15	10	5
Sandi	150	150	130	0	130	130	20	16	4
Madhoganj	150	150	146	0	145	145	5	0	5
Mallawan	150	150	146	0	132	132	18	10	8
Sahabad	160	160	154	0	147	147	13	0	13
Toderpur	103	103	103	0	99	99	4	0	4
Pihani	176	176	176	0	163	163	13	0	13
Kothawan	120	120	115	0	109	109	11	0	11
Sandila	150	150	142	0	142	142	8	8	0
Kachuna	120	120	111	0	105	105	15	0	15
Behander	170	170	164	0	151	151	19	5	14
Bharawan	120	120	114	0	110	110	10	0	10
Harpalpur	150	150	144	0	144	144	6	6	0
Bharkhani	150	150	144	0	137	137	13	0	13
Total	2865	2865	2747	0	2608	2605	260	76	184

No trainings have been conducted on Module 6 & 7 for ASHAs in either of the districts. There is no training institution for ASHA training and their trainings are generally conducted at block/PHC level.

ASHAs met during the field visits were vibrant, knowledgeable and very enthusiastic about their work. They have been contributing largely towards the RCH program only and were found reluctant to work for the disease programs due to delayed payments. During a focus group discussion held with some ASHAs at CHC Kacchuna, the team was told that being ASHAs gave them an identity, a sense of importance, some degree of economic independence and confidence to speak at any forum. More importantly, they acknowledged the impact of being an ASHA in their personal lives stating that they were adopting hygienic practices in their houses, sending their children to school etc. Discussion with the ASHAs at *CHC Bangra* and *CHC Kacchuna* revealed that, on an average they get honorariums ranging from Rs. 1,000 to 4,500 per month, depending upon their population coverage, which ranges from 700 to 3,000. The honorariums are deposited in their account by online transfer. However, no non-monetary incentives were being given to ASHAs. In fact ASHAs were not provided with mobile phones and were using personal phones. Rest Rooms have been set up in 16 delivery points in Jhansi but in Hardoi, except for the two facilities, no facilities were providing ASHA rest rooms. Even the ASHA restrooms in the two facilities were not functional. However, blankets were being provided to ASHAs and they were using the patient beds in facilities, which had vacant beds. The common refrain of the ASHAs was for a consolidated payment instead of programme wise payment, refresher training course for ASHAs rather than reading material and also the desire of a uniform, which they feel will provide them with more “PEHCHAAN”.



The drug kits have not been replenished since they first received it upon selection as ASHA. No HBNC kits have also been provided. Communication Kits were also not available with ASHAs. However, ASHAS had been given ORS and zinc tablets.

Both the districts had an ASHA Mentoring Group consisting of BDO and BSA as members. It acts as a form of grievance redressal mechanism, wherein they give recommendations based on the ASHA’s grievance to the District Health Society. The ASHA Mentoring Group meets on a quarterly basis. However, there is no ASHA grievance redressal forum. In fact, apart from the

ASHA Mentoring Group, there is no support structure for the ASHA in the district. Only the position of District Community Mobilizer (DCM) has been filled and there are neither ASHA Facilitators nor any support at the Block level. The DCM is saddled with many other tasks. Further, there is no formal mechanism of performance monitoring system /performance assessment of ASHAs. Their performance is judged from the payment pattern as reflected in the Master Payment Register, maintained at the Block Level which incidentally is also used for giving of awards to best performing ASHAs. The State hopes to implement the ten indicators based ASHA performance monitoring system from the next financial year.

ASHAs are selected by the VHSNCs based on interviews conducted. Upon selection, the candidates are referred to the block CHC/PHC for formal designation as ASHA for the particular area/village.

Community involvement in the health programs was found to be non-existent. No *Jan Sunwais* or *Jan Samvad* have been held. The only semblance of community-based involvement was through the *Tehsil Diwas* held at Tehsil level on a monthly basis by the SDM. In this forum the community gets an opportunity to air their grievances on any matter pertaining to any department, including Health and get them addressed. Representatives of all departments and the community attend this and the issues raised therein by the community are being followed up by action taken reports. This is not only a good forum for community monitoring but also a good illustration of sectoral convergence.

The districts have not contracted with any NGOs. However, there are some NGOs that are working on their own such as Manthan, PATH, etc.

RECOMMENDATIONS:

1. ASHA drug kits must be replenished regularly.
2. ASHAs must be selected at the earliest for those villages which do not have an ASHA
3. ASHAs training module should have a refresher course of two to three days to hone their knowledge and skills
4. Training of PRI members is recommended for building a robust community based monitoring
5. Community involvement in planning, implementation and monitoring needs to be encouraged

TOR-VII: Promotive Health Care, Action of Social Determinants and Equity Concerns

There are VHSNCs and ASHAs in every village visited by the team in the district of Jhansi. These VHSNCs are of 10 members comprising at least one member from OBC, one member from SC/ST and a woman member and headed by Pradhan of the village. As such it appears that the services might well be within the reach of marginalized section with the inclusion / representation of members of such sections in VHSNC.

There is only one Nutrition Rehabilitation Center (NRC) located at Medical College, Jhansi. It treats Severely and Malnutrition (SAM) cases. But these cases come through OPD of the Medical College and not as referred cases through Sub Centers, PHCs CHCs etc. There is complete lack of follow up action of these cases.

The team assessed the activities undertaken by the VHSNCs and it was found that the committees were part of water sanitation, scavenging litter and mud out of village, filling pits with soil to avoid water logging, sprinkling DDT powder etc as and when the need arise. VHSNCs have been facing a problem of not fully utilizing the funds allocated to them and substantial amount of money remaining unutilized. It was observed that the co-ordinations of the committees with PRI were minimal. Better co-ordination needs to be ensured for better functioning of the committees. It was observed the funds are not being transferred to the accounts of the VHSNCs in the district due to new nomenclature of the committee as VHSNC instead of VHSC following inclusion of nutrition component. The funds for these Committees under NRHM is transferred through drafts drawn in the new name of the committee, while Committee still hold account in old name (VHSC) with the Banks. An immediate necessary action is required to be taken at the district level to remove this technical problem to ensure further fund transfer.

There is a District Advisory Committee in place under DM, Jhansi. The meeting is generally convened on bimonthly basis to take up issues related to PC-PNDT act 1994. A total of 54 Ultra Sound Clinics are registered in the district, however, only 45-50 clinics send monthly reports along with F- form submitted to the district. On an average, the CMO office receives 250-300 F-forms every month. It was observed that these F- forms submitted by the clinics are not scrutinized properly as some of the forms do not have the mention of date of LMP..

Civil registration - birth and death rate is streamlined in rural area on account of timely cooperation of ANMs at sub center level and good coordination between and Panchayat-Secretary and Nagar Panchayat office. However efforts are required to ensure timely reporting in the urban area by the municipal corporation.

District Vigilance and Monitoring Committees (DVMC) were constituted in March 2012 under chairmanship of the Member of Parliament of the constituency. MLA, President of District Panchayat and District Magistrate are members of the committee. But the Committee has not met so far.

School Health Program has not been implemented in the district. Even the team for the SHP is not yet formed for the district. Efforts of State Government under the mission are on for nominating Nodal Officers in the Districts for Ashirwad - Bal Swasthya Guaranty Yojana

during 2012-13 for all school children under 2-18 years of age in rural areas for Health Examination.

Implementation of PC-PNDT Act

Hardoi shows a low sex ratio across all age groups including sex ratio at birth. A total of 25 centers are registered under the Act. Of these two are public health facilities: the DH and DWH Hardoi. Of these DWH machine is non-functional presently due to absence of a radiologist. District level Committee has been constituted and meetings are held. Inspection reports are also available on record. One to one discussion with the doctors did not elicit any definite response regarding the reasons for low sex ratio at birth (856, Census 2011) and in age group 0-6 years (863, census 2011). Apparently the doctors believe that Ultrasound clinics are not resorting to sex determination or sex selective abortions in Hardoi district. However, clients' accessing these services in neighbouring districts was not ruled out. It was however accepted that the social status of women was low in the feudal set up of the local society/community and reproductive decision making rested with the male partners/husbands.

District Advisory Committee has been found formed under District Magistrate in the District of Jhansi. The meeting is generally convened on bimonthly basis to take up issues related to PC-PNDT act 1994. A total of 54 Ultra Sound Clinics are registered in the district, however, only 45-50 clinics send monthly reports along with F- form submitted to the district. On an average, the CMO office receives 250-300 F-forms every month. It was observed that these F-forms submitted by the clinics are not scrutinized properly as some of the forms do not have mention LMP date

TOR-VIII: Programme Management including logistics and issues of integration and institutional capacity

The structure of the SPMU in the State is being strengthened and this year 18 new cells have been formed and recruitments are going on:

1. Admin/HR/DAP & Legal Cell under AMD
2. Construction cell Under Mission Director
3. Maternal Health cell under G.M-MH
4. Child Health cell under G.M-Child Health,
5. School Health and Adolescent Health Cell Under GM-SHP/ARSH
6. Routine Immunization Cell Under GM-RI
7. MMU and Urban Health Cell Under GM-Urban
8. MIS and MCTS Cell Under GM-MIS
9. National Disease Control Programme Cell Under GM-NP
10. Monitoring and Evaluation cell for quality assurance Under MD, NRHM,
11. Planning Cell Under GM-Planning,
12. Family Planning Cell under GM-Family Planning,
13. AYUSH Cell under GM-AYUSH,
14. EMTS (108)/Ambulance service (102) under AMD
15. Procurement Cell (Logistics, Printing, Services) under AMD
16. IEC Cell under MD ,
17. Community Process Cell under GM-CP
18. Finance Cell at SPMU under Finance Controller

Most of the positions of GMs of the above cells have been filled up through 'on deputation' appointments. The vacant posts have been advertised in the newspapers.

District Programme Management Unit (DPMU): There are large-scale vacancies in the District Program Management Units.

Designation	Sanctioned	In-Position	Vacancies
Divisional PM	18	16	02
DPM	75	52	23
DAM	75	43	32
DDAA	75	47	28
DCM	75	60	15

Overall, there are 100 vacant posts in DPMUs all across the state

Block Programme Management Unit (BPMU) - At BPMUs there are 527 Block Programme Managers/HEOs in position and 293 are vacant and 745 BDAAAs are in position and 75 are vacant. The State is contemplating to rope in NHSRC, New Delhi for recruitment of the vacant positions of DPMUs.

It is noteworthy that the most of the vacancies at DPMUs are there since 2008 when the initial appointments were done however some of them have resulted due to resignations. The vacancies in the DPMUs and BPMUs in the State cannot be attributed only to the High Focus districts. The attrition rate in the Programme Management Units is not high, the high vacancies have been due to inability of the State to have efficient recruitment mechanism in place.

The State Finance Controller posted on Deputation in the SPMU primarily does the financial management at the State level. There are 4 Finance Managers at the SPMU who take care of the finances and accounts.

District Observations

There is a team for preparation of district programme implementation plan consisting of Chief Medical Officer, Deputy CMO, Divisional Programme Manager, District Immunization Officer and Programme Officers of NDCP. However, in actual practice DPMU staff, wherever available is saddled with entire preparatory responsibilities.

In Hardoi District, Block MO/IC or Supdt. holds monthly meetings with DPMU staff however the DPMU in the district Hardoi consists of only District Community Mobilizer (DCM) and One Data cum Accounts Assistant..

The HR policy regarding career development of the NRHM staff is lacking in the State. The job description and TORs of different levels of programme management units need to be clearly spelt out. The performance Appraisal of the DPMU staff is being done in the prescribed format provided by the SPMU. However, there are no provisions of performance-based incentives for the NRHM staff.

General Managers are in-charge of thematic areas such as Planning, Community Processes, and Administration etc at the State level. DPMU staff approach these officers for guidance, whenever required.

The DPMU conducts monitoring and supervisory visits and provides feedback to the Chief Medical Officer (CMO), Divisional Programme Managers and Programme officers. Monitoring and supervision plan was available in the district, however documents stating compliance were not available. The DPMU monitors activities of BPMUs and provides necessary guidance. In both Jhansi & Hardoi district, the DPMU is severely understaffed, with only the DCM handling all the activities, which significantly affects the community processes in the district. Likewise, the post of District Accounts Manager is also vacant leading to District Data cum Accounts Assistant filling the gap. The effect of such a situation on the accounts management of NRHM funds can be well understood.

The Block Programme management is functioning under the Health Education Officers (HEO) and supported by Block Data Assistant (BDA). Out of 19 posts of BDA, 15 are in position. In the district Hardoi, the accounts management is being done by the district data cum accounts assistant since the post of district accounts manager is vacant.

The NRHM implementation activities are primarily looked after CMO, Programme Officers and MO-I/C of the facilities; DPMU staff supports these activities. All the financial powers lie with the CMO & Programme Officer at district and MO-I/C & Supdt. at Block level.

Mechanism of drug and equipment procurement

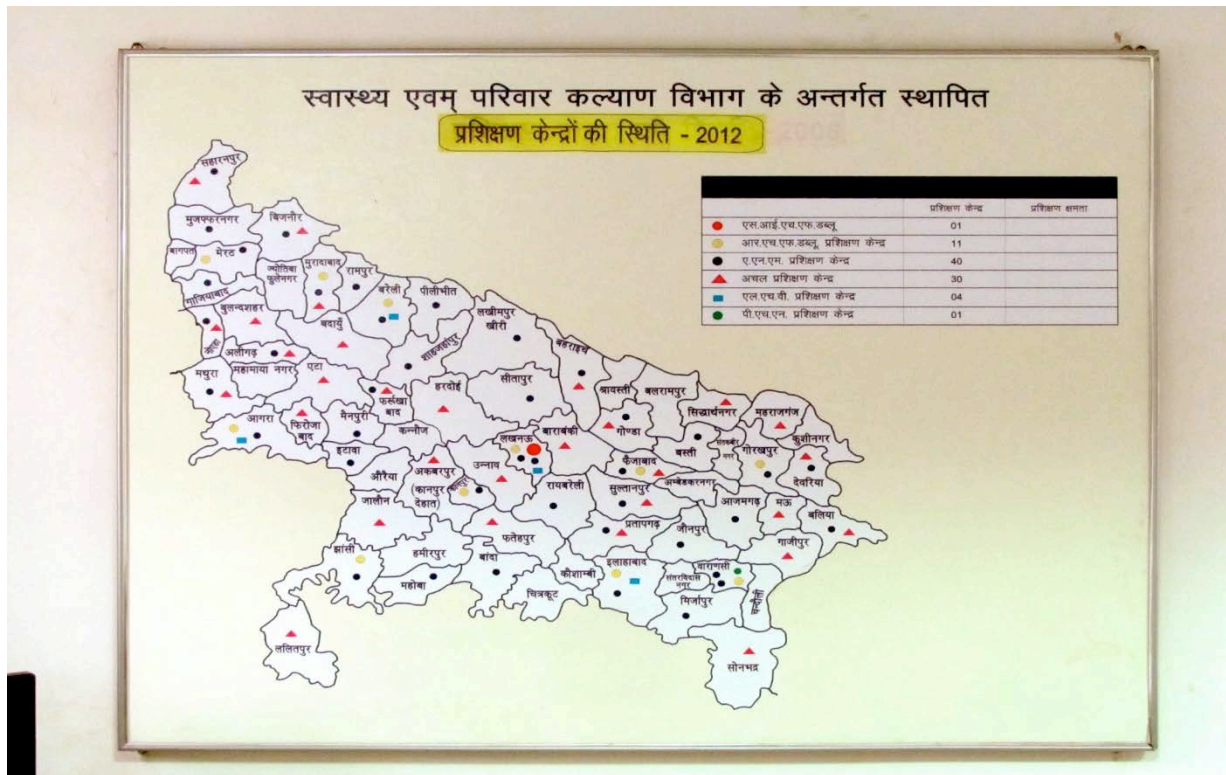
At district Level, there is a procurement committee consisting of CMO, CMS of male & female hospitals and SMO stores.

At district level, the process involves gathering demand generation from all the facilities in the district. The facility wise demand is based on the OPD and IPD caseload. Demand is raised from the facilities in a fixed format. The transportation of drugs to the facilities is the responsibility of the respective facility. The SMO store provides drugs to the facilities as per the Stock availability in the district store.

The inventory management system at district level is paper based and no computerised system at district and facility level is present. ProMIS implementation was not seen in any of the facilities visited.

At the State level, the estimation of quantity of drugs is being done on a normative basis set for each level of facility. Rate Contract (RC) for different types of drugs is fixed by the State and the district level procurement of drugs is done on that basis.

TOR-IX: Knowledge Management: Including technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology.



A. LEADERSHIP OF SIHFW IN TRAININGS

SIHFW is providing technical support in preparation of PIP in comprehensive training plan of allotted trainings. Preliminary needs assessments of district level officers were conducted on the basis of feedback during training sessions and analysis of their job chart.

Pre and post training assessments are done for long duration trainings. SIHFW works in several state level policy initiatives like establishment of IEC bureau, population policy, training policy of medical and health department, streamlining work in different training institutes of the department.

45 double-seated rooms are available in SIHFW. Renovation work of these rooms is under way through NRHM budget. 27 rooms are under construction.

In 2011-2012, SIHFW conducted training of Medical Officers in Medico-legal aspects. Also, it supported TOT on Health Care Waste Management.

Gap: SIFHW, RIHFW, NRHM Directorate/ Health and Medical Directorate conduct different kinds of trainings independent of each other.

Solution: Need for a "training agenda" for the State with a training in integration governed by SIHFW, RIHFW, GM - NRHM, Directorate of Health and Medical

B. INFRASTRUCTURE FOR TRAINING

Gap: One SIHFW, 11 RIHFM, 40 ANM training Schools available. SIHFW and RIHFW are utilized; ANM training Schools are less utilized and not all 40 are functional; District Training infrastructure not available, No residential facilities available except at SIHFW. There is vacancy of 9 out of 15 sanctioned faculties in SIHFW.

Solution: Completion of work of Physical facilities at SIHFW, Lucknow; Up gradation of ANM training Schools as per IPHS standards District Training centers could be a worth the consideration; need to fill 9 faculty positions at SIHFW and other staff.

C. MONITORING AND EVALUATION

Status of Progress of training: Trainings under NRHM are mostly incomplete in spite of the load reflected for completion in quarter II.

Action recommended:

State should take adequate steps for speeding up the remaining load for completion of trainings and innovating to enhance the training capacity as State is already facing crunch due to some unsaid difficulties.

D. SIHFW AND PARTNERSHIP

SIHFW /Directorate/NRHM has/had partnerships with project driven trainings - UNICEF, WHO, Manthan70, Intra health, The PATH, etc Partnerships exist with Medical Colleges for Clinical Training although developmental partners could be utilized at very limited places and partner's landscape mapping is lacking.

E. SHSRC

State Public Health Resource Institute proposed and Rupees 2 Crore has been sanctioned.

Gap: Awaiting take off, proposed to be anchored under SIHFW.

Solution: HR recruitment, procurement of equipment and other necessary gadgets etc. SIHFW seeks the support of a resource group/agency to initiate development of the Institute. A detailed proposal is already in place and it is useful to consider support of NSHRC/NIHFW/PHFI. If MPH course is started, 25/25/25 programme staff can be trained and human resource on public health built in three years time. The course can also be fine tuned to have one year field training in NRHM itself so that absence of personnel can be minimized to one year.

F. RESEARCH AND EVALUATION, INNOVATION

- SIHFW has brought out various resource materials on Primary Health Care Issues worth the commendation
- Area of research; involvement in evaluation needs to be taken as a focus agenda.
- SIHFW completed a study to find out reasons related to dropout s of medical officers of Government jobs. A study related to FRUs is under process.
- SIHF has contributed in a large way - publications in the area of Public Health including NRHM activities.

- ASHA sammelan are being held.
- Village level disaster preparedness and mitigation programmes are being held with the help of State Disaster management committee. State Innovations in Family Planning Services Agency is to provide technical support.
- Saas Bahu Sammelan initiated from Andhra is continued hence onwards.
- Gram Pradhan Sammelan also started since last year.

G. TRAINING AND SKILL DEVELOPMENT OF HEALTH SYSTEM MANAGERS

- Medical and paramedical staff is being trained continuously.
- SHSSP - new project by World Bank has been initiated.

Epidemiologist, Data entry operator in position in most of the Districts

H. NON CLINICAL MANAGEMENT STAFF

Although there is an initiative impart training from time to time and new programmes are also introduced, but Training and Skill development of clerical staff has not received adequate attention. There are Project Management Units in all districts. In those Units - DPM-1, DCM-1, DAM-1 and DDAA-1 are in position from NRHM. They all are given training for Accounting, MCTS and HMIS.

There is opportunity to upgrade their computer, data entry and documentation skills

On the job training on Hospital waste management for ward boys regarding segregation at base level started and TOT at SIHFW for senior clinicians started.

I. GENERATION OF HMIS REPORTS:

Presently the monthly reports have been manually prepared for all the programmes and hard copies have been forwarded to the concerned officers at the district level. The data manager appointed at the district level uploads the programme wise aggregate in to the HMIS. All the districts in the State started reporting on HMIS portal since 2009. Data validation checking mechanism and monitoring and feedback mechanism was introduced in 2011-12 in UP however; districts are yet to initiate feedback system to the facilities based on the monthly reports submitted by the facilities. The data quality has improved since then and now validation errors/outliers are corrected at the level of districts itself. Monthly feedback is sent to districts by SPMU on reporting quality and discrepancies (if any) on the basis of data available on the portal, however, use of available data at the district level observed to be minimal across the programmes where the team visited.

Computers and internet connections were available in all the block level facilities (CHCs) where the data entry is done.

State has initiated shifting of monthly reporting to facility based reporting on HMIS and all the district officials were trained twice before March 2012. In the first phase, 18 districts were selected for facility based reporting and these districts started facility based reporting from

April 2012. However, only 10 districts have started uploading facility wise monthly reports on HMIS.

J. DATA QUALITY:

No check on the quality of the reports submitted by the facilities is done at the district and Block level. The monthly reports have been prepared by the facilities and CHCs by first week of every consecutive month and the same has been uploaded on HMIS. However completeness of the data is major area of concern. It has been observed that many indicators have been not reported at the district level on HMIS, especially the death reported in the field.

The team has observed that many of the registers such as Delivery register, stock registers etc are prepared manually by the staff in the facilities. This results in poor quality of monthly reports submitted by the facilities.

The State has not achieved the pace of implementation for the facility wise reporting. The field level functionaries are yet to be trained on HMIS formats. In Jhansi, district level training on HMIS has been completed only for the 5 data entry operators out of 8 appointed at the CHC level

The team has noticed that the use of data by the district and block level programme managers was minimal. The block and district level health managers need to ensure analysis and use of physical and financial reports for close monitoring of the programme.

K. MOTHER AND CHILD TRACKING SYSTEM

Online feeding on Mother Child Tracking System portal was initiated in UP in July 2011., however, data entry of only 45.7% pregnant women and 29.6% Children in MCTS is completed in the state. MCTS has been initiated in all the districts of UP. In Jhansi, district has shown a considerable improvement Mother and Child Tracking System (MCTS), 61% of the mothers and 41% of the children have registered on MCTCS as on October, 2012. The entries of the data entry are performed by the data entry operators appointed at the Block level. Work plans have been generated for the ASHAs and ANM and regular monitoring and updation is ensured through close monitoring necessary documentation system. The MCTS entry of the urban area is not initiated yet, district has to ensure that the entry is done through data entry operator.

Dedicated data entry operator for the MCTS needs to be made available at blocks. Appointment of data entry operator for MCTS for 820 blocks of UP is pending. It is being clarified that the operators are expected to appointed by December end..

Call center has been established at state level to check the correctness of beneficiaries data and districts have also nominated verifiers to do the same.

Recommendations

- Expansion of facility wise reporting on HMIS & MCTS, Online reporting of JSY payments, improvement of quality reporting etc are key priorities in the monitoring and evaluation programme in the State. Vacancies of required officers for the field are a matter of

concern. The State has to expedite the recruitment of the District Data and Account Assistants (DDAA) and Data Entry Operators in the block level.

- Training of field level functionaries to be completed
- Printed registers and reporting formats are required to ensure the quality of the reports submitted by the facilities. Necessary instructions need to be issued to ensure printed registers in the facilities.
- In order to improve the quality of the data, State has to ensure that HMIS/MCTS data is used for the performance review of the programmes. The feedback system from the State, district and Block level need strengthening and the same need to be monitored closely.
- Supervisory visits of the State, District officers to the facility were observed minimal, especially with regard to Monitoring and Evaluation activities in the State. Supervisory visits to be scheduled to the prioritized districts, blocks facilities by the concerned officers.
- Progress in the MCTS and HMIS should be a key indicator at the State and District level program reviews.

TOR-X: Financial Management

OBSERVATIONS:

Books of Accounts

- a) Books of accounts are being properly maintained
- b) The requisite records and registers are being except in DHS Jhansi where fixed assets/stock register was unavailable for review.
- c) At SHS level books of accounts are being maintained on double entry system
- d) The accounts are being maintained on cash basis

Status of Audit

- a) The statutory audit for the period 2011-2012 was pending as on October, 2012
- b) The concurrent auditors for year 2011-2012 were yet to be appointed as on October, 2012
- c) Actions based on the statutory audits of DHS for period 2010-2012 is yet to be initiated

Status of HR pertaining to Accounts in DHS

- a) The positions of DAMs were vacant both in DHS Jhansi and Cardio
- b) The position of DDAA was vacant in Jhansi
- c) No block level accountant to oversee financial transaction in Blocks
- d) It is observed that regular training to the staff dealing in accounts and finance are not being imparted

Status of Tally accounting software

- a) The Tally accounting software was operational both in SHS and DHS visited
- b) Block level implementation of tally is yet to be initiated

Operations of Bank Account

- a) The Bank accounts at the SHS and DHS are being operated jointly as per the NRHM guidelines except in Hardoi, where for the period Sept, 2011 to June, 2012 the DHS bank accounts were operated by CMO and F& A officer of Basic Sikhsha Adhikari , which is not as per the guidelines

Status of Income tax & legal compliances

- a) The SHS and DHS's are operating without income tax registration pertaining to exempt status under income tax act. 1961.
- b) No, Income tax return of the SHS and DHS's are being filed
- c) The SHS, DHS and RKS are registered under the relevant societies act and renewal of registration are being made, however the yearly compliance are not being made regularly

Status of Budgetary Planning

- a) The annual district budgets were not available
- b) Expenditure planning were based on the receipt of funds from the SHS, rather than annual activity planning leading to delay in the planning the activities.

Governance

- a) The SHS, DHS's and RKS's is properly constituted and registered
- b) Necessary committees are constituted
- c) The minutes of the meetings are properly recorded and maintained
- d) The frequency of the meetings and the attendance needs to be monitored for speeding up decision making process

Expenditure analysis (as on 31.10.2012) (Figures in lakhs)

SHS/DHS	Budgeted	Released + Available	Utilized	Percentage of released	Percentage of PIP
SHS					
RCH	120450.55	63279	17992.72	28	15
MFP	201869.19	91392	6065.55	7	3
Overall (30.09.2012)	419837.69	186775.89	78642.74	42	18.73
DHS - Jhansi					
RCH	N.A	961	240	25	
MFP	N.A	573	26	4	
Over all (31/10/2012) in	N.A	1760	388	22	
DHS - Hardoi					
RCH	N.A	1256	459	37	
MFP	N.A	558	23.3	4.2	
Overall (20/09/2012)	N.A	2076	570	27	

- a) The mission flexi pool part of the budget is being utilized at a very slow pace
- b) Over all utilization rate for the state in comparison to SPIP is approx. 19 % and based on release the utilization rate is around 42 %

Reporting

- a) The reports are compiled manually at the block level
- b) The reports being sent to SHS with some delay
- c) Advance details were available

RECOMMENDATIONS:

- a) The bank accounts should be operated through the mechanism provided under NRHM guidelines
- b) The positions for accounts at the district and block level should be filled up in a time bound manner
- c) The state should immediately undertake process of registration of SHS and DHS under income tax act
- d) Budgetary planning for expenditures should be made at the district and block level
- e) The observations made by statutory auditors in year 2010-2011 audits should be followed and any anomalies referred needs to be rectified

- f) All the compliance under societies registration act of UP should be done regularly in accordance with relevant provisions
- g) Regular training to the staff dealing with accounts needs to be imparted, a training calendar in this regard should be maintained
- h) DPMU needs to be strengthened by clearly defining the roles and responsibilities among the DPMU staffs and the district authorities. The low motivation of DPMU staff is observed; the vacancies at the level of DPM and DAM at both the districts of Hardoi and Jhansi might be an indicator of that. It is advisable that a formal HR policy and process be designed in this regard

